RESEARCH PAPER

Relevance of Strengthening Mentor-Mentee Relationships in Medical Education Through Counselling Skills Integration: A Review

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ABSTRACT

Mentorship in medical education has traditionally been emphasised as a structured relationship focused on academic supervision, professional socialisation, and career guidance. Beyond academics, mentors often serve as role models who influence professional identity formation, ethical orientation, and interpersonal development among medical undergraduates. The environment of medical education marked by high expectations and limited space for emotional expression, can intensify students' psychological burden and reduce help-seeking behaviours. With such an increase in psychological distress among students, the need arises to strengthen mentor's role to include basic psychological support. Existing literature suggests that medical students experience high levels of stress, anxiety, burnout, and identity-related challenges during their undergraduation, yet structured counselling-skills training for faculty mentors remains limited, particularly within the Indian context. This review paper studies existing models of mentor training in medical education, discusses the psychological demands placed upon students, and explores the role of basic counselling skills in strengthening mentor-mentee relationships. International frameworks and globally recommended capacity-building models are also reviewed to evaluate their applicability to medical faculty training. The review highlights a persistent gap between expectations placed on mentors and the formal preparation or the lack of it, for addressing student distress. Integrating basic counselling skills into structured Faculty Development Programmes may enhance mentoring effectiveness, improve early identification of psychological concerns, and foster a more supportive educational climate.

Keywords: Mentor-Mentee Relationship, Medical Mentor, Basic Counselling Skills

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INTRODUCTION

The concept of mentorship is not new and has long been an integral part of human civilization. The concept of mentoring in professional education, particularly in medicine, has evolved from a didactic, instruction-based model to a more holistic, relational, and developmental framework. In the context of India, the Guru-Shishya parampara is one of the earliest forms of mentorship and is considered one of the most significant. In the context of mentorship, it is said that in ancient India, it was not just the transfer of knowledge that was significant but the moulding of the individual as a whole. The mentor-student relationship between Lord Krishna and Arjuna is often regarded as a classic example of mentorship, in which a mentor guides his student through a period of moral confusion and helps him achieve clarity and purpose in life. The story of Eklavya is a classic example of dedication and the aspirational value of mentorship. The mentor-student relationship between Chanakya and Chandragupta Maurya illustrates how mentorship can lead not only to personal growth but also to leadership and broader societal change. Another example is the of Guru Dronacharya and

Arjuna. Similar instances may also be found in Western thought as well, especially in the lineage from Socrates to Plato to Aristotle.

Scholars have defined mentoring as a dynamic and interactive relationship through which a more experienced individual (the mentor) supports the development of a less experienced individual (the mentee), both personally and professionally (Sambunjak et al., 2006). In this process, the mentee takes an active role in learning and growth, while the mentor functions as a teacher, guide, role model, and facilitator (Frei et al., 2010).

The Need for Mentorship for Medical Students

In medical colleges, where students are immersed in rigorous academic and clinical environments, the mentor-mentee relationship serves as a vital conduit for not only professional guidance but also for emotional support, identity formation, and personal growth. Given the highly demanding and complex nature of medical education, mentorship is considered particularly important in this field. Research indicates that mentorship has a significant impact on academic performance, career guidance, research productivity, and overall professional satisfaction among medical trainees (Bhatia et al., 2013; Kukreja et al., 2017). Further evidence shows that mentorship helps in the achievement of long-term career success (Straus et al., 2013). Besides these specific outcomes, mentorship is critical in the formation of professional identity, as it impacts the manner in which students adopt values associated with the medical profession (Cruess et al., 2019). Furthermore, mentors play a crucial role in shaping ethical practice, clinical reasoning, and professional behavior in future healthcare professionals, thereby contributing to their overall competence (Kashiwagi et al., 2013).

High levels of psychological distress are commonly associated with medical education. Studies have shown that medical students and residents experience increased levels of stress, anxiety, burnout, and fatigue (Dyrbye et al., 2014). The fact that the prevalence of depression and anxiety among medical students worldwide is high is further emphasized by the findings from the meta-analytic study (Rotenstein et al., 2016), and further research has shown that emotional exhaustion and burnout among medical students are high (Ishak et al., 2013). These conditions are further exacerbated by factors such as academic demands, long working hours, competitive environments, and exposure to patients' suffering. In such contexts, mentorship has been shown to function as a protective factor, supporting coping and resilience among trainees (Jackson et al., 2003). In this context, mentorship can play a vital role by offering a support system, coping strategies, emotional reassurance, and a safe space for open discussion. Additionally, studies from India and other South Asian countries indicate that medical students perceive mentors as essential sources of both academic guidance and psychosocial support (National Board of Examinations, 2023; Raza et al., 2024).

Mentorship has gained prominence internationally in recent years as a crucial approach to strengthening health professional education systems. The World Health Organization has underscored the significance of a supportive learning environment and mentorship within its strategies aimed at enhancing the quality, equity, and sustainability of global healthcare training (World Health Organization, 2013). Previous research indicates that formal mentoring programs can result in enhanced learner satisfaction and decreased burnout when the mentoring program is structured or the mentor is trained (Allen et al., 2004; Frei et al., 2010). Empirical studies have shown that formal mentoring programs, which are distinguished by clearly defined roles, consistent interactions, and trained mentors, correlate with improved learner satisfaction, decreased burnout, and enhanced professional development outcomes (Frei et al., 2010; Sambunjak et al., 2006).

Relevance and Need of Mentorship in Indian Medical Education

Indian medical students, like their global counterparts, face numerous stressors during their academic journey. These include high academic expectations, demanding clinical exposure, emotional exhaustion, and in some cases, isolation due to cultural, linguistic, or socio-economic disparities. Studies have indicated that medical students report higher rates of anxiety, depression, and burnout compared to other undergraduate cohorts. In the Indian context, this is further exacerbated by a hierarchical educational structure, limited student support services, and a traditional teacher-centric pedagogy that leaves little room for emotional ventilation or open dialogue. Consequently, the availability of trained mentors who can not only advise but also listen, empathise, and guide with psychological insight becomes paramount.

One may argue that if any psychological support is required, the students can approach the counsellor or avail professional psychological support. However, considering the rigorous pattern of the MBBS curriculum over the 4.5 years and the internship period, it is a challenge for each student. Availing professional help from psychologists may induce stigma or discomfort in the student. At the same time, faculties are the closest point of contact with the students, who are not only aware of the common challenges faced, have experience, but also easier to approach and identify students in need. Considering the dire need of support and mentorship for MBBS students and lack of adequate number of mental health professionals, bridging the gap by training the faculty mentors with basic counselling skill may act as a big

preventive step, leading to overall wellbeing and growth of the mentees.

Despite being expected to fulfil mentorship roles, many faculty members in medical colleges have received little to no formal training in counselling or mentoring skills. This lack of preparation often results in superficial or transactional mentor-mentee interactions, where the focus may be restricted to academic performance or logistical support. Furthermore, barriers such as time constraints, role ambiguity, and discomfort in addressing sensitive issues like mental health or burnout contribute to an ineffective mentoring climate. Faculty may also struggle with managing boundaries, offering constructive feedback, or recognising signs of psychological distress among students, skills that are fundamental to the mentoring role.

Recognising these gaps, the National Medical Commission (NMC) of India, formerly the Medical Council of India (MCI), introduced the Faculty Development Programmes (FDPs) as a core initiative to improve teaching-learning processes in medical institutions. These programmes aim to build faculty capacity across multiple domains, including educational technology, curriculum design, professionalism, and more recently, mentorship (MCI, 2020). FDPs that include mentoring components seek to equip faculty with the necessary communication, interpersonal, and reflective skills to effectively support their mentees. However, counselling as a distinct skillset encompassing empathy, active listening, non-judgemental feedback, and psychological boundary management remains under-emphasised in most conventional FDP modules.

Even though competency-based medical education frameworks have been developed in India with a mentoring component, there is significant variability in structure, implementation, and evaluation. The lack of standardisation is hindering the effectiveness of mentorship, which is crucial for helping medical students deal with the increasing psychological and academic challenges they face. Therefore, there's a clear need to improve mentorship practices in Indian medical education by using a more structured and research-based approach. The integration of basic counselling skills, including empathy, active listening, emotional validation, and effective communication, into mentorship may help improve the quality of the mentor-mentee relationship. These relational skills, which were first theorized in a therapeutic context, have a foundation in the principles of empathy, genuineness, and unconditional positive regard (Rogers, 1957). Their relevance in medical education is also supported by models of communication and emotional intelligence that emphasize the significance of relational skills in professional education (Silverman et al., 2013; Arora et al., 2010).

Although Indian literature on counselling-based mentor training remains limited, there are emerging initiatives. Institutions such as AIIMS Rishikesh, CMC Vellore, and Manipal Academy of Higher Education and more have piloted peer-support programmes and faculty sensitisation workshops that include elements of empathy training and mental health awareness. However, a structured, evaluated programme that trains medical faculty in counselling-specific mentoring skills remains largely absent. Therein lies a vital research and implementation opportunity.

Evolving Role of a Medical Mentor

The landscape of undergraduate and postgraduate medical education has undergone a fundamental shift over the last two decades. Historically, the mentor-mentee relationship in medical colleges operated under an informal, master-apprentice model focused almost exclusively on clinical competency, procedural mastery, and academic milestones (Rose et al., 2005). However, modern medical training environments demand a transition toward a more holistic, supportive paradigm.

Global Frameworks and Capacity-Building Models

The World Health Organization (WHO) mhGAP Framework

The WHO Mental Health Gap Action Programme (mhGAP) provides a validated global template for utilizing non-specialists to identify and manage neurological and substance use disorders (World Health Organization, 2015). While originally built for primary healthcare workers in low-resource settings, its core philosophy applies perfectly to medical education. The mhGAP emphasizes that frontline personnel do not need to act as primary therapists; instead, they require structured competency to execute basic "distress triage"-accurately identifying early clinical features of depression or anxiety, providing immediate psychological first aid, and establishing a safe, structured referral bridge to specialized professionals.

The AETCOM Module (National Medical Commission, India)

In the domestic landscape, the National Medical Commission (NMC) (formerly known as the MCI) introduced the Attitude, Ethics, and Communication (AETCOM) module as part of the Competency Based Medical Education (CBME) curriculum (MCI, 2019; NMC, 2024). AETCOM represents a significant step forward by shifting institutional focus toward the affective domain of learning, explicitly teaching empathy, ethical decision-making, and communication skills to undergraduates. However, a systemic gap remains: while AETCOM focuses heavily on shaping student communication patterns with patients, it offers minimal structured infrastructure to train faculty on utilizing basic counselling techniques when managing their own distressed mentees.

International Accreditation Benchmarks (ACGME & CanMEDS)

Globally, the Accreditation Council for Graduate Medical Education (ACGME) explicitly integrates interpersonal and communication skills alongside professionalism into its core residency milestones. Similarly, the Canadian CanMEDS framework outlines the "Communicator" and "Professional" roles as essential competencies for practicing physicians (Frank & Danoff, 2007). These frameworks embed relational competencies directly into institutional accreditation requirements, demanding that faculty evaluate and model supportive communication. Nevertheless, translating these macro-level competencies into micro-level skills training for daily faculty-student interactions remains an ongoing challenge across high-volume medical centres.

The Disconnect Between Expectation and Preparation

A critical critique of current medical mentorship models reveals several institutional, structural, and psychological barriers that hinder effective mentor-mentee interactions.

Institutional and Structural Gaps

The core limitation of the current paradigm lies in the Expertise Paradox. Medical institutions routinely assign faculty to mentorship roles based on clinical expertise or institutional seniority. There is an unwritten, flawed assumption that an outstanding clinician or experienced professional naturally possesses the pedagogical and interpersonal skill sets required to guide a struggling student through emotional or psychological distress.

Furthermore, institutional infrastructure lacks operational support. High patient workloads and intensive teaching schedules create extreme time poverty for faculty, resulting in rushed, transactional, or purely administrative mentor-mentee meetings. Compounding this issue is the lack of confidential, standardized record-keeping systems tailored for mentorship sessions, leaving interactions fragmented and without longitudinal continuity.

The Psychological and Skill Gap

From a skill-based perspective, faculty development programmes focus on technical teaching methodologies, assessment designs, and digital literacy, while neglecting baseline interpersonal counselling strategies. This lack of training breeds the "Hesitation Factor". Well-meaning mentors frequently hesitate to engage with an emotionally distressed student due to a self-preservation instinct or fear of overstepping professional boundaries or entering grey areas.

Conversely, a profound power dynamic inhibits the mentee. Because mentors are often senior professors who hold evaluative authority, students are highly reluctant to discuss vulnerabilities. When mentorship remains strictly academic, it reinforces this hierarchy, preventing the psychological safety necessary for true disclosure.

The Solution: Counselling Skills Integration into Faculty Development

To resolve the discrepancies identified in the gap analysis, medical institutions must systematically integrate core counselling skills into structured Faculty Development Programmes (FDPs). This integration does not aim to turn medical educators into professional psychotherapists, but rather to equip them with specialized interpersonal tools to optimize their supportive role.

Core Counselling Competencies for Faculty

- **Active Listening and Empathetic Mirroring:** Moving beyond passive hearing to recognize verbal inflections, body language cues, and emotional undertones, while validating the student's experience without immediate judgment.
- **Being Open-Ended:** Utilizing specific questioning techniques that allow students to articulate complex stressors without feeling cross-examined or defensive.
- **Cultural Sensitivity and Non-Judgemental Attitude:** To incorporate a healthy and safe environment for student to share their distress and discuss comfortably.
- **The Structured Referral Bridge:** Training faculty to clearly map out institutional psychological resources and comfortably transition a student from a basic mentorship interaction to a professional mental health intervention as per requirement.

When mentors utilize these techniques, it fundamentally alters the educational climate of the institution. The relationship transitions from a transactional check-in to a safe space. This perceived psychological safety reduces the student's cognitive load, alleviates isolation, and helps mitigate burnout early, before it escalates into clinical anxiety or academic failure.

Future Implications and Policy Recommendations

The systemic integration of counselling skills into medical education requires a coordinated shift across institutional policy, curriculum design, and faculty recognition metrics.

- **Mandatory FDP Curricular Revisions:** Medical education units must update faculty development modules to make interpersonal communication and basic psychological first aid core requirements rather than optional workshops.
- **Separation of Evaluative and Mentoring Roles:** To address the power dynamic barrier, institutions should ensure that a student's assigned mentor does not serve as their direct examiner or grader.
- **Updating Assigned Mentor:** If need arises, mentor reassignment should be done, in case any faculty mentor is occupied, leaves institution or is unable to take sessions.
- **Structured Sessions and Regular Feedback:** Mentoring sessions should be fixed in the time table,

so as to not clash it with any academic preoccupation, and regular feedback can be maintained for improving the same with confidentiality.

- **Long-Term Longitudinal Studies:** Future medical education research must track the longitudinal efficacy of counselling-integrated mentorship models, measuring quantitative outcomes such as student mental well-being, referrals and overall institutional burnout metrics.

CONCLUSION

The standard operational model of mentorship within medical education is no longer sufficient to meet the psychological realities faced by modern trainees. Expecting educators to protect student well-being without providing formal training in interpersonal communication creates a significant competency gap.

Integrating baseline counselling skills into structured Faculty Development Programmes offers a pragmatic, scalable, and evidence-based solution. By equipping faculty with the skills to listen actively, engage empathetically, and manage distress referrals systematically, institutions can close the gap between clinical expectation and educational reality. Ultimately, supporting the well-being of medical students is essential to training resilient, capable future physicians.

REFERENCES

1. Allen, T. D., Eby, L. T., Poteet, M. L., Lentz, E., & Lima, L. (2004). Career benefits associated with mentoring for protégés: A meta-analysis. Journal of Applied Psychology, 89(1), 127–136. https://doi.org/10.1037/0021-9010.89.1.127
2. Arora, S., Ashrafian, H., Davis, R., Athanasiou, T., Darzi, A., & Sevdalis, N. (2010). Emotional intelligence in medicine: A systematic review through the context of the ACGME competencies. Medical Education, 44(8), 749–764. https://doi.org/10.1111/j.1365-2923.2010.03709.x
3. Bhatia, S., Singh, S., & Bhatia, S. (2013). Mentoring for first-year medical students: Humanizing medical education. International Journal of Medical Education, 4, 1–5. https://doi.org/10.5116/ijme.50c6.0e7c
4. Cruess, R. L., Cruess, S. R., & Steinert, Y. (2019). Supporting the development of a professional identity: General principles. Medical Teacher, 41(6), 641–649. https://doi.org/10.1080/0142159X.2018.1536260
5. Dyrbye, L. N., Thomas, M. R., & Shanafelt, T. D. (2014). Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. Academic Medicine, 89(3), 443–451. https://doi.org/10.1097/ACM.0000000000000135
6. Fleming, M., House, S., Shewakramani, V., Yu, L., Garbutt, J., McGee, R., Kroenke, K., & Rubio, D. M. (2013). The mentoring competency assessment: Validation of a new instrument to evaluate skills of research mentors. Academic Medicine, 88(7), 1002–1008. https://doi.org/10.1097/ACM.0b013e318294fd03
7. Frank, J. R., & Danoff, D. (2007). The CanMEDS initiative: implementing an outcomes-based medical education framework worldwide. Medical Teacher, 29(7), 642-647.
8. Frei, E., Stamm, M., & Buddeberg-Fischer, B. (2010). Mentoring programs for medical students: A review of the literature. Medical Teacher, 32(3), 248–257. https://doi.org/10.3109/01421590903173733
9. Ishak, W., Nikravesh, R., Lederer, S., Perry, R., Ogunyemi, D., & Bernstein, C. (2013). Burnout in medical students: A systematic review. The Clinical Teacher, 10(4), 242–245. https://doi.org/10.1111/tct.12014
10. Jackson, V. A., Palepu, A., Szalacha, L., Caswell, C., Carr, P. L., & Inui, T. (2003). "Having the right chemistry": A qualitative study of mentoring in academic medicine. Academic Medicine, 78(3), 328–334. https://doi.org/10.1097/00001888-200303000-00020
11. Kashiwagi, D. T., Varkey, P., & Cook, D. A. (2013). Mentoring programs for physicians in academic medicine: A systematic review. Academic Medicine, 88(7), 1029–1037. https://doi.org/10.1097/ACM.0b013e318294f368
12. Kukreja, P., Chhabra, N., Kaur, A., & Kaur, S. (2017). Introducing mentoring to first-year medical students. International Journal of Applied and Basic Medical Research, 7(Suppl 1), S42–S46. https://doi.org/10.4103/ijabmr.IJABMR_123_17
13. Medical Council of India. (2019). *Attitude, Ethics and Communication (AETCOM) competencies for the Indian Medical Graduate*. Academic Cell, Medical Council of India. https://www.nmc.org.in/wp-content/uploads/2020/01/AETCOM_book.pdf
14. Medical Council of India. (2020). Faculty Development initiatives for the Undergraduate Medical Education Program, ten years' experience – status report, 2020 (pp. 1–24). Medical Council of India.
15. National Board of Examinations. (2023). Exploration of mentees' perception of mentoring among medical students. National Board Journal.
16. National Medical Commission. (2019). *Competency based undergraduate curriculum for the Indian Medical Graduate* (Vols. 1–3). Undergraduate Medical Education Board. https://www.nmc.org.in/information-desk/for-colleges/ug-curriculum/ Raza, S., et al. (2024). Mentor–mentee relationship in medicine: How to develop trust. Pakistan Journal of Medical Sciences. https://doi.org/10.12669/pjms.40.1.9372

17. National Medical Commission. (2020). *National Faculty Development Programme initiative for undergraduate medical education* (Policy Document No. FDP-initiative-UG-Med-Education). Academic Cell, National Medical Commission. https://www.nmc.org.in/wp-content/uploads/2020/09/FDP-initiative-UG-Med-Education.pdf
18. Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21(2), 95–103. https://doi.org/10.1037/h0045357
19. Rose, G. L., Rukstalis, M. R., & Schuckit, M. A. (2005). Informal mentoring between faculty and medical students. Academic Medicine, 80(4), 344-348.
20. Rotenstein, L. S., Ramos, M. A., Torre, M., Segal, J. B., Peluso, M. J., Guille, C., Sen, S., & Mata, D. A. (2016). Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: A systematic review and meta-analysis. JAMA, 316(21), 2214–2236. https://doi.org/10.1001/jama.2016.17324
21. Sambunjak, D. (2015). Understanding wider environmental influences on mentoring: Towards an ecological model of mentoring in academic medicine. Acta Medica Academica, 44(1), 47–57. https://doi.org/10.5644/ama2006-124.125
22. Sambunjak, D., Straus, S. E., & Marušić, A. (2006). Mentoring in academic medicine: A systematic review. JAMA, 296(9), 1103–1115. https://doi.org/10.1001/jama.296.9.1103
23. Silverman, J., Kurtz, S., & Draper, J. (2013). Skills for communicating with patients (3rd ed.). Radcliffe Publishing.
24. Straus, S. E., Johnson, M. O., Marquez, C., & Feldman, M. D. (2013). Characteristics of successful and failed mentoring relationships: A qualitative study across two academic health centres. Academic Medicine, 88(1), 82–89. https://doi.org/10.1097/ACM.0b013e31827647a0
25. World Health Organization. (2015). mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. World Health Organization.
26. World Health Organization. (2013). Transforming and scaling up health professionals' education and training: WHO education guidelines 2013. WHO Press.