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Exploring the dark side of informal mentoring: Experiences of nurses and midwives working in hospital settings in Uganda

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Abstract

Mentoring literature explores the dark side of mentoring as factors such as gender and race and how they affect the overall mentoring experience. The sociocultural context of the nursing and midwifery professions presents unique characteristics warranting a qualitative exploration of negative mentoring experiences. We aimed to characterise the dark side of mentoring based on informal mentoring relationships occurring among nurses and midwives working in hospitals. Utilising semistructured interviews in a qualitative descriptive design and reflexive thematic analysis, we examined the perceptions of 35 nurses and midwives from three public hospitals located in the Western, Northern and North-western regions of Uganda. Findings emerged in four overarching themes mentoring process deficits, mentoring relational problems, organisational challenges in mentoring and implications of negative mentoring experiences. Our study findings underscore that, while mentoring is frequently beneficial, it can also be interspersed with negative experiences arising from relational dynamics, particular mentoring processes and the overarching hospital environment. Notably, nurses and midwives actively transformed these challenges into opportunities for growth and self-improvement, while introspectively examining their roles in contributing to these negative experiences. Such a proactive approach highlights their resilience and steadfast commitment to professional development, even in the face of adversity.

KEYWORDS
hospitals, informal mentoring, mentor midwives, nurses

1 | BACKGROUND

While the concept of mentoring in the nursing and midwifery professions is a relatively recent addition to the academic literature, only gaining prominence in the late 20th century (McCloughen et al., 2006; Stewart & Krueger, 1996; Vatan & Temel, 2016), it has historical roots tracing back to the inception of modern nursing under Florence Nightingale. Historical records indicate that Nightingale actively mentored selected individuals. She maintained consistent communication with her mentees, both through occasional face-to-face meetings and, more frequently, through letters (Lorentzon & Brown, 2003). This approach is analogous to today's psychosocial

support offered by mentors. This longstanding tradition has led scholars to largely view mentoring positively, promoting its incorporation into contemporary nursing and midwifery practice. Consequently, formal mentoring programmes have been established in hospitals, aiding in recruitment, retention and the integration of new evidence into practice (Djiovanis, 2022; Kakyo et al., 2022). While there have been reports of negative experiences in mentoring, these often revolve around issues like insufficient mentor training, lack of dedicated time for mentoring, and poor attitudes towards the process (Rohatinsky et al., 2018; Wissemann et al., 2022). Often, these negative experiences are primarily evaluated using quantitative surveys that focus on how predetermined factors, such as gender, level of education and race, influence mentoring (Fleig-Palmer & Rathert, 2015; Huang & Weng, 2012).

Mentoring, as an approach to professional development, involves an interpersonal relationship where both parties engage in a series of supportive and educational activities within the hospital environment (Mullen & Klimaitis, 2021). This type of mentoring relationship can be formal, wherein the organisation is responsible for matching mentors with mentees and coordinating the structured programme (Giacumo et al., 2020). Formal mentoring is distinct from informal mentoring and is part of recruitment, retention and career development strategies in organisations, such as hospitals (Mohtady et al., 2016). In contrast, informal mentoring involves the spontaneous initiation of a relationship between mentor and mentee, with the aim of providing support and guidance to the novice nurse/midwife for the mutual professional and career benefit of both parties (James et al., 2015). This relationship typically follows the phases of mentoring and lasts for an extended period (Hale, 2018; Kram, 1983). It is based on a mutual understanding between the parties, thereby fostering a natural chemistry that makes the relationship functional. However, challenges have been reported in both formal and informal mentoring relationships (Kakyo et al., 2022; Wissemann et al., 2022).

Challenges in mentoring can stem from relational dynamics, specific mentoring activities or the broader work environment—the hospital. From a functional perspective, mentoring challenges manifest in various ways: a complete lack of mentorship, mentors being inaccessible or the presence of mentors without the appropriate qualifications (Huang et al., 2023; Wissemann et al., 2022). Mentors often cite challenges such as heavy workloads, time constraints, competing priorities, mentees who are reluctant to learn and a general negative attitude of new graduates towards the nursing/midwifery profession (Merga et al., 2020; Rohatinsky et al., 2020). On the relational side of mentoring, nurses and midwives have reported mismatch within the mentoring dyad based on factors such as personality, leadership styles and teaching styles (Huang et al., 2023; Rohatinsky et al., 2018). Issues of poor communication and perceived disrespect further exacerbate these challenges (Eller et al., 2014). The hospital has contributed to negative mentoring through factors such as the lack of structured mentoring programmes, an unsupportive mentoring culture and an absence of career development positions that would bolster career advancement through mentoring (Huang et al., 2023; Kramer et al., 2021; Rohatinsky et al., 2018).

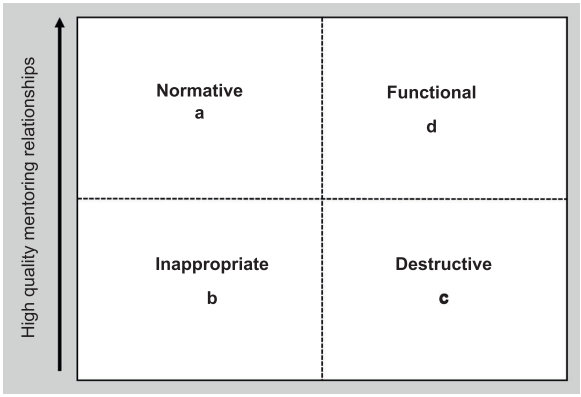

FIGURE 1 Conceptual dimensions of negative mentoring.

Negative mentoring can essentially be viewed in terms of what is ethically and morally acceptable but also in terms of functionality (Carr & Heiden, 2011; Feldman, 1999). Conceptually, mentoring approaches can be visualised on two continua (Figure 1). On the 'appropriateness' continuum, one end represents a normative mentor–mentee relationship marked by trust and mutual respect (Carr & Heiden, 2011). The opposite end features a relationship marred by distrust, characterised by snide remarks and overt disrespect. Meanwhile, on the 'functionality' continuum, one end represents relationships that fulfil both career and psychosocial mentoring roles. In contrast, the other end signifies relationships where mentoring is absent, or there is a deliberate attempt to harm the mentee's career prospects or tarnish the mentor's reputation within the organisation (Carr & Heiden, 2011).

Whereas all these challenges are what contribute to dysfunctional mentoring (Ragins, 2016), Eby suggests that both positive and negative elements simultaneously exist in the same mentoring relationship (Eby & Allen, 2002; Eby et al., 2008). For instance, two individuals might have clashing personalities, yet the mentor might still provide valuable career opportunities and adeptly coach the mentee in specialised clinical skills. Therefore, an ideal mentoring relationship seamlessly integrates normative attributes with functional experiences (a + d). Most of these challenges affect the effectiveness of mentoring programmes by impeding the attainment of mentoring goals of retention and career development (Kow et al., 2020). Literature in nursing and midwifery is silent on how these negative experiences impact the clinicians qualitatively. Despite these negative experiences and challenges, clinicians have continued to provide mentoring to new graduates and novices have persisted in mentoring relationships (Cheong et al., 2020). Drawing from the principles of the social exchange theory (Blau, 1964), clinicians weigh the benefits and costs of entering or persisting in a mentoring relationship, especially when faced with negative mentoring experiences. Nurses and midwives are likely to persist in mentoring if perceived benefits exceed the costs (Eby et al., 2008). For instance, combinations of normative attributes with destructive elements (a + b) or engaging in inappropriate behaviours but remaining functionally beneficial (c + d) could still be viewed as permissible (Carr & Heiden, 2011; Kumar & Blake-Beard, 2012). However, a relationship that is both inappropriate and

destructive (c + b) signifies the need to terminate the mentoring relationship (Washington & Cox, 2016) (Figure 1). Beyond a cost–benefit approach, scholars also contend that the nature of benefits derived from mentoring also influences persistence, the stage of the mentoring relationship and the level of support provided by the hospital organisations (Kow et al., 2020; Washington & Cox, 2016). In the literature on nursing and midwifery, the majority of scholars characterise the dark side of mentoring as a low score on positive mentoring scales (Choi & Yu, 2022; Pham et al., 2019). Negative mentoring should not be simplistically equated to a low score on positive mentoring scales. Instead, it warrants explicit examination and assessment in all mentoring relationships and programmes. Additionally, the experience of negative mentoring can differ markedly, especially in settings without structured mentoring programmes or in hospitals located in resource-limited environments (Ssemata et al., 2017).

2 | AIM OF THE STUDY

We therefore aimed to characterise the dark side of mentoring based on informal mentoring relationships occurring among nurses and midwives working in hospitals.

i. What negative mentoring experiences did nurses and midwives encounter in hospital settings?
ii. What factors did nurses and midwives perceive as contributing to negative mentoring experiences?
iii. How did the negative mentoring experiences impact nurses and midwives?

3 | METHODS

3.1 | Study design

The study was informed by the qualitative descriptive design (Sandelowski, 2000). This design allowed for exploration of the experiences of nurses in midwives with mentoring in their natural setting. Qualitative descriptive design is grounded in data allowing patterns to emerge naturally from the data. Qualitative descriptive design was especially useful in exploring a less researched area of negative mentoring (Sandelowski, 2000).

3.2 | Settings and participants

We conducted the study in three public hospitals in Uganda located in the North, Western and Northwestern parts of the country. Two of the hospitals were regional referral hospitals and one was a teaching hospital. All the hospitals are located over 300 km away from the capital city Kampala. The staffing at the hospitals was between 50 and 170 nurses/midwives (Department of Human Resource Management, 2021). These regional hospitals are crucial in providing services to adjacent districts and neighbouring countries that border Uganda. We selected these hospitals because they have similar human resource structures, including nurses and midwives with diverse qualifications. Additionally, their designation as regional facilities situated away from the capital, Kampala, and their comparable infrastructure—marked by the availability of hospital equipment and materials—were also crucial factors in their selection (Department of Human Resource Management, 2021). These factors contribute to shaping the clinical practice environment and lead to a degree of uniformity in clinical practices. For instance, research indicates that mentoring in regional and rural areas is perceived differently compared to mentoring in facilities situated in metropolitan areas (Rohatinsky et al., 2018). The process of recruiting participants involved posting the study advertisements on the hospital notice boards, which included the contact details of the lead researcher. Interested individuals who reached out were then evaluated to determine if they met the study's inclusion criteria and, if so, were arranged for an interview. The inclusion criteria for the study were twofold: first, participants had to be employed as nurses or midwives at the hospitals, with no specific rank or position required. Second, they needed to have either self-reported current and previous involvement in a mentoring relationship or be currently engaged in mentoring activities.

3.3 | Positionality of the researchers

The lead researcher, a practicing nurse at a regional hospital in Uganda and a nurse educator at a public university, brought invaluable insights from her experiences to the study. Her background in clinical work and education, coupled with her personal involvement in mentoring, equipped her with a profound empathetic understanding of the challenges encountered by both novice and senior nurses/midwives in mentoring relationships and support for new graduates. Aware that her mentoring experiences and professional status might not reflect those of the participants, she consciously adopted an open approach during interviews to embrace diverse perspectives. Recognising her potential influence on participant interactions—possibly seen as an insider familiar with their challenges—she aimed to balance empathy with objectivity, carefully navigating the dynamics to ensure research integrity. The expertise of the second and third authors as experienced qualitative researchers with a background in mentoring and professional development research, although in different contexts, played a critical role in the design, execution, and interpretation of the study. Their expertise provided depth and rigour to the research process, while their outsider status to the Ugandan context added a layer of reflexivity and comparative analysis to the interpretation of the findings.

3.4 | Data collection

The data were collected from June to September 2022 through a guided, semistructured interview guide (Rubin & Rubin, 2011).

The interview structure was divided into parts, with the initial section focused on collecting demographic details of the participants. We included questions to guide the exploration of the negative experiences encountered during mentoring processes: what factors hindered you from learning from your mentor in the workplace, what experiences hindered you from successfully mentoring other nurses/midwives in the hospital, what costs or disadvantages have you experienced while engaging in mentoring in the workplace and what institutional resources are available to you to foster mentoring in the hospital? Probing questions were used to explore the details of the dark side of mentoring and to clarify understanding. The interviews took place at the hospital premises, either in ward offices or in board rooms. The lead researcher (T. A. K.) was responsible for conducting all the interviews. These sessions were recorded and later transcribed by TAK. The duration of each interview varied, ranging from 20 to 90 min.

3.5 | Data analysis

Data analysis was conducted concurrently with data collection and transcription, adhering to the principles of reflexive thematic analysis for inductive reasoning (Braun & Clarke, 2019). The lead researcher, T. A. K, undertook the activities of transcribing and anonymising the transcripts, followed by preliminary coding in NVivo software. Subsequently, co-authors L. D. X. and D. C. independently assessed and refined these initial codes. The lead researcher searched for patterns in the codes to formulate initial themes. These were independently reviewed by the second and third author and the outcomes were discussed in regular meetings. Any discrepancies, insights, and reflections arising from their reviews were collaboratively addressed in research team meetings. Throughout the data collection and analysis process, researchers maintained a research memo, which played a pivotal role in shaping the interpretation of results.

3.6 | Rigour

We adhered to the four standard criteria to ensure rigour in qualitative studies (Guba, 1981). Auditability is evident in the decision trail, which can be traced from the research questions to the choice of methods of data collection, and analysis, which are described in the methods and the presentation of findings (Nowell et al., 2017). Credibility was maintained by keeping a research memo and seeking clarification from participants during data collection to ensure accurate interpretation. To facilitate transferability, we detailed the study's context and the characteristics of the participants, enabling the applicability of our findings to similar settings. Lastly, confirmability was established by basing our themes, subthemes, and codes strictly on the data collected from participants (Nowell et al., 2017).

3.7 | Ethical considerations

Ethics approval for the study was provided by the Flinders University Research Ethics Committee (5313) and TASO Research Ethics Committee (TASOREC/056/21-UG-REC-009 (AMEND)). Permission to access the study participants was granted by the administrative bodies of the involved hospitals. Participants were given an information sheet document detailing the study's objectives and procedures. Upon understanding the study's scope, they provided their written consent before the initiation of data collection.

4 | RESULTS

For this study, we recruited 35 nurses and midwives working in three regional public hospitals in Uganda. Participants were included if they expressed that they were in a mentoring relationship. Majority ($n = 25$) of the participants were female, with fair representation of senior clinicians with more than 5 years of experience (mentors, $n = 17$) and junior clinicians less than 5 years of experience (mentees, $n = 14$). We included executive nurses/midwives ($n = 4$). Only one participant had previous experiences with formal mentoring programmes (Supporting Information S1: 1). While mentoring was predominantly viewed positively, with a few participants ($n = 5$) specifically mentioning they had no negative experiences, four main themes emerged when discussing the dark side of mentoring: deficits in the mentoring process, issues in mentoring relationships, organisational challenges related to mentoring and the implications of negative mentoring experiences.

4.1 | Mentoring process deficits

Participants expressed negative mentoring in terms of experiences that impeded and affected their access to mentoring activities. These were expressed in four ways: *lack of mentoring*, *insufficient competence required for effective mentoring*, *mentoring equates to extended work responsibility and appropriation in mentoring relationships*.

4.1.1 | Lack of mentoring

Some participants ($n = 3$) reported a pure lack of mentoring in the units in which the new nurses worked hence requiring them to seek mentorship outside of their unit or ward 'within the ward I don't have yet, people have not opened up yet, giving me a chance, nobody has shown me that kind of environment am not saying they are bad people' (P-21). This was in some instances attributed to senior nurses' unwillingness to engage in mentoring. Furthermore, poor attitude towards clinical practice, the profession and mentoring in general had impact on the overall mentoring practices as experienced by many participants ($n = 20$). This negative attitude had repercussions on the

mentoring process even for those inclined to provide mentoring opportunities, as delineated by Participant 14:

> Also, poor attitude of some staff because I remember when I had just come [names a mentor] was willing to mentor us on surgical ward, … then some other nurse came saying 'this is theoretical what you are doing you are wasting time, they are waiting for the patients in theatre, let's just push[transfer] the patients'. (P-14)

Participants underscored a prevailing reluctance among some clinicians in nursing and midwifery to both learn new and unlearn old practices. Clinicians were aware that clinical practice was dynamic, yet some nurses and midwives often believed they already knew everything and resisted embracing new concepts or shedding outdated practices. These practitioners were considered set in their ways as Participant 4 explains:

> Yet sometimes it's something very simple that would make a whole big difference but because they have preconceived minds, and they say this is how I learnt it in school. You know science is not static and some of them are stuck in the past, I think that's the biggest challenge in mentoring. (P-04)

4.1.2 | Insufficient competence required for effective mentoring

Incompetence was expressed in the form of qualifications and mentoring ability. Participants described their mentors as lacking in mentoring techniques making it challenging to provide guidance, feedback or structure in a mentoring relationship.

> Incidentally not everyone you try to mentor will pick all that you teach them. And also, incidentally not every senior person can be a mentor. There is no classroom for that when it comes to nursing. (P-23)

Although some mentors possessed the clinical competence to mentor, they did not have the qualifications that were above or very least matched those of the mentee. This left the mentor feeling inadequate to establish a mentoring relationship.

> There is insecurity on the side of the ones who did certificate, may be sometimes as a BSN [Bachelor of Science in Nursing], or someone who has a masters [degree] even when you are quiet or you have not said anything, you are a threat to them. (P-13)

On the other hand, new graduates misunderstood the true nature of mentoring, often seeing it as a form of dominance. Mentoring was sometimes seen as too authoritative, which contributed to a sense of burden for both the mentor and the mentee: 'Yes, sometimes someone will feel like they are being despised, they feel you are showing off, you are showing them that you have a lot of knowledge' (P-11).

4.1.3 | Mentoring equates to extended work responsibility

A heavy workload was reported by majority of the participants ($N = 17$). This was expressed as a lack of time to engage in mentoring, too many clinical tasks and competing demands on the nursing and midwifery job. Nurses and midwives talked of being understaffed with heavy workloads on their units of work in the hospitals. Mentoring was therefore perceived as extra responsibility. The daily clinical tasks for nurses and midwives in the hospital placed competing demands on their job making it hard to dedicate time for mentoring others.

> The nurse is alone on duty, they are understaffed. She will focus on her work and ignore the other side of mentoring because at the end she will be paid for her work not the mentoring part. (P-14)

Participants reported that very few clinicians were willing to participate in mentoring, this left them overworked trying to take on the mentoring load left by the senior nurses/midwives that were unwilling to mentor 'You find a fraction are motivated, those motivated feel overworked, they are the ones doing everything, the others don't want to do certain things saying that's not my job' (P-12).

Some categories of mentees for example intern nurses had very brief periods of interactions with the mentors. For some senior clinicians, these mentoring relationships were too brief to fully realise their benefits and positive experiences.

4.1.4 | Appropriation in mentoring relationships

Mentors also felt that the rewards for their mentoring efforts were being given or taken by the people who did not directly take part in the mentoring. The act of credit taking was surprisingly being blamed on the executive management for not remitting rewards of mentors that had been delivered by the training institutions and partner NGOs. There were also instances whre fellow senior nurses and midwives reaped other clinicians' mentoring efforts:

> But I think its normally given[rewards] like those schools when they bring in students, they take to administration but they [administration] don't give us, they remain with everything. …am sure they give them some money but the in-charges you don't get anything. It remains in the administration, the big man

> keeps everything so the person who has not done anything is the one who enjoys everything, it's not fair at all. (P-25)

Exploitation was also a recurrent category in the data. Mentors leveraged their position in the mentoring relationship to exploit mentees for their own benefit. Mentees described taking part in activities that were not for the common goal in the mentoring relationship. They talked of having to sacrifice their time and comfort to please their mentors. Mentors were often cunning and given the power imbalance in the relationship, made it difficult to turn down their request: 'she calls you my son, today I know you are off [day off] but my son you come and help me and do this. When someone calls you son, you find you are going to bow down to any work they ask you to do' (P-14).

4.2 | Mentoring relational problems

The nurses and midwives encountered a number of relational problems while engaging in mentoring. These included: *heterogeneity in the mentor–mentee dyads*, *disrespect experienced and discerned*, *hostility in mentoring relationships*, *impartiality in mentoring and rivalry in mentoring*.

4.2.1 | Heterogeneity in the mentor–mentee dyads

There were various sources of mismatch between the mentor and the mentees that were reported by the participants. Mismatch was based on misaligned interests, expectations and stereotypes. There were stereotypes expressed by the participants that had implications for mentoring experiences. Oftentimes, mentoring experiences were viewed through the lenses of age, generations, gender and ethnicity, resulting in stereotypes such as ageism, sexism, genderism and tribalism.

> … tribalism you find the other feels much more comfortable mentoring his or her tribemate and can give him or her everything and when she or he is mentoring you and you are different tribe—there are some tribes that are against each completely—and when they realise you are from that specific tribe, they cannot feel open to give you all the required information. (P-30)

These stereotypes affected how the mentors and mentees perceived each other in a mentoring relationship. In fact, Participant 1 stated that on one occasion she felt the mentees judged her physical appearance: 'May be sometimes they look at the height, the weight and they say aaa now this one what can she do?' (P-01).

The influence of gender disparities between mentors and mentees was identified within the cultural context. This included a prevalent fear of forming close relationships with individuals of the opposite gender.

> But also, social perceptions interfere with the mentorship relationship even if there is something going on but the community around think that these people are too close and that in the long run affects how the two interact. (P-06)

Additionally, cultural norms dictated that males should not openly express vulnerability and should possess more knowledge than their female counterparts. Female mentors also expressed challenges while mentoring males, as this required them to display vulnerability in addressing the mentees' needs.

> But these males, sometimes you give a task then when you are not there to monitor, they walk away. The following day you come you ask about the task, they give excuses. So, they are more interested than their female counterparts to my understanding. But not all of them, you will always get outliers but when you get a male nurse, they can be so good. (P-05)

Some personalities posed challenges in mentoring relationships. Junior nurses/midwives found certain mentors distant, difficult and with their 'their mean face is on' (P-13). Whereas other participants expressed generational differences as the source of their relational differences. Different generations often had distinct professional values and attitudes and professional educational experiences, as well as clinical practices:

> when you come most especially nursing and midwifery profession, the old generation have their ways of how they used to do things and how they want people to … of which when you come to the new 21st century, things have changed, so of course you will actually think the old generation mentor is against your preferences kumbe [not knowing] it's because of the old training. (P-09)

Conversely, senior clinicians noted challenges when working with mentees who appeared shy or disengaged which attitude, they attributed to generational differences: 'in fact the challenges we get the young ones are not serious. When mentoring them they don't care, they seem to be playful all the time, they don't concentrate' (P-29).

4.2.2 | Disrespect experienced and discerned

Participants reported both explicit and covert forms of disrespect. Both senior and junior clinicians were equally adept at discerning behaviours and attitudes that indicated a lack of respect for each

other's contributions to the mentoring processes. Mentors felt undermined, unappreciated and unneeded 'the people who are unappreciative which is expected because all of us are unique we don't expect people to react the same way. And then sometimes, yes, the ungratefulness in some people' (P-03). Notably, the mentees believed that respect should be mutual. However, they perceived that this perspective was not reciprocally endorsed by the senior clinicians: 'you only go to somebody you feel you can learn something from and if you don't respect them, respect is reciprocal, if you can't give it to them, they will not give it to you' (P-13).

4.2.3 | Hostility in mentoring relationships

There were instances of hostility experienced by the mentee from the mentor. This manifested through comments that demeaned the mentees' accomplishments. On some occasions, these snide and belittling comments were delivered in the presence of patients and other junior colleagues. The mentors were frequently described as displaying rudeness, contentiousness and a persistent inclination to scrutinise and criticise the mentees, as indicated by Participant 12: 'For me I can put a canular and you have a bachelor's degree and me a certificate and you cannot put a cannular, … for you what were you studying?' (P-12).

4.2.4 | Impartiality in mentoring

Impartiality was a significant issue experienced by nurses and midwives, both as mentors and mentees. Often, mentors chose their mentees themselves, resulting in some individuals being excluded until they found a mentor willing to collaborate with them. This method of selection was perceived as favouritism by novice nurses and midwives. Additionally, there were instances of discrimination where senior nurses/midwives provided mentoring opportunities only to a select few of their mentees. This practice resulted in feelings of exclusion among other mentees.

> At some point you will find they are favouring one mentee over the other, you find am favoured over others and another person is favoured over me and mentor makes it obvious. Me, there are times I have experienced it, it has made me feel like, hhhm am I less competent, am I hmmm you struggle with yourself, you struggle to find out why are all these opportunities are being given to so and so. (P-07)

Additionally, bias was observed in the allocation of mentoring resources, as management predominantly directed these resources toward a specific group of mentors. This resulted in unequal access to mentoring resources among mentors. Mentors themselves recognised the role that favouritism played in perpetuating these biases within the mentoring programme 'I have not had chance whereas a mentor I have hand-picked because I would not want to be biased. I don't want to be biased' (P-03).

4.2.5 | Rivalry in mentoring

Mentors were perceived as being envious of the mentees, whom they saw as advancing rapidly through the career ranks with relative ease. There was a perceived anticipation that junior nurses and midwives would encounter similar career challenges as their predecessors did: 'I remember someone telling me, for you, you had an easy life, you went straight into a degree I went through a diploma. So, they feel like they painfully got there, why are you getting the easy way out? Why are you being a boss to them, yet you were a junior yesterday?' (P-24).

Mentors were consciously aware that due to the human resource structure in the hospitals where promotions were based on qualifications, mentees had higher chances at securing these promotions given some of the senior clinicians had lower academic qualifications. Mentors perceived it unfair to mentor junior nurses who would soon surpass them in their career journey as explained by one participant: 'The problem in our settings they take time to promote and confirm once confirmation is delayed, its demoralising to mentor others, how can I mentor someone to be in a better position that me myself I have not reached' (P-22). This left the mentors feeling threatened and uncomfortable in their mentoring role.

4.3 | Organisational challenges in mentoring

Nurses and midwives pointed out challenges related to the hospital hosting the mentoring activities. They highlighted issues such as *insufficient infrastructure for mentoring, the absence of relevant policies and uneven mentor-to-mentee ratios*.

4.3.1 | Inadequate infrastructure to facilitate mentoring

These barriers were related to the clinical environment and the organisation as a whole. There were four main classifications within this subtheme. First, the participants indicated there was a lack of infrastructure to support mentoring in the hospitals. The nurses and midwives expressed concern that the hospitals in their current state did not provide an ideal environment to translate knowledge and teach nursing and midwifery skills. The lack of infrastructure ranged from a lack of equipment for both diagnosis and treatment to a lack of basic supplies like gloves and other personal protective supplies. Mentors felt that they passed on knowledge to junior staff, which was based on theory and improvisation, a practice they believed was contrary to the ideal quality of care. This was well explained by P-08:

> Then in terms of supplies, they are not there, you know if you teach somebody, we use a cord scissor to cut the cord, then in actual sense the is no cord scissor instead you have to look for a razor blade, it becomes hard for this person to appreciate. (P-08)

The deficiency in infrastructure was also related to a lack of safe mentoring spaces where skills would be taught at a pace reasonable for the novice practitioner. Participants had concerns regarding teaching patients in high-fidelity settings. There were no demonstration rooms where learning could occur in a simulated setting before being exposed to the actual patient. The clinical environment can be fast-paced but also unsafe even for the novice; for example, event learning occurs with a highly infectious patient. Safe mentoring spaces would allow for mentoring, especially on high-fidelity wards as Participant 33 explained:

> So, some procedures are bit tricky to teach people, you wait until it's there [happening] or when it's there this person[mentee] might not be available or if he is there you don't know if he has understood … You make an assumption that he has understood but that's wrong. … by the time you involve the person [mentee] you are already in the middle of what you are doing, they probably missed the important part … By the time you finish either the patient survives, or the patient dies, now you are in the second procedure of last office. (P-33)

4.3.2 | The absence of established policies and guidelines to direct mentoring practices

Nurses and midwives in this study observed the noticeable absence of well-defined and structured mentoring systems. This deficiency encompassed a lack of comprehensive guidelines, explicit standards and tangible incentives to motivate and support mentors in their roles. This resulted in a lack of uniformity and consistency in mentoring practices. Within this context, the provision of mentoring relied predominantly upon the inclination and readiness of a limited group of mentors who were willing to engage in such mentoring practices. This meant that the extent and quality of mentoring available often rested heavily upon the discretion and enthusiasm of this select cohort of mentors. It is important to highlight that, in this scenario, the act of mentoring itself was neither enforced nor made compulsory by any overarching regulations or mandates. In other words, participation in mentoring activities was not obligatory, leaving the decision to engage in mentoring relationships largely at the discretion of individual mentors and mentees.

> You know now the system itself, the system right from ministry of health, the system has provided for mentorship. But it is us who are in these facilities that we do not see it, but if you look at the structures, me I think the system has provided. (P-01)

4.3.3 | Unbalanced mentor–mentee ratios in the clinical settings

The current state of the human resource structure had issues of insufficient staffing numbers, high workloads and conflicting work priorities that affected mentoring as Participant 22 described:

> I would say lack of human resource, we are not enough, this is supposed to be fully fledged regional referral … the nurses, the hospital is using the old staffing norm of general hospital, the nurses are not enough, there is a lot of work and so many project are brought in but the personnel is not there. (P-22)

Participants also talked about the overwhelming number of mentees on the ward. The hospitals had partnerships with nurse and midwifery training schools that often sent students to the wards for clinical placement. Since the schools were many per region, this further affected the mentoring experience as the student numbers were overwhelming for the mentors:

> Now you go to the hospital, 10 students from one school and we have 10 schools within [names location of hospital]. So, when they are on the ward, they are just standing looking at each other and there is no one to teach them. Even the senior staff are already demotivated because they are overwhelmed. (P-01)

4.4 | The implications of negative mentoring experiences

We explored the repercussions of negative mentoring, which manifested in two main dimensions: first, the *impact on nurses and midwives*, and second, the *strategies clinicians employed to navigate these adverse experiences*.–

4.4.1 | Negative experiences do not leave you the same

Participants acknowledged that mentoring was never aimed at being bad however these negative experiences had an impact. The experience of bad mentoring had impact on the mentee, mentor and the relationship. Negative experiences such as favouritism created a rift between the mentees in their struggle to get attention and acknowledgement from the same mentor. Furthermore, there was also a rift between a nurse/midwife willing to mentor and

another who perceived mentoring as a waste of time. The rift arose when the two mentors worked on the same ward 'I think that can discourage the mentor, because he will be wondering how the other staff look at him, because you would want to keep the relationship with the co-workers as well' (P-14).

Negative experiences left the participants feeling overwhelmed and mentally exhausted. As Participant 14 indicated at the end of the bad experience, 'you are overwhelmed' (P-14). In some instances, negative mentoring experiences caused clinicians to become less invested in their mentoring relationships. In more extreme cases, others decided to terminate these relationships and resolved not to engage in mentoring in the future: 'At the end of the day, you are overwhelmed' (P-14) or 'When I experienced them, I didn't really leave the mentorship but I began attaching less value and less commitment to it' (P-07).

When individuals opted to continue with the mentoring relationship, mentors often harboured resentment towards the mentees. Conversely, mentees felt that their mentors were withholding knowledge, due to the fear that the junior clinician might soon surpass them: 'and you are working with them, and they are at the same level with you or some are better than you because sometimes you mentor people they become better than you in certain aspects, which can make someone be negative' (P-24).

4.4.2 | Navigating the negative mentoring experiences

To navigate and persevere through adverse mentoring encounters, participants remained steadfastly focused on their ultimate objectives. They recognised that negative mentoring experiences could occur, although such experiences were never the intended outcome of mentoring. As long as their individual and professional aspirations were being realised, negative experiences were often tolerated. 'You know your goal, at the end of the day you learn, and you go away, leave the attitude that came with the learning' (P-2). Participants concluded that mentoring was worth the time despite the negative experiences: '… that's another disadvantage but they are really not that many [bad experiences], it's [mentoring] more beneficial' (P-13).

Interestingly, for some participants, encountering negative mentoring fuelled a determination to excel and surpass adversity: 'I actually want to do something and change it' (P-21). Otherwise, in some cases, the participants rationalised the bad behaviours experienced during mentoring as Participant 7 expressed 'I don't know, maybe they do it subconsciously' (P-07).

As explained by Participant 8, after experiencing a negative encounter, he would engage in self-reflection and endeavour to navigate these experiences in his own manner 'Even where it seems like this is not correct, I sit down and think about it and after a week I say maybe they were right' (P-08). At times, participants rationalised the mentor's behaviour as appropriate for the specific circumstances. For example, they assumed that the mentor might have had higher expectations for the mentee's performance.

5 | DISCUSSION

Our study makes a contribution to mentoring literature by exploring the dark side of informal mentoring among nurses and midwives working in hospital settings. Our findings show that mentoring is not always a positive experience. Sometimes there are negative experiences stemming from relational dynamics, specific mentoring processes and the broader hospital context. These findings are consistent with findings from Huang et al. (2023), who identified dimensions of negative mentoring as mentor, mentee and management-oriented factors in their quantitative study done among nurses. The problems arising from relational dynamics resulted in behaviours that were considered inappropriate for the normative functioning of the mentoring relationship. These were mainly heterogeneity between the mentoring dyad, disrespect experienced by either pairs, hostility, impartiality and rivalry inherent within the relationship. These findings are similar to what was found in research done in other organisations outside the acute care settings (Eby, 2007; Eby et al., 2004; Ragins & Scandura, 1999). Our research contributes to the existing literature by highlighting that while informal mentoring among nurses and midwives emerges spontaneously, it is not without its relational challenges. This finding is consistent with previous research on mentoring in low-resource settings (Ssemata et al., 2017).

Much of the existing literature examining the challenges in mentoring emphasises factors like race and gender, and their influence on positive mentoring experiences (Choi & Yu, 2022; Gong & Li, 2019). While these elements certainly shape access to mentoring, our findings show that personal attributes can also play roles in shaping experiences of negative mentoring. Unlike previous literature that shows that females are prone to disadvantages in mentoring, within the nursing and midwifery fraternity, the male gender seems to experience these issues more predominantly than the females as shown in this study. This can be explained by these professions being female-dominated (World Health Organisation, 2020). Heterogeneity in this study was also based on ethnicity where participants complained of tribalism. These findings have implications for implementation of structured mentoring programmes that it is important to evaluate the source of heterogeneity in the present relationship as opposed to popular matching of mentor to mentee according to personality traits. Relational problems in mentoring are detrimental as they erode trust, hinder open communication and can damage the mentee's self-esteem and professional growth (Ragins & Verbos, 2017; Wissemann et al., 2022). Therefore, fostering an environment of mutual respect and consideration is crucial for the success of mentoring relationships, as it enhances the mentee's learning experience and facilitates effective knowledge transfer from mentor to mentee.

Our study also revealed functional issues in mentoring processes ranging from a pure lack of mentoring, to mentoring appropriation. These findings echo previous results that highlight the negative aspects of mentoring, including the lack of expertise, as well as the significant amount of time and energy required for effective

mentoring (Eby & Allen, 2002; Ragins & Scandura, 1999). Our findings emphasise the unique context in countries like Uganda, where only 9% of professionals in the nursing/midwifery field hold a graduate qualification. This situation frequently results in mentors having lower academic qualifications than their mentees (World Health Organisation, 2017). Our study illuminates the varied competencies perceived as essential for effective mentoring. For instance, mentees might prioritise a mentor's specific skill set over their academic qualifications. Conversely, a mentor with clinical expertise might still be viewed as lacking in competence if they do not hold the relevant academic qualifications.

In concurrence with prior research, our findings suggest that irrespective of whether mentoring challenges are normative or functional, both the mentor and mentee can play roles as either the recipient or the source of these adverse experiences (Carr & Heiden, 2011; Feldman, 1999; Wissemann et al., 2022). Consider, for example, that perceptions of inadequate mentoring can arise from both a lack of requisite skills and qualifications among mentors and an insufficient grounding in foundational nursing or midwifery knowledge among mentees. Although given the inherent power imbalances in mentoring relationships, mentees may be more susceptible to these issues, especially in the context of the inherently hierarchical nature of clinical practice (Gergerich et al., 2019; Kow et al., 2020). Regardless of the source of the negative mentoring experiences, they adversely impact the work environment in the hospital. Such experiences can lead to strained relationships among colleagues, and reduced commitment to both mentoring and clinical practice (Bloxsome et al., 2019). Additionally, they often create a lack of sense of belonging, which may drive clinicians to quit the hospital organisation (Chamberlain et al., 2019). Those who choose to remain often do so under considerable distress. Consistent with prior research, our study underscores that negative mentoring experiences can hinder the attainment of fundamental mentoring objectives, including recruitment, retention and fostering a positive workplace atmosphere (Djiovanis, 2022).

Our study findings, in line with social exchange principles, suggest that nurses and midwives evaluate the costs and benefits of the mentoring relationship when deciding whether to remain committed to it or to terminate mentoring relationships (Blau, 1964; Wissemann et al., 2022). Clinicians frequently weigh the merits of mentoring, rationalising that if it aids in attaining their objectives, then the commitment of time and resources is warranted. Notably, our study reveals that negative mentoring experiences do not invariably result in undesirable outcomes (Mohtady et al., 2016; Zhang et al., 2016). In this study, the clinicians did not simply succumb to the negative aspects of mentoring. Instead, they actively leveraged these challenging experiences as opportunities for growth and self-improvement. They frequently engaged in introspective self-reflection, striving to understand and recognise their own roles and contributions to the negative dynamics of the mentoring relationship. This proactive approach underscores their resilience and commitment to personal and professional development, even in the face of adversity.

An organisational culture that is supportive of mentoring is crucial for the outcomes of mentoring and effectiveness of mentoring relationships. An organisational culture in mentoring is demonstrated through instituted mentoring guidelines and formal mentoring programmes (Giacumo et al., 2020; Kow et al., 2020). However, our study revealed a lack of resources to support mentoring. This can be explained by the fact that most of the mentoring in this study was informal in nature. Informal mentoring arises naturally among clinicians without explicit support from the organisation (Liu et al., 2021; Mullen & Klimaitis, 2021). Furthermore, it is a common finding that hospitals in developing countries often grapple with resource deficits (Kakyo & Xiao, 2019). The organisation's mentoring culture is further impacted by lateral violence and bullying often present within the nursing and midwifery professions (Bambi et al., 2018; Blackstock et al., 2018).

5.1 | Implications for the nursing profession

Mentoring is crucial for the nursing profession worldwide, yet negative mentoring experiences can lead to attrition, exacerbating the global nursing shortage and negatively impacting patient care. Negative mentoring experiences, such as constant criticism, belittlement or lack of support, can erode a mentee's confidence and competence. This undermines their ability to perform effectively, acquire new skills and grow professionally, with far-reaching consequences for the hospital or organisation. New graduates subjected to negative mentoring may become disillusioned and disengaged, leading to decreased job satisfaction and increased burnout rates among nurses. This, in turn, affects their retention within the profession. High turnover rates disrupt the continuity of care, inflate recruitment and training costs and place additional strain on an already understaffed healthcare system.

Nurses lacking adequate support or guidance from their mentors may struggle to deliver high-quality patient care. For example, negative mentoring experiences can lead to errors, lapses in judgement and compromised patient safety, ultimately affecting patient outcomes. Collectively, negative mentoring experiences can foster a toxic organisational culture marked by distrust, poor collaboration and low morale. Dysfunctional mentoring relationships can have a ripple effect across the nursing team and the broader healthcare organisation, potentially deterring senior nurses from engaging in future mentoring activities to support new nurses. Our study shows that mentoring needs vary by context and organization, sometimes, individuals with less educational experience may find themselves mentoring newer nurses with higher education levels. To address and enhance mentoring practices, organisations could consider providing mentor training programmes to support and improve mentoring within the organisation, ensuring a positive impact on the nursing profession and patient care.

6 | CONCLUSION

Our study findings underscore that negative mentoring experiences arise from specific mentoring processes, relational dynamics and the overarching hospital environment. For nurses and midwives working in

hospitals in a resource-constrained context, coping with these negative experiences involved transforming these challenges into opportunities for growth and self-improvement, while introspectively examining their roles in contributing to these negative experiences. Such a proactive approach highlights their resilience and steadfast commitment to professional development, even in the face of adversity.

Pinpointing the root causes of detrimental aspects in mentoring is crucial for hospital administration to effectively address and rectify them. Many formal mentoring programmes, aiming to mitigate these negative elements, involve the hospital management in meticulous matching processes. Here, clinicians are paired based on congruencies in personality traits and demographic characteristics. While findings from informal mentoring suggest that such matching can alleviate relational issues, it may not rectify functional deficiencies. For instance, even if a mentor and mentee share compatible personalities and harmoniously interact, the mentor might still lack the requisite expertise to guide the mentee or the necessary organisational connections to advance the mentee's career. Hence, a thorough understanding of the issue is paramount in devising appropriate solutions.

To the Ugandan nursing and midwifery fraternity, the study highlights the context-dependent nature of mentoring within the healthcare system, which predominantly relies on informal mentoring to support novice nurses and midwives. Despite the organic development of this mentoring type, it is not devoid of negative experiences. Larger systemic factors, such as human resource structures, infrastructure and organisational policies, significantly influence the mentoring processes and their outcomes. It is crucial to regularly address these factors for both mentors and mentees, as they substantially impact the organisation's mentoring culture. Continuously evaluating the mentoring experiences of both senior and novice nurses/midwives is essential to understand specific challenges they encounter, thereby facilitating timely interventions. There should be mechanisms in place to mitigate the effects of ineffective mentoring. This is vital to ensure that the profession retains its professionals and is not adversely affected by poor mentoring practices.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data are available upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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