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Mentoring: A Personal Perspective From Academia and Industry

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Several very thoughtful articles on mentoring written for a GI audience have appeared in the Mentoring Education and Training (MET) Corner of *Gastroenterology* and elsewhere.[1–9] Rather than attempt to amplify or refine the excellent points made by these distinguished mentors, I have chosen to touch briefly on important lessons I learned as a GI training program director as well as several less frequently covered topics in mentoring that reflect my experience in academia and industry.

Lessons From an Experiment in Structured Mentoring

One of the most enjoyable and personally instructive experiences during my 6 years (1990-1996) as Division Chief at the University of California, San Francisco, was the restructuring of the training program. The senior faculty and I undertook the redesign with an eye toward addressing 2 issues:

1. Fledgling academics seeking a career in laboratory-based research must necessarily establish a mentee–mentor relationship with their laboratory supervisor. By contrast, the mentoring situation for our trainees interested in a clinically oriented research career seemed comparatively hit and miss.
2. Although blessed with exceptional trainees and outstanding clinical talent among the faculty, and perhaps owing at least in part to the emphasis on laboratory-based mentoring, our division was best known for turning out laboratory-based as opposed to clinical investigators.

Therefore, we made several major changes to our training program, including (a) requiring that each trainee, during their first year, select a faculty mentor and a research project, (b) establishing a clinical research track with a formal curriculum in addition to the basic research track with laboratory-based training, and (c) extending the training from 2 to 3 years (a change subsequently adopted by the American Board of Internal Medicine) to allow sufficient time for trainees to develop specialized clinical skills, for example, in transplant hepatology (later recognized by American Board of Internal Medicine as requiring special certification) and engage meaningfully in research.

This experiment in rigorously structured mentoring and training proved successful and taught us several valuable lessons.

- Initiating and sustaining a successful mentor–mentee relationship requires hard work on the part of both the prospective mentors and mentees and continuous monitoring of progress by the training program director and faculty. It should not be left to chance and is best institutionalized.
- Requiring each trainee to pick a laboratory or clinical research project early in their training catalyzed the mentee–mentor search and relationship by providing common focus and incentive.
- With respect to curriculum, there is no need to reinvent the wheel. Coursework, for example, in epidemiology, biostatistics, and ethical conduct of clinical research, is already in place in most major academic institutions. Taking advantage of them, however, does require establishing intra-institutional connections and configuring the training schedule appropriately such that trainees have the time to fully participate.
- Training is a powerful centripetal (cohesive) force. There are many areas in which faculty may disagree or pursue different agendas, but most concur that helping the next generation is a top priority. A structured program that institutionalizes the importance of mentee–mentor relationships can be leveraged to create

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an academic environment where the whole is greater than the sum of the parts.

- Mentees are often the best teachers. Dr Robert S. Brown, Jr., currently Frank Cardile Professor of Medicine and Medical Director of Transplantation at Columbia University College of Physicians & Surgeons in New York City, was one of our trainees and worked in my laboratory. During his training, Bob wrote a short piece on mentoring, which included Ten Commandments for mentors and mentees. It was so good that I have kept the original for over 20 years and reproduced with his permission the Ten Commandments (Table 1).

Tough Topics in Mentoring

Several important issues from the perspective not only of academia, which is the focus of most mentoring articles, but from the perspective of mentoring physicians involved primarily in the business side of medicine, are discussed herein.

Mentoring vs Coaching in Academia and Business

Mentors cannot be all things to their mentees; there are times when specific training or coaching may be required to teach a particular skill set. In contrast with the successful mentor–mentee relationship, which typically matures and evolves over years, coaching is temporary and may be as short as 1 or 2 sessions. However, recognizing the need for specialized coaching, as well as finding and hiring a coach to teach a specialized skill set, requires time and money. My experience has been that mentoring, perhaps because it is a natural extension of the student–teacher relationship, is better developed in academia than business; whereas, for coaching, the reverse is true. In addition, perhaps because there is more employee turnover in industry than in academia and less collegiality and/or information flow between companies than between academic institutions, the mentor–mentee relationship tends to be more durable in academia than in industry.

The need for specialized coaching, often in nonmedical areas, is particularly common for physicians entering the business of medicine, a broad category in which I include jobs involving health care delivery (eg, management of a health care provider network), financial services (eg, health care consulting, venture capital, financial analysts, or fund managers), and medical product development (eg, biotechnology/pharmaceutical or devices). Such physicians almost invariably confront job challenges for which they were not previously trained. Examples include budgeting, team management, and effective communication with investors or analysts.

The good news for physicians entering business is that the necessary financial and human resources are typically in place to make specialized coaching available. Moreover, some training, for example as required by US Food and Drug Administration or Securities and Exchange Commission compliance regulations is generally provided. The problem is that, although coaching and resources may be available, mentor–mentee discussions that would naturally trigger dialogue about the need for specialized coaching tend to be less well developed.

The situation for fledgling academic physicians is different. Because most of their activities are medically and/or scientifically oriented, there is less need for specialized "out-of-field" coaching, and mentor–mentee relationships are better developed. That is the good news. The bad news is that, when a legitimate need for specialized coaching arises (e,. presentation or communication skills, leadership skills), it is less often recognized and/or directly addressed and the necessary resources tend to be less readily available.

Table 1. Mentoring: The Ten Commandments

For the Mentor	For the Mentee
1. Be a role model	1. Take initiative
2. Be an advocate	2. Choose a role model
3. Be enthusiastic and encouraging	3. Find a niche
4. Critically evaluate projects and career goals	4. Look for compatible interests and communication styles
5. Encourage individuality and differentiation	5. Define your projects and role
6. Guidance not ownership	6. Think big
7. Focus, focus, focus	7. Focus on concepts and techniques as well as topics of study
8. Take the long view	8. Focus, focus, focus
9. Push the limits	9. Seek advice
10. Market your product	10. Shop around

NOTE. These 10 Commandments are based on unpublished work by R.S. Brown RS (personal communication, 1993).