Mentorship in Nursing: An Interview with Connie Vance

Connie Vance, EdD, RN, FAAN, is professor of nursing, The College of New Rochelle, School of Nursing, New Rochelle, NY. Dr. Vance is a graduate of Washington Hospital Center, Washington, DC; and holds BSN and MSN degrees from Washington University, St. Louis; and a doctorate from Columbia University, Teachers College, NY. She is a fellow of the American Academy of Nursing; a fellow of the New York Academy of Medicine; member of the Nursing Hall of Fame at Columbia University; and honorary member of the American Association of Colleges of Nursing.

Dr. Vance’s scholarship, teaching, and writing have been in the areas of mentorship, leadership development, nursing education and curriculum development, health policy and politics, and global nursing and health. She is co-founder of the Global Society for Nursing & Health, and co-founder of the Nurse Advocacy Forum for Novice Nurses at The College of New Rochelle. She is a prolific author, speaker, and consultant. In this interview, Dr. Vance shares her thoughts on the nurse mentor relationship, why mentoring is important for contemporary nurse leaders, best practices of mentoring, power mentoring, and offers important advice for new and aspiring nurse leaders on the value of mentorship in their careers.

The Nurse Mentor Relationship

Donna Nickitas (DN): How did you become interested in the topic of mentorship in nursing?

Connie Vance (CV): During my doctoral studies at Columbia University Teachers College in the mid-'70s, my focus of investigation was leadership and leadership development. While doing an extensive literature search, I found the “mentor” word kept appearing in every discipline, particularly in the older professions like law and medicine, and also in the business and corporate world. At the same time, I discovered “mentor” was glaringly absent in nursing’s lexicon—the word was not used. This was very puzzling. I was curious: Was this something that we didn’t do in our profession, or were we mentoring each other, but not using the word? Since mentoring seemed so essential for developing people for high-level leadership positions in every field, I decided to incorporate a section on mentoring in a leadership study. My dissertation, “A Group Profile of Contemporary Influentials in American Nursing,” was completed in 1977. My questions were: Did the 71 national and international nursing leaders in the study engage in mentoring? If so, how did it work for them; who were their mentors; what were the outcomes of these relationships? I discovered that 83% of these leaders could describe their mentoring relationships in great detail, and 93% of them were mentoring others for leadership roles. They were establishing a kind of “generational” mentoring legacy that continues today in various nursing circles. A significant finding was that the nursing leaders’ mentoring relationships were different...
from the classic exclusive, dyadic, expert-to-novice model. They engaged in peer mentoring, as well as having several mentors at various points of their careers, both senior experts as well as peers. Indeed, they attributed much of their success and advancement as leaders, and sometimes even their survival, to their mentor relationships. Their protégés would also begin to mentor others, and so their legacy lived on. My conclusion from this early study was mentoring has always been present in our profession; we just didn’t use the word, in contrast to “role modeling” and “preceptor.” In other words, we didn’t openly acknowledge the mentor relationship, but nurses were mentoring each other, and this continues today.

**DN:** We know the concepts of “mentoring” and “mentor” actually come from ancient Greek mythology. What do you believe is the significance and relevance of that historical mythology to today’s professions and the corporate world? Did the Greeks get it right? Are there other lessons that we in nursing can learn from the concept of mentorship?

**CV:** I believe the story about mentoring in Homer’s *The Odyssey* is absolutely relevant today. We certainly have put some new twists on it, but it is an enduring human relationship that is essential for both personal and professional growth for anyone. As the story goes, while King Odysseus was absent from home during the Trojan War, he engaged his friend, Mentor, to teach, protect, and guide his young son, Telemachus, in his development as a leader—prince. Athena, the Goddess of Wisdom, also got into the act as the “protector of heroic men,” and helped Mentor do his work, making mentoring an androgynous idea. This original mentor model was elite, exclusive, dyadic, expert-to-novice, and patriarchal. You can see this traditional model in the older professions, the corporate world, and the “old boys’ network.” It was not until the 1970s, when women began entering the professions and corporate world in greater numbers, that the traditional Greek model began to include women, albeit differently. For example, my study and additional research have demonstrated that peer mentoring and having multiple mentors are important for women and nurses. The Greeks got it right, and we give them credit. At the same time, we have put a particular contemporary stamp on mentorship, particularly as professionals in a female-dominant field.

**Why Mentoring?**

**DN:** What is your definition of mentoring? And why mentoring? Is it important for contemporary nurse leaders?

**CV:** I first used the definition from the original Greek ideal: a developmental relationship between an older, more experienced, probably more educated person serving as a mentor to a younger, less-experienced person who was getting “educated.” The mentor and protégé, in this case, usually had similar professional, cultural, and gender backgrounds and value systems. This was the traditional expert-to-novice model usually occurring between men. The relationship lasted as long as the younger person needed it, usually about 10 years, according to the literature. In *The Mentor Connection in Nursing*, which I co-edited in 1998 with Dr. Roberta Olson, we concluded that a useful, more inclusive definition would be: a developmental, empowering, nurturing relationship extending over time, in which mutual sharing, learning, and growth occur. In this book, over 100 nurses told their stories about mentoring relationships. Their mentoring occurred in different contexts — academe, clinical practice, research and scholarship endeavors, and professional association activities — at both local and global levels. Their anecdotes demonstrated that both expert-to-novice and peer-to-peer mentor relationships are useful for nurses, and are not limited by age, gender, experience, education, culture, and roles. This inclusive definition works very well for us as nurses and leaders. My current definition is that mentoring is developing and empowering each other through relationships and connections that lead to professional and personal development and leadership skills.

**DN:** Is mentoring relevant to every nurse?

**CN:** The evidence is compelling. Mentoring promotes talent, achievement, leadership, knowledge, and skill development in a career. Every nurse requires the invested interest and involvement of others to fully develop their talents, to imagine our future possibilities, and “polish” our special gifts. I strongly believe our mentor networks are essential to our success and satisfaction as nurses and as human beings. The bottom line is the absence of mentors in life and work is a major handicap.

**DN:** So a mentor advises, guides, encourages, and inspires someone over a period of time. Your definition identifies there are also mutual benefits to all persons in a mentoring relationship. What are the key elements of a successful mentor-protégé relationship?

**CV:** First, both parties should share mutual values and goals for the relationship to work. There has to be the whole idea of commitment and passion for a professional career, and a desire to excel and achieve. Another success factor is generosity and willingness to share resources, including time, energy, networks, and knowledge. Mentoring requires giving! Commitment to the relationship also entails mutual sharing and driving each other forward. There has to be strong trust, belief, and interest in each other, as well as respect, understanding, and empathy. Ongoing communication and honest feedback keep it going. As with any good relationship, there needs
to be ongoing interaction, or the relationship won’t endure or grow. In an authentic mentor relationship, there should always be an expectation of reciprocity and mutuality of growth and development — that each one gains something from the relationship — it’s not just a one-way street. Mentors give a lot. Protégés should also give to their mentors, and pass it forward by becoming mentors to others. This creates an ever-expanding legacy of excellence and power in the profession.

**Best Practices of Mentoring**

DN: Is there a best practice of mentoring – an organizational vs. a traditional one?

CV: Well, there are various ways to mentor, and all are helpful. The most important thing is that mentoring occurs! Of course, the classic mentor-protégé dyad still works very well. This dyadic relationship can occur informally between two people who meet over shared interests, values, and have a natural emotional and professional connection. Mentor-protégé relationships can also occur through matching in a formal mentoring program, sponsored by a professional association, a clinical organization, or a nursing program. We’ve talked earlier about mentoring that occurs informally or formally, between experienced and less-experienced persons, and also between peers. Through anecdotal evidence and research studies, it appears a combination of these is really the best. In other words, organizations and associations should provide formal opportunities for planned mentoring experiences and matching mentors and protégés. Hopefully, out of these formal programs, informal relationships of choice develop. In best practices, experts should mentor novices, and peers should mentor their peers. This could include, for example, faculty mentoring students, students mentoring each other, faculty mentoring faculty, nurse managers mentoring their staff, upper-level leaders mentoring managers, and the combinations go on. There are no limits to what can be accomplished through strong mentor connections.

DN: As I hear you describe some notions around best practices of mentoring, it makes me think mentors may have some kind of special intelligence. How does one become informed, educated, and learn to develop a mentor IQ, if there is such a thing?

CV: Yes, I believe there is a special intelligence in possessing successful mentor relationships. I’ve been developing the idea of mentor intelligence, which I’m calling “MQ.” Successful people have a level of cognitive intelligence, or IQ, and also emotional intelligence, or EQ. This third intelligence, MQ or mentor intelligence, I define as the capacity and ability for creating and sustaining successful mentor relationships and connections. Successful mentoring requires a skill set, imagination, experience, generosity, and sought opportunities. Mentor intelligence is essential for becoming successful leaders of change and innovation.

I suggest three components of MQ: (1) mentoring mentality, (2) mentoring lens, and (3) mentoring momentum. Let me briefly explain these: Mentoring mentality is the knowing part of mentoring, the knowledge factor, that entails study, reflection, and practice. The second component – the mentoring lens – is the seeing aspect, or viewing self and others as needing this vital relationship for personal and professional development. Seeing means there is intentionality in looking for talent, noticing gifts in each other, and providing a chance to allow potential and leadership to emerge. And, finally, the third component is mentoring momentum – the doing of it. It’s actively creating, expanding, and sustaining mentor relationships and networks through engagement, networking, and outreach in the workplace, schools, and professional organizations. It’s living mentoring as a lifestyle. I want to point out mentoring is not an “add-on.” It is not a thing; it’s not a stand-alone. It’s a way of knowing, seeing, and being with our colleagues and students and novices for their and our own talent development.

**Power Mentoring**

DN: I’ve also heard you speak about another notion relative to mentoring, and that is “power mentoring.” What is power mentoring? Where is it happening in our profession?

CV: Well, this is the idea that nurses have expanded the original concept of mentoring from the Greeks from the exclusive, dyadic, look-alike model to a more inclusive idea. In nursing, power mentoring is being active in a broad, diverse network of multiple mentoring relationships, opportunities, and connections. This could be the classic dyadic relationship, which could be with one’s boss or teacher or a peer. It could also occur in a group, association, or an organization like the workplace. Family and friends are another strong component of power mentoring.

In addition, power mentoring may occur in a legacy situation where someone is mentored for a particular role or position. Power mentoring is increasingly occurring through e-mentoring and also through 1-minute mentoring in short, efficient contacts. Mentors may theoretically be “hired,” although I think when mentors are “hired,” they really are coaches who provide specific skill guidance. Power mentoring suggests mentoring relationships should be present in all nursing programs, at every level; in all professional associations at international, national, and local levels; in all scholarship and research endeavors; and of course in the clinical workplace. It’s a very big idea. In nursing, we’ve come a long way since the
Since the late 1970s; from not having the “mentor” word in our literature and not using the word in our practice, to extensive investigation, action, and writing about it. This is a moment of potential for us to be power mentors in our profession.

The first place that mentor relationships have flourished is in educational and academic settings. This seems natural, because teachers and students are accustomed to working in collaborative and supportive teaching-learning relationships. From basic education through doctoral study, relationships are occurring in both informal and formal programs; some are for faculty mentorship, and many programs target students in peer relationships and between faculty and students. Acade me is a hotbed of mentoring activity.

The second active place where mentor relationships are occurring is in professional associations. It’s very exciting, and I am so proud of what association leaders have done to promulgate mentor connections and relationships to help their members. They’ve started very creative formal programs, with international, national, and local chapter involvement. Frankly, I can’t think of a major association that isn’t trying to do something in mentoring. It is definitely creating important outcomes for us in terms of leadership and expansion through various sectors of our profession, and that will ultimately have an impact on the larger world.

The third area for nursing mentorship is the clinical workplace, and this is the area that needs attention and expansion. Leaders and administrators in clinical organizations, I’m sure, are aware of the necessity for mentoring novice and experienced nurses, but the complexities of the workplace seem to create many barriers for these relationships. This is certainly an important area for clinical leaders to explore and act on.

Many workplaces start with formal mentoring through the orientation of the novice nurse. But many of these approaches aren’t built to last at least 1 to 2 years, which is the length of time a novice in any profession needs to develop, be safe, and feel confident. So, this is something more workplaces need to improve upon. We know retention is improved when mentoring relationships occur, so it’s a bottom line issue in clinical organizations. It’s a good business investment for many reasons, not only for the novice, but also for every nurse’s practice in the work organization. For example, establishing formal workplace mentor programs would be very significant in developing safe, quality nursing practice and effective leaders. The workplace requires we commit to creating and supporting serious mentor relationships and connections.

Advice for Nurse Leaders

DN: What advice would you give to new and aspiring nurse leaders about mentorship as they progress in their careers?

CV: First, I believe everything good that happens in our careers is largely due to networks and mentor connections. So, to develop leadership potential, my advice is to attract good mentors. Mentors are everywhere. But to be “chosen” by mentors, new and aspiring leaders must show they are worth the costs, because mentoring requires an investment of precious scarce resources. Essential “attractors” are necessary, such as having a career attitude and leadership commitment, a strong work ethic, the drive to achieve, curiosity, and passion to learn. There also has to be a “readiness factor” to commit to mentoring relationships and willingness to take on new initiatives, to learn and “stretch.” Another piece of advice is to develop our MQ — mentor intelligence — through learning, being on the lookout for mentoring opportunities, and creating mentoring networks on a regular basis. I also suggest we jump in and just “do” power mentoring; that is, get actively involved in broad and diverse networks, relationships, and mentor connections. Growing as leaders through both professional and interprofessional power mentoring opportunities will help us become more influential and powerful in our work.

DN: The Institute of Medicine’s (2010) Future of Nursing report states that nursing associations and work organizations should provide mentor programs for all members. The American Nurses Association (2010) Nursing: Scope and Standards of Practice says leaders must mentor colleagues to advance nursing practice, the profession, and health care if we want to develop a talent pool of transformative leaders who can deliver innovative, high-quality humanistic care and who make the changes that health care desperately needs today. What must we do to engage in mentoring the next generations of leaders?

CV: To engage the next generation of leaders means developing mentor intelligence as individual nurses and as a profession. This will require us to engage in power mentoring both in and outside the profession. It’s a big mandate, and it will change everything.

Professional Ethos and Behaviors

DN: In summary, you have made mentorship a central component of your scholarship and legacy. Would you agree that mentorship has been essential to your professional work?

CV: Thank you for that question. Since the late 1970s mentorship has absolutely been the focus of my professional work. I am very passionate about conveying to nurses and leaders that we can’t and don’t achieve alone; mentors are absolutely essential to our individual and collective success. I hope the legacy I have brought to the nursing profession is awareness of the “mentor” word and the vital nature of mentoring to our
evolving power and influence. Hopefully, my work has raised the consciousness of mentoring for nursing students, clinicians, educators, researchers, and professional nurses in all specialties and at all levels. The best thing for me is that nurses now know and use the word mentor! I believe promulgating mentorship has set the stage for ongoing research; the initiation of formal programs in schools, associations, and workplaces; and the development of power mentor networks among all of us. We know there is an enormous demand for nursing leaders who are prepared and committed to transforming our profession, and who can lead change and advance health.

My study of the “nurse influentials” demonstrated nurses are able to make a major mark in the profession and influence societal change through the legacy of being mentored and mentoring others. As I indicated earlier, we’ve come a long way since the late ’70s when “mentor” was never uttered; and if it was done, it was “underground” and labeled something else. Now, leaders are increasingly aware they have an obligation to find good mentors and to mentor others. And, hopefully, we are socializing the next generation of nurses to expect mentor relationships, to seek, and to cultivate these connections. Thus, mentoring will increasingly become part of our professional ethos and our professional behavior.

DN: Thank you, Dr. Vance, for your insights and beliefs on mentorship in nursing. This interview emphasized the importance of mentoring within the nursing profession. I am grateful for your contemporary definitions and descriptions of mentoring. I could not agree more that we must adapt the necessary professional ethos and behaviors to ensure the next generation of nursing will recognize and cultivate these mentoring connections.

REFERENCES

ADDITIONAL READING