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WEB PAPER

Is there a role for mentoring in Surgical Specialty training?

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Abstract

Over the last decade, there have been considerable advances in the field of medical education and great strides in education research. Although all trainees should nowadays have educational supervisors there remains a focus on assessment which may detract from global support for personal and professional growth.

Mentoring has been shown to help mentees overcome difficulties, discuss problems and fulfill goals and is flourishing in many areas of the private and public sectors. Within medicine, there have been such dramatic changes in training recently that additional support may be needed if the new generation of trainees are to maximise their learning and professional development over ever shorter training periods.

Having a mentor; a confidential ear and sounding board who is independent from their assessment may encourage more open discussion and provide better support than is currently available. This article focuses on the needs of the surgical trainee but the concept of mentoring should not be limited to this group, and the techniques described in this paper could equally apply to any other medical speciality.

The article reviews the current role of mentoring in medicine, outlines the current structure of surgical training in the UK, considers why mentoring might be beneficial in surgery, what forms it might take, how mentors would be trained and how the programme could become established.

Introduction

> *People do grow, learn, thrive and excel when organisations make provision for particular and specific interpersonal support at key times* (Cross 1998).

Mentoring has been defined by Whittaker as 'a relationship between two people in which trust and respect enables problems and difficulties to be discussed in an open and supportive environment' (Whittaker and Cartwright 2000). Connor suggests that mentors provide a safe place for reflection, they listen and support, explore strengths and blind spots, enable self challenge, generate insight and focus on goals (Connor et al. 2006). Ideally, mentoring should be independent from assessment, performance review or evaluation within a mentees' workplace (UKCC 2001).

Mentoring Schemes are in place in all sectors of society: education, the voluntary sector, private business or those disadvantaged in employment (e.g. ethnic minorities, prison service) (Megginson et al. 2006). This range of settings highlights the potential diversity of purpose, scope, setting, activities and standards of mentoring (Megginson et al. 2006). Medical schools have generally embraced mentoring but these mentoring schemes have not progressed up the same career ladders as their respective mentees. Medical mentor-mentee relationships have thus tended to cease either at the onset of the clinical years or at graduation into full time employment.

Practice points

- There are considerable changes in the structure of medical training currently and so support at this time is crucial.
- If we wish trainees to thrive and excel rather than "just be competent" we need to consider adjuncts such as mentoring to maximise training and development.
- Mentoring could be undertaken on a formal or informal basis; face-to-face or by email.
- Training for the mentors and interest from and engagement of the mentees is crucial.
- Mentoring should ideally be independent of assessment.

The article reviews the current role of mentoring in medicine, outlines the current structure of surgical training in the UK, considers why mentoring might be beneficial in surgery and what forms it might take. Setting up such a programme, funding it or measuring its outcomes are not within the remit of this discussion but these areas are dealt with well by the Mentoring Manual by Whittaker and Cartwright (2000). It is important to state from the outset that this article focuses on the needs of the surgical trainee but the concept of mentoring should not be limited to this group, and the techniques described in this paper could equally apply to any other medical speciality (Blixen et al. 2007; Mainiero 2007).

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Are there mentoring programmes already in place within medical training posts and are they successful?

Although mentoring has been shown to work in big organizations it has yet to be trialled on a large scale in the National Health Service (NHS). As part of the Modernizing Medical Careers initiative, the foundation and specialty training programmes represent a massive change in the training of most junior doctors. The NHS Scotland website suggests that training in the past lacked sufficient help in personal and professional development and the new training programme offers the chance of considerable improvements. Within the foundation programme, each doctor is allocated a foundation tutor whose roles include 'career guidance, appraisal, assessment, mentoring and ensuring the provision of formal education experiences' (NHS Scotland 2004). From informal discussions with Foundation trainees, they have found good support but see their tutors as supervisors and assessors primarily; rather than mentors. Certainly their appraisal and assessments use up most of their allocated feedback sessions and interferes with the potential mentee-mentor relationship (Mason 2005).

Buddeberg-Fischer and Herta (2006) undertook a medline review of formal mentoring programmes for medical students and doctors finding 16 studies (9 medical students, 7 doctors) where the main goals were to increase professional competence in research/specialisation or to build professional networks. Short and long term evaluations were lacking and a cost:benefit analysis has yet to be undertaken. Connor et al. (2000) described a hospital based mentoring network, set up and studied between 1994 and 1999 but which was maintained after study cessation. The study concluded that mentoring was important for all junior doctors, newly appointed consultants and those senior doctors who felt isolated.

Freeman et al. (1997a) commented on mentoring within General Practice in the South Thames region. They found that access to a mentor could increase a sense of well-being and bring about a reduction in negative stresses. The mentee was thus able to maximise their professional growth whilst the mentor was found to experience enhancement of their professional identity. The United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) also released guidance on mentoring although issues of assessment in particular and also that of 'role-modelling' could be debated (UKCC 2001).

Recently, in the British Medical Journal there have been a series of articles discussing mentoring and coaching. Interestingly, Houghton suggests that intensive mentoring (two hourly sessions fortnightly) is advisable for developing the relationship and the sessions should be ring fenced from other activities and disturbances (Houghton 2005a,b).

Current surgical specialist registrar training

The responsibility for ensuring good training (and personal development) in general surgery in the United Kingdom (UK) currently lies with the trainee, their present and past consultant trainers, the speciality programme training director and the postgraduate dean. In reality, the trainer remains the teacher, supervisor, assessor and opportunistic mentor (if so inclined) within what is essentially a mono-support model that lacks a formal mentoring programme.

Table 1. The scope and benefits of mentoring.

Trusted and faithful guide - to guide on the journey of development
Facilitator - enables the mentee to open up new possibilities and set/achieve goals
Coach - encouragement and feedback; acquisition of new skills
Sounding board - a safe place to try out new ideas
Critical friend - supportive challenge
Networker - helps develop useful connections at work
Role model - the example from which to learn

Connor, Johnson, Pokora & Redfern, 2006, Mentoring Development Programme Handbook.

Only once a year is a trainees' overall performance reviewed by a representative of an independent specialist advisory committee (SAC). The emphasis of these discussions are competence (operatively and clinically), patient safety and adequacy of surgical learning opportunities. The trainees personal and professional growth is not a focus and so an important part of their development is potentially untapped.

The benefits of mentoring, by someone not linked to assessment (i.e. surgical trainer) have already been described above. Table 1 highlights the broad areas of additional support that mentoring could provide (Connor et al. 2006). There are also alternatives to face-to-face mentoring. In an unpublished study, 13 E-mentees found electronic mentoring (E-mentoring) to be very useful as part of their global development as surgeons. Areas where E-mentoring were most useful included encouraging reflection on current training, identifying the good points of a job, providing career advice and improving audit skills (Macafee and Surgical E-mentoring Research Group 2007).

There is currently no recognition that having someone distinct from the trainer might be beneficial to the specialty trainees' professional and personal development. This apathetic state is probably compounded by the healthy number of applicants for registrar posts as these jobs are still sought after. Thus the comment 'trainees did fine without mentors in the past' is still seen as an acceptable conclusion to draw. As trainees we are also at fault for not highlighting the importance of personal development and maximisation of our professional growth.

Medical training as a whole is at odds with the nursing and midwifery professions, where mentoring programmes are already established within every placement. Most importantly, the process is taken seriously, emphasis is placed on it and this emphasis instils pride in the mentors. If we have a desire to see trainees thrive and excel, rather than 'just be competent', then we need to ensure that training does not become assessment obsessed and we should strongly consider adjuncts such as mentoring which focus on the broader development and personal growth of the trainee. There are several potential

directions to take from our current position. We could:

(1) accept that mentoring is not required as a separate entity within surgical specialty training;
(2) conclude that the key mentoring goals (e.g. personal development, reflection, career guidance) can be achieved by the trainer alone;
(3) decide that an independent mentoring programme needs to be introduced.

If specialty training has survived despite the lack of mentoring, why should there be a need for it now?

This is a time of considerable flux in many public organisations and surgery is no exception. Foundation and specialty training programmes will dramatically alter the structure and form of training in the future in every specialty, whilst the increasing desire for a better work-life balance and the proportion of female doctors have brought the issues of flexible training to the forefront (Bickel 2007). The aforementioned changes, combined with fewer hours at work and shorter training periods have led to many concerns about training. In addition, a loss of the team approach due to the onset of shift working patterns is unsatisfactory to both junior and senior staff.

Surgical training in the past has not been well structured: it was based on very heavy on call duties (1 in 2), many anecdotes of steep learning curves, no consultant input, many frightening moments and even evidence of bullying (McAvoy and Murtagh 2003; Quine 2002). In many parts of the UK these days, consultant support and involvement in patient care is superb and bullying is not tolerated but there are equally ever rising pressures on trainees both within training, medico legally, professionally and personally.

The current situation of combined training, assessment and opportunistic mentoring is therefore, I believe, becoming increasingly untenable not just in terms of professional support but also assessment. The trainer spends ever decreasing amounts of time with their respective trainee yet is expected to continue to make an assessment of their training potential and fitness to practice. Asking them to provide mentorship in addition is probably both unreasonable and unrealistic. These changes in workforce planning and the increasing regulations of the medical profession only strengthen the case for formalised mentoring schemes which would have the sole purpose of providing personal and professional support and guidance.

If mentoring was introduced what forms might it take?

Mentoring could be undertaken formally or informally; face-to-face or using electronic media such as email.

Garvey suggests that formal mentoring involves agreed appointments, venues and time-scales and may be part of a recognised scheme. An informal programme is managed on a more casual basis so making the mentee-mentor relationship fluid. This might make the process more achievable for surgeons' due to their heavy clinical commitments. The informal approach allows mentees and mentors to reflect on their learning styles and negotiate appropriate timetables to produce individually tailored mentoring plans. The more rigid formal approach does have some benefits and might prove more satisfactory to more inflexible individuals who have limited time. The Ashridge Mangement research group surmised that formalized mentoring arrangements could be as good as naturally occurring mentoring (Conway 1994).

The majority of mentoring relationships to date have involved face-to-face contact, which is still seen by many to be the gold standard format (Megginson et al. 2006). The growth of electronic media (e.g. email, podcasts, discussion boards) raises new and exciting possibilities although it does raise other problems such as confidentiality and a potential loss of non-verbal cues. E-mentoring has the same aims as face-to-face mentoring but it primarily uses electronic communications (internet, email, telementoring, cybermentoring) to build and maintain the mentoring relationship (Perren 2002). Electronic mail and other electronic mediums potentially offer economical ways of mentoring by impinging less on E-mentees' and E-mentors' time (e.g. travel) which could make frequent interaction more feasible (Stokes et al. 2003).

E-mentoring is a new concept to medical education but it has been used in both the public and private sector for over a decade. In nursing it aids recruitment and retention, in the NHS it supports aspiring clinical managers and in business it supports courses (e.g. MBA), provides career or business development advice and provides a link between students and future employers (Youth Trust 1997; Kalisch et al. 2005; Garrett-Harris 2006; Gunning et al. 2006).

What mentoring models could be used and what are their relative merits?

Five major mentoring models are described in the literature (Edgehill 2005).

- Apprenticeship (mentor acts as master)
- Competency (mentor acts as supervisor and assessor)
- Reflective (mentor becomes a reflective practitioner)
- Informal (mentor acts as sponsor or friend)
- Continuum of mentoring.

Apprenticeship, which would probably be the most recognizable model to surgeons, sees learning occurring by emulation of experienced practitioners and by supervised practice (Edgehill College 2005).Within medicine, there is currently a move towards competency based training although having your mentor as an assessor is not ideal. A reflective mentoring practice involves the mentor as a 'wise man' aiding the mentee to reflect on their skills, their knowledge, their decision making and moral values (Edgehill College 2005). Informal mentoring is less restrictive and prescriptive whereas the continuum of mentoring sees the process as a journey for both mentee and mentor where both learn new skills and develop over the mentoring period.

As to which model is best could be answered by considering who would benefit from each model most. The majority of surgical trainers who train and informally

Table 2. Mentoring profile form.

Name?
Describe key events in your life?
What would a partner, close friend or relative say about you?
What are your values? What's really important to you?
What are your main interests?
Why are you interested in mentoring?
Wht skills do you have which would help you as a mentor?

Whittaker & Cartwright 1990, The Mentoring Manual.

mentor well, could continue follow the apprenticeship or informal models with no detriment to their trainee. Such an approach would not rock the boat nor would it require further manpower and educational support. Competency based models may be forced upon the profession as our abilities to perform individual tasks in isolation becomes the accepted assessment of training but I think increasingly a reflective model of mentoring is required completely separate from the assessment process. This could mean that a trainees' mentor need not necessarily be a past, present or future trainer or assessor.

How to prepare surgical mentors

Although there are no surgical mentoring schemes to use as examples, I can envisage mentors, allocated by the programme director, providing infrequent (three monthly) but formalized mentoring sessions. The first stage in the programme would be to identify suitable mentors, probably by identifying the most respected surgical trainers in the region. Garvey suggested that the characteristics needed for the programme to work were; the right people with the right understanding, right value system and the right attitude (Garvey 1997). Crucially, Megginson reminds us that mentoring should be 'off-line'; so someone that is not the mentees' line manager or trainer (Megginson et al. 2006).

Time and funding to train mentors would be crucial as there are specific skills and concepts to grasp (e.g. Egan model of mentoring) and important management areas to be discussed (e.g. setting of boundaries, confidentiality, mentoring vs. assessment) (Egan 2006). It should be remembered that mentoring is a powerful tool and so has the potential for harm if not used appropriately by sufficiently trained people. Colley's review of the myths around mentoring is a powerful read, looking at issues of feminism, class and social exclusion and some of the potential pitfalls and myths of mentoring (Colley 2001).

Whittaker's mentoring profile form would be an interesting early exercise as it contains some very personal questions which some surgeons might be hesitant to answer (Table 2) (Whittaker and Cartwright 2000). The completion of this form might be indicative of how willing the potential mentor would be to share their thoughts and feelings with their current or future trainees/mentees. Setting the mentor direction, nicely summarised in the Edgehill University core content documents on mentoring, would provide a basic structure for the initial

Table 3. Setting the mentor direction.

What do you want to become?
What do you want to be different in your circumstances in 12 months time?
How do you want to feel about your work, or yourself at that time?
How will you know if you have made progress?
What will you do when you have made this transition?
What specific help would you find most useful?

Edgehill University; http://webct.edgehill.ac.uk (accessed 2005).

Table 4. The skills and qualities needed by a mentor.

Ability to
Listen and hear what is said
Question and challenge their own thinking and the thinking of other
Summarize and reflect back
Give and receive constructive feedback
Point out connections and contradictions
Display empathy and understanding
Encourage problem solving and seek solutions
Recognize and acknowledge emotions
Trust others and be trusted by others
Be open and honest with self and others
Be a "tough" friend
Give as well as receive unconditional time and space

Whittaker & Cartwright, 1990, The Mentoring Manual.

sessions (Table 3) (Edgehill College 2005). In addition, background reading using the works of Gay (1994), Furlong & Maynard (1995), Freeman (1997b), Garvey & Alfred (2000), Whittaker and Cartwright (2000), and Clutterbuck (2004) would be of benefit.

Although choosing the mentor candidates would rely on one person, either the programme director or the mentoring administrator, it is important during the training process for the mentor candidates to reflect on their own skills and decide if they have time to give and the ability and desire to mentor. The abilities of successful mentors was nicely summarized by Whittaker (Table 4) and is a useful aide me moiré (Whittaker & Cartwright 2000).

The content of the session would have been considered and agreed in advance with both sides (mentor and mentee) bringing issues to the session for open discussion. Common subjects would be surgical cases managed well, those managed badly and cases where there were management disagreements. Discussions could then move to personal and professional development where the future aims, hopes and issues could be discussed.

Getting surgical mentoring off the ground

Although this discussion has focussed specifically on mentors, the first step in this process must be a clear signal from higher

surgical trainees that they wish to be involved with a mentoring process. Currently, with obscure definitions of mentoring and overlapping functions of trainers/appraisers/coaches, mentoring must be as clearly defined as possible and then trainees must decide if it will be of benefit to them (Garvey 2004). Without the desire and realisation of those that will potentially gain most from the process, the programme will not survive. Ultimately, I suspect within general surgery it will either occur through enforcement (laid down by the Royal Colleges) or through minor or major recruitment crises when it becomes clear that even focussed surgeons might benefit from support, feedback and advice.

Should that desire become evident, it requires a receptive training committee who are responsive to their trainees to begin the process of training future mentors. The training of mentors is crucial and it needs to be focussed, relevant and timely. Maintenance of high standards for mentors must be a priority rather than trying to simply ensure there are enough mentors to go round: poor quality mentoring will only undermine the process. The process should be overseen by an administrator who initially ensures allocation and feedback but also coordinates regular meetings for mentor-mentor discussion. Finally, there must be some recognition within the appraisal and revalidation process for consultants if the programme is to be given that initial injection of enthusiasm.

Conclusion

Mentoring is well established in many areas of society and could be a useful adjunct and source of support in future specialist surgical training. I believe that we need to increasingly consider the global development of surgical trainees as both training, society and the medical profession have changed considerably since the traditional surgical training mould was created. Regular mentoring sessions could benefit both the mentee and the mentor and these sessions could be conducted either face-to-face or using modern electronic media to save time, travel expense and to enable increased flexibility. Although focussing on the needs of the surgical trainee the techniques and mentoring structure could equally apply to any other medical speciality.

Notes on contributor

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