Commentary

Mentor or tormentor? A commentary on the fractured role of mentoring in paramedicine

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Abstract

The relatively quick evolution of paramedicine and the inevitable 'growing pains' associated with an evolving profession has seen mentoring and the role of the mentor become clouded in confusion, ineffective education and a lack of specific research. Paramedicine's recent development as a registered profession has also seen mentoring explicitly outlined as being a capability expected of all registered paramedics. However, the paramedic-mentoring model in Australia seems to have been mostly left up to the individual paramedic to develop in isolation from adequate training and mentoring themselves. If paramedicine is to continue its evolution as a legitimate healthcare profession, the quality of clinical mentoring must be acknowledged as a significant factor by higher education institutions, and the public and private services who employ paramedics, and nurtured accordingly.

Keywords:

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Introduction

The concept of mentoring is not a new one, and has been widely researched in a range of clinical professions such as nursing and medicine (1-4). The relatively quick evolution of paramedicine and the inevitable 'growing pains' associated with this has seen mentoring and the role of the mentor in both jurisdictional ambulance services, and the private sector become clouded in confusion, ineffective education and a lack of specific research (5,6).

One of the key rationales for the recent inclusion of paramedics into the Australian Health Practitioner Regulation Agency (Ahpra) under the Paramedicine Board of Australia was to professionalise the role. The inclusion-conferred paramedicine as the fifteenth health profession registered under Ahpra and with it came professional responsibilities. As part of its regulatory functions the Paramedicine Board of Australia published the 'Professional capabilities for registered paramedics' document, which came into effect 1 June 2021. Domain 4 of this document explicitly outlines mentoring as being a professional capability expected of all registered paramedics. Yet a gap exists in mentoring education services and accredited paramedicine programs at every level. This is exacerbated by the recognised gap in the terminology itself as it relates directly to paramedicine and, consequently, a myriad of definitions for the term 'mentor' exists (7).

Additionally, the lack of clarity regarding definitions and the subsequent underdevelopment of mentoring in paramedicine has resulted in an often-haphazard implementation and poor results in the applied setting. Sibson & Mursell (8) concluded that while there is some recognition of the importance of effective mentoring in the paramedic-learning paradigm, the challenges of delivering high quality mentoring have meant that reliable and reproducible validity has not yet been widely achieved. This article aims to provide a timely discussion that suggests that the profession of paramedicine requires mentoring reform.

Discussion

The evolution of paramedicine from an industry-based education model to that of a higher education and professional registration model has resulted in a silo effect occurring between the 'teaching' and the 'doing' in the profession. Armitage & Burnard (9) investigated this presenting conflict and referred to it as the 'theory-practice gap'. Although more recent paramedic specific work by Clarke (10) saw both parallels and differences with previous health professions mentoring issues and reframed the paramedic specific issues the 'paramedic praxis'. Clarke (10) identified the issue as mentors not being educated to consider the developmental level of the mentee and facilitate their understanding of associated theory into the applied setting, rather than the classic 'gap' apparent in other professions.

One of the major obstacles in the development of quality

mentoring relationships in paramedicine is the mixing of the role of mentor, as a nurturing and trusted advisor who can offer advice, support and feedback in a formative manner, with that of a formal assessor (11). The assessor role varies significantly from that of a mentor and involves a more formalised, summative assessment of the mentee's ability, skills and knowledge (2). This creates a hierarchy of power, which in turn leads to a perception from both the student and graduate paramedic that they cannot and should not 'fail' in front of their mentor for fear of not passing the course or placement. This environment is restrictive to open, honest feedback and concurrent learning.

Traditionally the notion of a mentor is of someone with years of experience, however the duration of a paramedic's experience is not necessarily a criteria for good mentoring (10). Cameron et al (12) found that quality mentors are described by mentees as someone who they themselves seek to emulate, someone who creates a safe and nurturing learning environment, and someone who would act as an advocate. Peiser et al (13) identified that forging relationships and good communication were key to the mentor's supportive role to facilitate the transfer of knowledge.

Evidence suggests that qualified clinicians want to pass on their knowledge (2). Clinicians love to share, and paramedics are no different. However, the paramedic-mentoring model in Australia has evolved in a manner that often leads to individual paramedics developing in isolation from mentoring training and effective mentoring themselves. Here the theory practice gap widens, which begs the question: Who is mentoring the mentor? Who is supporting the mentor? Who is educating the mentor? These questions are critical to the very development and professionalisation of paramedicine. Jones et al (14) maintained that if paramedic mentors are a cornerstone of paramedicine development, they themselves require education, support and resources to achieve the tasks required of them.

Given the opportunity, the environment and the structures to provide guidance and support, mentoring moves from a perceived position of negativity to one that can promote positivity within the mentoring paramedic and mentee alike. This development has been identified in studies indicating the desire by student and graduate paramedics to be mentored in the development of 'non-technical skills', such as leadership, communication and conflict resolution (15). Moreover, mentees must also be made aware that mentoring is a difficult task that requires significant emotional and cognitive input from the mentor (16). In developing this understanding, mentees can give their mentors the space they need to perform their primary role as a professional healthcare worker and then have the time and energy to contribute constructive feedback and role modelling.

Conclusion

Acknowledgement that the position of a mentor as a required professional capability of a paramedic is critical. Importantly, educating mentees in the understanding of the

cognitive load required to mentor effectively requires open, honest conversations and realistic appropriate expectations. Furthermore, it is important to construct a system that rewards an intrinsic motivation to develop professionally. Conversely the notion of 'years spent in the profession' equaling a good mentor needs reform. The reality is that to develop quality mentors, education, support and resources to achieve the task must be prioritised.

If paramedicine is to continue its evolution as a legitimate healthcare profession, the quality of clinical mentoring must be acknowledged by educational institutions and employers as a significant factor and supported accordingly.

Competing interests

The authors declare no competing interests. Each author of this paper has completed the ICMJE conflict of interest statement.

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