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MENTORSHIP IN MEDICAL EDUCATION: A UKRAINIAN EXPERIENCE

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The article is dedicated to mentorship in Ukrainian medical education, viewing it as a historically rooted but insufficiently regulated part of medical training. The literature review shows significant role of medical mentorship in the world, within the professional and personal growth of the mentees. However, the article states that in Ukraine mentorship in medicine performs more formal roles than in world medical environment. The authors describe mentorship traditionally embedded in departmental apprenticeship and clinical learning, implemented today mainly as a voluntary, non-standardised practice rather than a curriculum duty. The authors analyse how mentoring in Ukraine is most often realised in clinical settings and through peer or near-peer support, frequently in hybrid formats, and largely dependent on local team rules and informal agreements. The basic constraints of medical mentorship lie in its "secondary" role related to clinical teaching, poor apprehension of mentor's roles, confusing teaching with mentoring by the mentors, and resulting under- or over-mentoring. The authors represent micro-mentoring, brief, regular, goal-oriented contacts, as the most feasible and practically effective mentoring style in contemporary Ukrainian conditions, especially under workload constraints and disrupted learning trajectories. The authors suggest a structured medical MENTOR model as an institutional framework that can be applied across medical educational institutions: mapping roles and risks, establishing expectations, narrowing goals, teaching feedback, organising regular contacts, and reinforcing professionalism. The authors conclude that Ukrainian medical education requires a clear national mentorship model supported by unified standards and measurable control criteria to ensure equity of access, consistency of mentoring quality, and, ultimately, improved outcomes of medical training.

Key words: mentorship, medical education, Ukraine, apprenticeship, peer mentoring, micro-mentoring, hybrid learning, professionalism.

Лимар Леся, Костюк Ірина, Демиденко Ярослава, Кефелі-Яновська Олена, Джалілова Ельвіра. Менторство в медичній освіті: український досвід

Стаття присвячена поняттю менторства в українській медичній освіті, яке розглядається як історично вкорінений, однак недостатньо врегульований компонент професійної підготовки лікарів. Огляд наукових джерел засвідчує вагому світову роль менторства в медицині як чинника професійного та особистісного зростання молодих лікарів. У статті наголошено, що в Україні медичне менторство нерідко виконує більш формалізовані функції порівняно зі світовим медичним освітнім середовищем. Автори описують менторство як традиційно інтегроване в університетську систему додипломної та післядипломної підготовки та власне в клінічне навчання, яке нині здебільшого реалізується як добровільна, не стандартизована практика, та не представляє чітко визначений елемент освітньої програми. Визначено, що менторства в Україні найчастіше здійснюється у клінічних умовах і через підтримку з боку ровесників або менторів з рівних (near-peer), нерідко у гібридних форматах, та значною мірою залежить від локальних правил роботи педагогічної чи медичної команди й неформальних домовленостей. Основні обмеження менторства в медицині пов'язані з його «вторинною» роллю щодо клінічного викладання, недостатнім усвідомленням наставниками власних функцій, підміною менторства власне навчанням, а також із наслідками у вигляді недостатнього або, навпаки, надмірного менторського супроводу. Автори представляють мікроменторство, короткі, регулярні, цілеспрямовані контакти, як найбільш реалістичний і ефективний стиль менторства в сучасних українських умовах, особливо за наявності військового стану. Запропоновано структуровану медичну модель MENTOR як основу, придатну для впровадження в закладах медичної освіти: визначення ролей і ризиків; узгодження очікувань; концентрація цілей; навчання зворотного зв'язку; організація регулярних контактів; зміцнення професіоналізму. Підсумовано, що українська медична освіта потребує чіткої національної моделі менторства, підкріпленої уніфікованими стандартами та вимірюваними критеріями контролю якості, аби забезпечити рівний доступ, узгодженість його якості та, зрештою, кращі результати підготовки медичних фахівців.

Ключові слова: менторство, медична освіта, додипломна та післядипломна медична підготовка, гібридне навчання, професіоналізм.

Relevance. Mentorship overall is associated with improved educational trajectories, professional socialisation, improved productivity, and career satisfaction, in healthcare particularly. The official notion of mentorship in medical Ukrainian education is relatively new, though it has existed for many years informally. In practice it is unequally distributed, vulnerable to workload, depending on the personal will of the tutors and senior physicians. The position of the mentor remains undefines in Ukrainian educational environment, while that one of a teacher corresponds to certain requirements. The medical education in Ukraine, particularly after the war onset, has suffered stressful and disrupted educational routines, intermittent physical access to clinical settings, and other challenges related to wartime. Under such conditions, the medical students and interns lose their motivation, and a sense of professional belonging, experience professional burnout and often drop from the study and profession. This requires for the mental and professional support of a mentor, who is more like a supporting figure for the students than a mechanical tutor. In Ukraine, mentorship was embedded in some clinical and educational departments as a part of their culture and history. However, its role remains undefined and often neglected. What the Ukrainian educational system needs of a transition from the tradition and a goodwill of some senior tutors and clinicians to a designed practice with defined rules.

Objective: To analyse the description of mentorship in Ukraine and define its characteristics, to propose authors' own model and framework for the mentoring implementation in medical undergraduate and postgraduate education.

Methods: conceptual theoretical literature review, contextual mapping, generalization and concluding. Formal ethical approval is not applicable to the study. The limitations of the study may include potential selection bias of narrative synthesis. The proposed model should be piloted and evaluated in practice. In the article, AI Napkin was used to generate the graphs.

Review. Mentorship in medical education is recognized by most authors as an educational and professional relationship which is characterised by guidance, psychological support, and professional socialisation [1]. There are two notions: the mentorship and clinical supervision, where clinical supervision is related to securing the treatment process, and mentorship is guiding a young specialist through his pathway. In Ukraine both models are relatively new, without distinct regulation. The peculiarities of mentorship include several issues: mentors support planning, treatment strategy choice and reflections of the supervised doctors; mentors should model standards and give feedback all the time; mentors should help their learners foster professional standards; mentors support the young doctor at all his steps in medicine [2], [3]. Another important function of a mentor is to support the trainee in his personal growth and on career development path [4]. So, a mentor is not a tutor, or supervisor, his role is much broader in medicine. Traditional medical mentorship typically involves face-to-face relations between men-

tors and physicians, with longitudinal engagement and under personalized guidance. Ventimiglia et al.'s systematic review examines mentoring in hospital settings, where the authors state that "support from a senior colleague positively impact junior healthcare workers" [5]. The studies demonstrate the potential of digital mentorship models which help overcome georgraphical barriers [6]. The prerequisite for mentorship is a trusting atmosphere, where young specialists can admit their mistakes without punishment; clarity of standard and shared goal [7]. Thus, medical mentorship should be based on behaviour-specific feedback and discussions of each step of actions. In cases, where the traditional guidance is too conservative and authoritative, informal peer mentoring becomes a saving solution in medicine [8]. Another significant issue is the trauma-informed communication of a mentor with the physician, particularly under the crisis conditions, like during the war in Ukraine. Stratton-Maher et al. describe how students often feel "underprepared, overwhelmed, and emotionally vulnerable" when transitioning to clinical practice [9]. In Ukraine, the system of mentorship is particularly needed, though it is being informally introduced. However, positive effect of mentorship, or observership, as a type of postgraduate medical education is evident [10], [11].

Discussion. Traditionally, medical mentorship (or its components, as the medical mentorship has been regulated as a teachers' supervision, seniors supervision and consulting by more proficient specialists, the last ones often adopted on personal initiative or by the so-called unspoken rules) integrates teaching in departments and clinics, teaching and guiding medical students and interns in research societies, and further supervision of practice. Academic medical mentorship is closer to tutoring, including teaching students the curriculum and preparing them for examinations. In Ukraine it occurs in departments, both theoretical and clinical, via interaction with teachers, which is often more assessing than supporting. Medical teachers often depend on the curriculum requirements, aiming to prepare students for the state examinations, and the pathway support is often considered non-essential component of such interaction. The clinical mentorship (during practice and postgraduate education) is anchored in bedside learning and rotation supervision, while, under the stressful conditions of war and physicians' overload, it is also appointed a secondary role. However, the supervision of postgraduate medical interns is more definitely pronounced, with two basic drawbacks: either the under-supervision is observed (due to unclear mentor role, absence of state regulation, etc.), or over-supervision, authoritative mentorship, while the tutors do not allow freedom to the younger colleagues in their search. The possible solution of this may be gradual introduction of micro-mentoring around small cases, and official regulation of the mentors' roles by the educational and medical institution. The other direction of peer mentoring is also voluntary one, depending on the atmosphere and rules in the working students' or medical team. A senior peer can share learning strategies, guide the colleague in his working activities, and share his personal experience. Such interventions prove to be effective, although they are sometimes of inconsistent quality due to low teaching experience of peer mentors, that's why we consider necessary the program of peer mentoring to be introduced into the medical curriculum. Also, the boundaries of such peer mentoring between advising and mentoring are unclear, so we recommend institutional regulation of it.

Another direction is the research and leadership mentorship of medical students during their undergraduate education, i.e., participation in research societies, students' self-government and other organizations. Usually such supervision includes methodology, ethics approval, academic and professional communication literacy, self-growth tasks. However, it is also often unstructured and depends on the organization.

Having analyzed the experience, basing on our own experience, the author would like to suggest the model of undergraduate medical mentorship, which could easily be adapted for the postgraduate education. Initially, it requires clear institutional policy and adoption of standard of mentorship, with clear mentor's role and distribution of the mentor's tasks between the administrative offices and teaching departments. Secondly, micro-mentoring, lasting for 10 minutes at each class or lecture, should be introduced into the curricula of all courses. The tutors must teach the students regularly stop at brief points and reflect over the situations. The so-called "upbringing" objective of medical classes, written officially in each class or lecture plan, should be introduced in practice. This should include such themes as ethical communication, confidentiality in medicine, teamwork and trauma-sensitive communication, but the list of the themes is not finite with these directions. Under the present conditions, hybrid mentoring should be realized, via video calls, messaging and sharing documents. The last but not the least is the mental support provided by the mentors to their students, particularly under the wartime conditions.

Here we would use the abbreviation MENTOR to note the following steps of the medical mentorship scale (see Fig. 1):

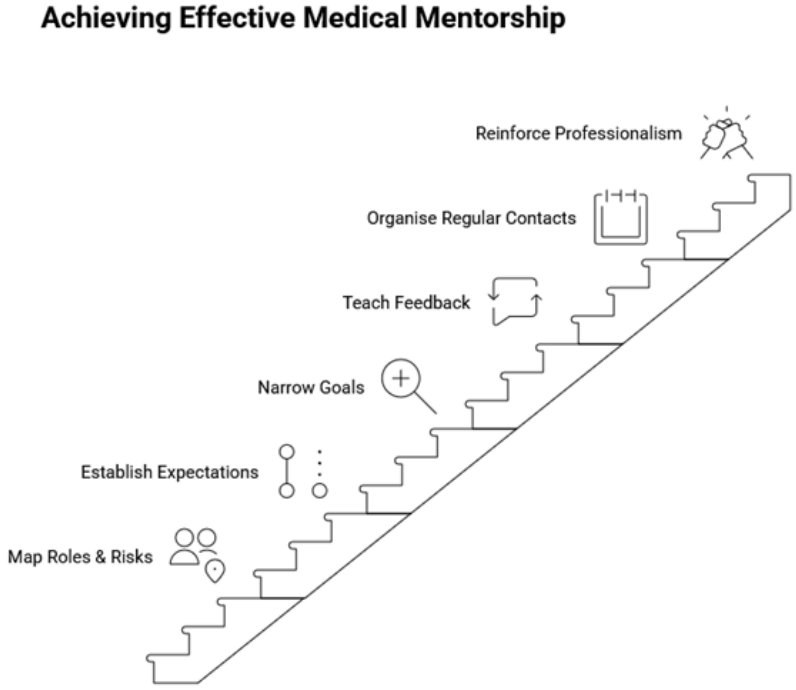

Fig. 1. The scheme of MENTOR scale

M – mapping roles and risks, standardize the mentor's and medical student's roles, context of communication and risks of such communication. The authors consider, the first-year students, displaced students and students who returned to study after academic leave represent the risk group.

E – establish expectations, as the educational institution must have the standards of mentoring documents adopted, with defined frequency of mentoring, distribution of mentors procedure, channels of communication and conflict resolution policy.

N – narrow goals to competencies, defining priorities of mentorship in clinical reasoning, communication, documentation, research, etc.

T – teach feedback as teaching mentors giving and receiving feedback, without criticism, as well as ability to dialogue turns crucial.

O – organise regular contacts between peers and a mentor, 15-20 minutes each day. As a rule. The basic questions to be discussed are: changes and main messages, priorities and agreements of the day, insights of the day.

R – reinforce professionalism, which includes brief check-ins, trauma-informed communication, and supportive mentoring.

The authors have also defined basic strengths and constraints of the Ukrainian medical mentoring. Thus, the strengths of the medical mentoring include deep apprenticeship culture shaped since the previous centuries, strong departmental continuity, hybrid mentoring and high professionalism of mentors as physicians. The constraints of the medical mentoring include indefinite mentoring status in educational system, resulting in insignificant mentor's status; role conflict, under-mentoring and over-mentoring, and emotional burnout of both mentors and students.

Conclusions. Mentorship in Ukrainian medical education is historically embedded in traditions of apprenticeship at departments and in clinical settings. Nowadays, medical mentorship is not regulated by definite standards, and in its world-accepted meaning it is more a voluntary activity than a curriculum-established duty. In Ukraine, mentorship is often realized in clinical settings and by peers, in hybrid format, depending on the existing working team environment rules, being informal in its structure. Micro-mentoring appears the most useful style of the mentoring. The proposed by the authors medical MENTOR model (mapping roles and risks, establishing expectations, narrowing goals, teaching feedback, organizing regular contacts, reinforcing professionalism) could be accepted as a mentoring model for all medical educational institutions. In future, Ukrainian medical education needs clear model, national standards and control criteria of medical mentorship to ensure high quality of medical education.

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