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Giving Constructive Feedback to Clinical Mentees and Local Health Authorities: What Makes a Difference?

When you look at the literature and read about professional development, mentorship tends to come up in the list of strategies to improve professional skills. Recently, the concept of mentoring has been introduced and encouraged in HIV Clinical Practice. It is seen as 'a new practice' that needs to be learned by practicing doctors and nurses, both the young and new in the practice and the long-service folks who did not have an opportunity to experience formal clinical mentoring during their time in medical and nursing schools. However, the practicality of mentoring for adult learners might be so challenging that someone might have to use extra skills and have inestimable amount of courage and nerve to be able to continue working as a mentor

Over the last four years, my primary job responsibility has been clinical mentorship, training, team leadership and, on a smaller scale, provision of supportive supervision to HIV/Palliative Care doctors in designated hospitals in Tanzania. In the events of fulfilling my roles and responsibilities, there has often been a question in the back of my mind on what my mentees think of my ability or skills as a mentor. The apprehension had even been more obvious when the mentees are more senior colleagues who have been practicing medicine for a number of years. In such situations, that period of about one week pre-mentorship had frequently found me deep in thoughts of challenges I might encounter when I do commence mentorship process. This sometimes led me into having nightmares.

I sometimes came to the point of feeling useless, and had wished I had not committed myself to that kind of work. To be more specific, my thinking of "giving feedback" was so unhealthy that I labeled it a "battle with the host". The dilemma was choosing between sharing issues with your mentees/hosts that you found needed improvement, something that could make them unhappy, or only celebrate with them the little achievements and good practices found. I could see areas in which performance was very low and at the same time saw a lot of potential for improvement. Mentees were not performing in the way they should, partially because of lack of necessary skills

and partially due to lack of needed support from management. I would have to give constructive feedback to facility management as well as to individual mentees. Instead, I often mostly ended discussing areas in which mentees and the hospital are doing well. I found this made me happy and maintained my already "good" relationship with my mentees and hospital authorities. I very rarely opened my mouth to discuss the areas that needed improvement mainly because of my personal anxiety and fear of what my audience would feel like at the end of the talk. This approach never led to strategies for improvement, but rather left my mentees without "tasks" to concentrate on to bring more improvement in health care delivery. I, from time to time, revisited my decision to work as clinical mentor. To me, the whole process was not motivating and sometimes I felt that I should let someone else come forward and help out or even take up the job. However, there were not many doctors doing multi-site clinical mentorship in the country and I and my team were left to carry out this difficult task.

Much of my mentorship practice, prior to participating in the LDI program, was marked by frequent and deliberate avoidance and shying away from giving *realistic* feedback. My reasoning was that I did not want to have my mentees feeling disappointed and discouraged. I never wanted to allow any move that could potentially create "unfriendly" relationship with my mentees. With this in mind my feedback would almost always comprise of the good things and all the issues I "liked" in them. I never mentioned what improvement I "wished" to be accomplished and hence make my mentees expand the set of their skills by doing things in a different way.

As time went on, there was little that my mentees benefited from me, and I guess they must have been asking themselves as to whether it was worth spending more time working with me. I assumed that this was the reason why most of my mentees became unavailable for mentoring. Even those who do not seem to have a lot of responsibilities seemed "busy" when the schedule indicated that they were supposed to be with me. I had to use extra effort to get hold of them; sometimes I had to be assisted by the facility management. This had a very negative impact as mentorship is supposed to be a voluntary relationship. For some of my mentees, the process now became compulsory. I got the impression that they appeared for mentorship only because they were asked and thus "required" by their managers. This had a negative impact on their willingness and readiness to learn.

The feedback from the Myers-Briggs Temperament Indicator (MBTI) assessment that I completed at the beginning of my engagement with the Leadership Development Initiative program (LDI), triggered a desire to change in the way I responded to people, especially my team and my mentees. I gained better insight into my strengths and weaknesses as a leader. I reflected carefully on my personal preferences and the reasons for the decisions I was making. I sometimes found myself making decisions that I felt uncomfortable with. These decisions favored peoples' feelings at the expense of what logic demanded. As an example, I remember at one time, when we went upcountry for a mentorship activity, I had let the team stay over at a guest house about 50 km from working station despite the fact that there was adequate accommodation nearby. The reason for this decision was that the team preferred to sleep in relatively better guest houses in the far town and they were willing to travel the extra distance every day. In a way, this made my team members feel valued and that their preferences are considered during decision making.

During the LDI program in San Diego I met participants and mentors from many different countries. Through the presentations and discussions I came to a new understanding of many aspects of leadership. I gained new insight and skills in communication, decision making, giving constructive feedback and handling interpersonal conflicts. I started to reflect on my leadership role in my

primary job, clinical mentorship. One of the first areas that got more consideration is what I have to do at least once every week, and that is the process of giving feedback to my mentees and health managers in the facilities where I work. I started to understand ways of giving constructive feedback to more experienced, senior colleagues without jeopardizing the existing working relationship.

Contrary to the way I thought previously, the new approach created a friendlier, open and trusting working environment between me, my team, my mentees and hospital managers. During one of my feedback sessions, a senior health official, the District Medical Officer, requested that I, with my team, should share this feedback with the higher level health officials in the region as he thought it was so well constructed and presented. He felt that it is more likely to result into improvements if the higher health authority heard it directly from us. We accepted his request, shared the feedback with Regional Medical Officer who then directed the regional AIDS Control Coordinator to act immediately on the issues that were identified as needing immediate attention.

As a result of this new approach I began to enjoy my work again. My confidence increased dramatically and my work performance improved. More mentees began to request my service. Even more importantly, the quality of patient care and treatment at the majority of the facilities I support increased. Remarkable improvements were noted in the documentation of patients' information, the number of patients initiated on anti-retroviral drugs (ARVs) and their adherence to their treatment regimens. There was also improvement in the monitoring for treatment outcomes and detection of ARVs' side effects. The diagnosis and treatment of tuberculosis also improved. More patients with cancer were detected and those needing palliative care received better symptom control.

As a result of this I have, in collaboration with my colleagues, started identifying and developing "local" HIV clinical mentors who will in future continue the mentorship process for health care workers working in the lower health facilities, health centers and dispensaries, which provide treatment, care and support to patients with HIV/AIDS and/or cancer.

In summary, my participation in the LDI program has led me to do much reflection of my work. I no longer avoid giving much needed constructive feedback during encounters with my mentees and health managers. This in turn, has resulted in on-going improvements in patient care through the application of the knowledge and skill I gained from my own mentorship and my growth as a leader.