



Editorial

Mentoring during surgical training: Consensus recommendations for mentoring programmes from the Association of Surgeons in Training



A B S T R A C T

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Mentoring has been present within surgical training for many years, albeit in different forms. There is evidence that formal mentoring can improve patient outcomes and facilitate learning and personal growth in the mentee. The Association of Surgeons in Training (ASiT) is an independent educational charity working to promote excellence in surgical training. This document recommends the introduction of a structured mentoring programme, which is readily accessible to all surgical trainees.

A review of the available evidence – including an ASiT-led survey of its membership – highlights the desire of surgical trainees to have a mentor, whilst the majority do not have access to one. There is also limited training for those in mentoring roles. In response, ASiT have implemented a pilot mentoring scheme, with surgical trainees acting both as mentors and mentees. Based on the existing literature, survey data and pilot experience, ASiT formalises in this document consensus recommendations for mentoring in surgical training.

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1. About the Association of Surgeons in Training

The Association of Surgeons in Training (ASiT) is an independent professional body and registered educational charity working to promote excellence in surgical training for the benefit of patients and surgical trainees alike. With a membership of over 2300 surgical trainees from all 10 surgical specialties, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations.

2. Modern mentoring in surgical training

The term mentoring is derived from the character 'Mentor' from *Odyssey* written by Homer in the 8th century BC [9]. Mentor served as a teacher and guide to Odysseus' son, Telemachus. Despite its historic name, mentoring only began to enter modern literature in the 1970s but has rapidly gained popularity over recent years. There is good evidence in many fields such as law, business and nursing, that mentoring can benefit career progression and heightened job satisfaction [14,16,18]. The Royal College of Surgeons of England has stated that mentoring is "hugely beneficial to doctors, their colleagues, patients and to the [NHS] organisation as a whole", and strongly advocates mentoring at all stages of a surgeon's education and throughout their career [4].

There is debate as regards the true definition of mentoring (Table 1); in healthcare it has traditionally been taken to mean a senior clinician providing advice and trainee development opportunities to a junior. In surgery it is typically an informal, popularity-based system, with little structured preparation or training for mentors. Trainees face numerous challenges during a highly competitive surgical training process, including their own career planning and external issues such as working hour limits and work-force changes. To address such issues and the many other everyday trainee concerns, there is clear need for a more robust system to help equip trainees with the skills necessary to generate solutions to their own problems/goals and to enhance their own career progression.

Given the proven utility and accepted role for mentoring in other occupations, medicine as a whole has been slow to adopt and formalise this within the profession. To date, mentoring has been most widely studied within academic medicine, where it is perceived to play an important role in influencing personal development, career guidance, career choice, and research productivity [15]. Given the high-stakes performance and competitive nature of surgery, it is therefore surprising that the benefits of mentoring have not been more broadly taken on board as they have been in the corporate environment. Personal examples of the arrangements and benefits typically seen in high-level law and business environments are provided in Table 2.

Table 1
Examples of the various definitions of mentoring.

1. A mentoring relationship [1]:
 - a. Focuses on achievement or acquisition of knowledge.
 - b. Consists of three components: Emotional and psychological support, direct assistance with career and professional development, and role modelling.
 - c. Is reciprocal, where both mentor and mentee derive emotional or tangible benefits.
 - d. Is personal in nature, involving direct interaction.
 - e. Emphasizes the mentor's greater experience, influence, and achievement within a particular organization.
2. An effective mentor will facilitate the development of independence, self-confidence, job satisfaction, upward mobility, and decision-making/problem-solving skills in the protégé (aka mentee) [7].
3. The process whereby an experienced, highly regarded, empathetic individual (the mentor) guides another individual (the mentee) in the development and re-examination of their own idea, learning, and personal and professional development [2].
4. A mutually beneficial, goal orientated, two-way interaction between two individuals aimed at facilitating the mentees to achieve their goals and realise their potential (ASiT Consensus).

3. Current status of mentoring in surgery

Previous commentaries have discussed the paucity of formalised mentoring in surgery, citing a lack of volunteers, support, rewards and time constraints as potential limiting factors [12]. Additional perceptions of mentoring being related to weakness or poor performance may have influenced its uptake [4]. Perhaps related to this, a recent systematic review of mentorship in surgical training noted the scarcity of studies pertaining specifically to this area [5].

In the UK and Ireland, mentoring during surgical training remains the exception. One regional study of UK surgical trainees reported only 34% had a mentor, but amongst those identifying one, 85% were satisfied with their experiences to date [10]. Another recent national study highlighted the lack of a deliberate approach to mentoring in surgery, with only 52% of surgical trainees identifying a mentor [8]. In agreement with this, a national pan-specialty study undertaken by ASiT showed that 48% of surgical trainees did not have a mentor and, of these, 72% felt that having a mentor in surgical training was important. Only 8% of respondents had previous training in mentoring skills, whilst 83% wanted formal coaching and mentoring training [17]. There is increasing evidence of demand for mentoring as part of surgical training, with recent studies discussing the potential role of mentoring and various models [11].

Numerous steps have been taken towards introducing structured mentoring across medicine in order to formalise

Table 2
Examples of the mentoring arrangements and their benefits in law and business.

"We are convinced that coaching and mentoring accelerates development and enhances commitment. From my own perspective, having a coach and mentor during my transition to partnership has been invaluable. It provides a safe developmental space whilst challenging me to perform at a consistently higher level."

Samantha Brown
Partner, Herbert Smith Freehills LLP

"Your mentor provides you valuable sounding board – someone with whom you can discuss your development or how you might approach the challenges of the moment. Mentoring works best when people seek out the right person to help them based on their own needs at the time; it is normal for people to change their mentor as their needs change."

Gideon Burke
Management Consultant, Business Transformation, PA Consulting Group

relationships, set goals and provide training for mentors, with the overall aim being maximisation of personal potential and professional achievements of the mentee. Specifically within surgery, it has been shown that focused mentoring can improve attainment of technical surgical endpoints, such as has been demonstrated in the context of laparoscopic colorectal training [13].

4. Purpose of mentoring

Coaching and mentoring schemes can be widely beneficial, including affording benefits to the mentee, the mentee's colleagues and those working around them, as well as the mentor. Importantly, it is felt that patients can be listed amongst the beneficiaries of a mentoring scheme for clinicians. Aspects of mentoring include, but are not limited to:

- Assisting in areas of life where people are facing choices, e.g. deciding on a specialty, taking time out of their training programme
- Working relationships with colleagues
- Academic development and scholarly projects
- Pastoral issues
- Career progression

Although ASiT has previously called for mandatory training and dedicated activity time for clinical supervisors, together with improved continuity in the trainer–trainee relationship [6], formalised mentoring has the potential to go much further.

5. Recommendations for mentoring in surgical training

Based on the results of ASiT's previous trainee survey [17] in combination with our experience establishing a national mentoring surgical trainee mentoring scheme pilot program, ASiT have worked to make the following recommendations for mentoring in surgical training. These resulting statements represent consensus opinion following extensive discussion and ratification by the ASiT Council. This therefore represents a definitive action list, detailing factors that would facilitate, support and encourage high quality mentoring during surgical training.

5.1. Recommendations regarding the availability of mentoring in surgical training

1. All surgical trainees in recognised training posts should have access to a surgeon who has undertaken training to act as a mentor.
2. Mentors may be loco-regional or remote, depending on the needs of the mentee and other potential constraints including geographical extent of the training region.
3. Mentees should have the choice of a mentor from within or outside their own surgical specialty, or outside of surgery if they so wish.

5.2. Recommendations regarding the delivery of mentoring in surgical training

4. Mentors should receive training in mentoring techniques by an accredited mentoring coach prior to mentoring trainees. This will ensure that the mentoring relationship benefits both participants.
5. Ongoing training for mentors should be available, with the option of peer mentoring from other mentors. This will

facilitate further development of skills in this area and allow wider discussion of experiences.

6. A robust protocol for matching should be in place, with mentees being given a choice of possible mentors. Clear guidelines need to exist surrounding mentee requests (e.g. a particular mentor) and that these may not be granted.
7. Mentors should be asked how many mentees they are willing/have time to mentor.
8. Mentors should aim to encourage their mentees to progress through reflection on their own goals, skills and knowledge, as opposed to simply providing them with advice.
9. Ideally mentors should not have a conflicting power relationship with the mentee. There should not be the potential for the mentor to *directly* impact on the mentee's career.
10. Mentor and mentee should establish and agree the 'ground rules' of the mentoring relationship from the outset; this ensures that all parties are clear regarding arrangements and expectations. This may include timing of meetings, duration of the mentoring relationship, general topics (professional and/or pastoral) and the medium through which the meetings will take place.
11. An agreed initial length of the mentoring relationship should be identified by the mentor and mentee at the outset. This may be extended if there is a need and at the discretion of both parties. Successful and beneficial relationships may continue long-term if both parties are willing.
12. The timing of sessions should be mutually agreed between mentor and mentee, however these should occur at least bi-monthly and ideally once a month in order to allow the mentoring relationship to develop. Additional meetings can be requested at the discretion of both parties.
13. Mentoring meetings can be held through any of a number of media in addition to face-to-face. This may include a combination of, telephone, online video call (e.g. Skype™, FaceTime™, Hangouts™) or email, and will allow geographical barriers to be overcome.
14. Mentoring meetings may cover both personal and/or professional matters, depending on mentee needs and what topics mentor and mentee feel comfortable discussing.
15. The mentoring relationship can be ended by either party at any time if it is felt to no longer be beneficial or productive.
16. Mentees should have a named contact in case they wish to discuss concerns regarding their mentor.
17. Mentoring should be mentee led, with mentees taking responsibility for session arrangements and topics.
18. Anonymised feedback should be sought from mentees to enable ongoing development of the scheme and aid mentor development. Feedback in relation to the mentoring programme should be provided by both mentors and mentees.
19. Absolute confidentiality is paramount in the mentoring relationship, accepting the limitations of professional responsibilities. Mentor and mentee should discuss this and be aware of them from the outset of the mentoring relationship.
20. Both the mentor and mentee should sign a mentoring agreement, agreeing to a code of conduct and the confidentiality policy.
21. A mentoring scheme manager or lead should exist, who has over-arching responsibility for running the scheme and is a further port of contact for mentees and mentors.
22. Goals should be set at each mentoring encounter. Documentation should be kept of expected goals and intended actions. Any further documentation is at the discretion of the mentor–mentee pair.

5.3. Recommendations for other stakeholders including the Surgical Royal Colleges, Local Education and Training Boards (LETBs) and healthcare providers

23. Trainees should be made aware of the rationale and benefits of mentoring in postgraduate training.
24. Mentors should be supported by their professional bodies and employing organisation in order to allow training to become mentors and the time in which to undertake mentoring.
25. Contributions to mentoring schemes should be recognised in employees' job plans and under the GMC's proposals to regulate the recognition and approval of trainers.
26. Existing and new formalised, recognised training programs should be further developed for all those wishing to obtain training in postgraduate mentoring [3,19].
27. Assessment of trainers could include how well they mentor juniors, which could be considered as part of the revalidation process
28. Further research is required to examine how the effects of mentoring can be measured and applied.

5.4. Recommendations for surgical trainees

29. Trainees should pro-actively engage in the mentoring process, taking a lead in order to derive maximum benefit.
30. Trainees should act professionally during the mentoring relationship, respecting the time provided to them by their mentor.

6. Conclusions

Despite considerable evidence establishing the positive benefit of mentoring across a range of domains, medicine as a profession has been slow to introduce formalised mentoring programs. This is particularly the case in surgery, where trainees work in a competitive, stressful and high-risk field. These consensus recommendations combine evidence from the existing literature, the views of surgical trainees from a National Survey on mentoring and experience from the ASiT National Mentoring Scheme Pilot to formulate key recommendations to improve access to and delivery of mentoring in surgical training. Implementation of these will help maximise an individual's personal potential and contribute towards high quality training, ensuring confident, competent trainees and ultimately safer patient care.

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References

- [1] R.A. Berk, J. Berg, R. Mortimer, B. Walton-moss, T.P. Yeo, Measuring the effectiveness of faculty mentoring relationships, *Acad. Med.* 80 (2005) 66–71.
- [2] Standing Committee on Postgraduate Medical and Dental Education, *Supporting Doctors and Dentists at Work: an Enquiry into Mentoring*, Standing Committee on Postgraduate Medical and Dental Education, 1998.
- [3] South West Peninsula Postgraduate Medical Education. Peninsula Mentoring Programme [Online]. Available: http://www.peninsuladeanery.nhs.uk/index.php?option=com_content&view=article&id=1280&Itemid=1184 (accessed 13.01.14).
- [4] The Royal College of Surgeons of England, *Mentoring – a Position Statement* by the Royal College of Surgeons of England, 2004.
- [5] P. Entezami, L.E. Franzblau, K.C. Chung, Mentorship in surgical training: a systematic review, *Hand* 7 (2012) 30–36.

- [6] J.E. Fitzgerald, C.E. Giddings, G. Khera, C.D. Marron, Improving the future of surgical training and education: consensus recommendations from the Association of Surgeons in Training, *Int. J. Surg.* 10 (2012) 389–392.
- [7] P.A. Gordon, The road to success with a mentor, *J. Vasc. Nurs.* 18 (2000) 30–33.
- [8] N.A. Healy, R.W. Glynn, C. Malone, P. Cantillon, M.J. Kerin, Surgical mentors and role models: prevalence, importance and associated traits, *J. Surg. Educ.* 69 (2012) 633–637.
- [9] F.R. Homer, E.V. Rieu, D.C.H. Rieu, *The Odyssey*, Penguin, London, 2006, 2003 (2006 printing).
- [10] U. Jaffer, A. Pennell, P. Musonda, General surgical trainee experiences of mentoring: a UK regional audit, *J. Surg. Educ.* 67 (2010) 19–24.
- [11] D.A. Macafee, Is there a role for mentoring in Surgical Specialty Training? *Med. Teach.* 30 (2008) e55–e59.
- [12] B. Memon, M.A. Memon, Mentoring and surgical training: a time for reflection!, *Adv. Health Sci. Educ. Theory Pract.* 15 (2010) 749–754.
- [13] D. Miskovic, S.M. Wyles, M. Ni, A.W. Darzi, G.B. Hanna, Systematic review on mentoring and simulation in laparoscopic colorectal surgery, *Ann. Surg.* 252 (2010) 943–951.
- [14] G.R. Roch, Much ado about mentors, *Harv. Bus. Rev.* 57 (1979) 14–20.
- [15] D. Sambunjak, S.E. Straus, A. Marusic, Mentoring in academic medicine: a systematic review, *J. Am. Med. Assoc.* 296 (2006) 1103–1115.
- [16] M.M. Schapira, A. Kalet, M.D. Schwartz, M.S. Gerrity, Mentorship in general internal medicine: investment in our future, *J. Gen. Intern. Med.* 7 (1992) 248–251.
- [17] P. Sinclair, J.E.F. Fitzgerald, S. Hornby, J. Shalhoub, Mentorship in Surgical Training: Current Status and a Needs Assessment for Future Mentoring Programs in Surgery, *World J. Surg.* 2014 (in press).
- [18] C.M. Underhill, The effectiveness of mentoring programs in corporate settings: a meta-analytical review of the literature, *J. Vocat. Behav.* 68 (2006) 292–307.
- [19] Viney, R., Paice, E. *The First Five Hundred. A Report on London Deanery's Coaching and Mentoring Service 2008–2010*. London Deanery.

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