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Editorial

Mentoring ethics in postgraduate surgical training: A developing country perspective from Pakistan

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INTRODUCTION

Transfer of knowledge and skill is the backbone of medicine. Moreover, transfer of the "art and science" of medicine requires close association between a senior physician, and his trainee. Mentorship is therefore, an essential part of medical education and is perhaps as old as medicine itself. The following article takes a look at the ethics involved in this complex relationship and discusses this in the light of authors' experience as health professionals in a developing country.

ARTICLE

The term "Mentor" is widely used in academia but despite its popularity, there is no consensus on a precise operational definition of the term.[5] Yet mentoring is considered the hallowed pathway to success in almost every profession[6] Unfortunately, data from the West suggests that while medical faculties have increased by nearly 600% over the past few decades, mentoring has suffered, and although it is recognized as a critical step to success, few medical students and educators appreciate its value.[10,15,18] Postgraduate medical education is unique in characteristic as it is still dependent upon apprenticeship, to variable extent depending upon individuals and institutions; despite various worldwide attempts at establishing structured training programs.[23] This is more so in surgical training programs as compared with others due to the requirement of transfer of operating skill in addition to knowledge. So a greater degree of supervision and interaction is involved, warranting a close and direct relationship between the trainer and trainee. These unique requirements are further complicated as often the expectations of both the parties are not well defined despite excellent on-paper structure of the program. Quite often, trainer being more experienced and in his role as a provider may assume that he/she is in a dictating position. The approach is not unusual as mentoring has been intimately correlated with ones cultural values and society norms.[6] Especially in a developing country with a dense social framework such as Pakistan, where increasing emphasis is on preservation of age-old cultural formalities, it becomes difficult to inculcate the sort of trainer–trainee relationship conducive for mutual growth. Interestingly, the same social formalities have been reported to hinder essential communication between aircraft pilots, hailing from countries with similar social frameworks. The result, a much higher frequency of aircraft accidents![22] The trainee–trainer relationship has to be a two-way street where both should know and respect their boundaries and autonomy, and should be encouraged to voice their opinions and concerns.

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Foucault has mentioned three classes of "mastership," that is, mentorship or apprenticeship: "The mastership of competence," where "knowledge, principles, abilities, know-how and so on" are passed along, "mastership through example," where a "model of behavior" is passed on, or even a tradition and "the Socratic mastership of dilemma and discovery practiced through dialogue."[12,17] Those who teach medicine have a responsibility to their students and a dual responsibility to society as they ought to provide society both with competent medical practitioners, as well as able, responsible citizens.[17] Mentors therefore need to teach students not only to be capable practitioners of their art and science, but also to be thoughtful, questioning professionals with regard to the society around them.[17] Here it is noteworthy that professional values like integrity, honesty, and respect, which are integral parts of the development of a doctor and despite being taught through direct observation of mentors, also need to be included as compulsory components in postgraduate curricula as is done in several countries.[11,16] Foucault also emphasizes immensely on the importance of *parrhesia*, which he describes as "free speech" or more appropriately, "fearless speech," including the duty to speak in a situation where the spoken word may lead to harm to ones reputation and even one's life.[12,17] In his opinion, a good mentor demonstrates and embodies the critical attitudes and values of the *parrhesiates*, allowing and encouraging the student to practice *parrhesia*.[1] In this way, the mentor allows the student to learn to challenge through frank interrogation, and at the same time prepares the student to think independently in social arenas and to question tradition, laws, institutions, and government on behalf of patients, public health, and medical profession itself.[17]

Apart from Foucault's points of view, ethical aspects of mentoring can also be categorized into two other distinct types of relationships, both prevalent in our setup where training programs are not as closely monitored. First being the traditional one where interaction has too often been associated with exploitive, uncaring, or unprofessional treatment of one or the other person, mostly if not always, the trainee. The second comprises of those values that are consistent with an ethics of care and of particularity rather than of impartiality and universalism. The first argument focuses on outcomes as it finds ethical value in the relative success and happiness of persons. The second is an appeal to principles, the values of care being coincident with moral principles.[16]

Pakistan is a developing country, which has a serious dearth of surgeons. A recent report estimates that the country suffers from a deficit of 17 million surgeries every year, surgical diseases accounting for more mortalities than infectious diseases inclusive of tuberculosis, HIV/AIDS, diarrheal disease, and childhood infections.[24] The accurate number of surgeons in the country is not known, however, estimates suggest the number of trained and untrained surgeons in rural Pakistan to be 0.36 per 100,000 populations.[7] The number of Neurosurgeons is estimated to be less than 0.1 per 100,000 populations.[21] This is in striking contrast to the developing world. United States, for example, has approximately 16 surgeons per 100,000 population, 44 times that of Pakistan.[2] To cope with the deficit, there are two lateral surgical licensing bodies with separate training formats. The more popular of these is the College of Physicians and Surgeons run Fellowship program at the end of which the trainee is awarded the FCPS diploma, and the other is the University-based Master of Surgery program at the end of which the trainee is awarded MS degree.[21] Both of these programs require the identification of one focal person who agrees to act as each individual trainee's mentor, and guarantees regular monitoring to ensure optimal training. At times each supervisor is required to mentor eight or more trainees. This combined with the overwhelming workload due to paucity of available surgeons, shifts the onus to finishing their training rather than providing classical mentorship. None of the two programs have well defined roles and responsibilities of the mentor other than supervising the transfer of clinical and surgical skills, and ensuring timely completion of training and fulfillment of requirements for the exit exams. Majority of these trainees once they finish their training, either change their centers, or migrate to other countries.

At national level, mentoring programs for faculty and mentees have been proposed.[17] Workshops focusing specifically on mentoring ethics are now mandatory before a particular faculty is assigned the role of training supervisor. At international level, two initiatives have been undertaken by Neurosurgical bodies, both relying on long distance relationships.[3,4] Both these programs should be appreciated but in essence, cannot replace or even entirely compensate for, the traditional mentor–mentee chemistry.

The best of these relationships can outlast the program and blossom into professional collaborations and even friendships that last entire careers. The historical relationship of William Osler and Harvey Cushing in 1900 that spanned over two decades is a prime example.[9] It has been stated that where Cushing found in Osler a role model to sculpture his ambitions and define his goals, in Cushing, Osler identified a surrogate son who joined with him in defining the course of medicine and surgery over the next century. The result is history. Mentoring relationships are necessary and desirable for the development of both parties and the profession. As such, they should be encouraged. But they should be initiated and managed with great care, as the stakes are high; professionally, personally and ethically. Poor mentorship leads to a poor work environment, which has been directly attributed to trainee under performance; a fact that has

lead to the notion that trainee underperformance is more of symptom rather than a diagnosis[14,15]

CONCLUSION

Mentorship, although still not properly defined in its goals and responsibilities, remains an essential component of medical education. The relationship between a mentor and a mentee is a complex one, and requires great care to insure that both are rewarded, professionally and personally.

REFERENCES

1. Arendt H. The human condition. 1998.
2. Association AH. Fast facts on US hospitals. Available from: http://www.aha org/aha/resource-center/Statistics-and-Studies/fastfacts html [Last cited in 2012].
3. Available from: http://www.aans.org/en/Young%20Neurosurgeons/Residents/Resident%20Membership/Resident%20Mentoring%20Program.aspx.
4. Available from: http://www.wfns.org/pages/young_neurosurgeons_forums/39.php.
5. Berk RA, Berg J, Mortimer R, Walton-Moss B, Yeo TP. Measuring the effectiveness of faculty mentoring relationships. Acad Med 2005;80:66-71.
6. Beverly P. Mentoring in multiple dimensions. J Cult Divers 2005;12:56-8.
7. Blanchard R, Blanchard M, Toussignant P, Ahmed M, Smythe C. The epidemiology and spectrum of surgical care in district hospitals of Pakistan. Am J Public Health 1987;77:1439-45.
8. Curran I. Managing trainees in diffi culty: Practical advice for clinical andeducational supervisors. NACT 2008. Available from: http://www.nact.org.uk/trainees_in_diffi culty_jan08.pdf.
9. Duffy TP. The osler-cushing covenant. Perspect Biol Med 2005;48:592-602.
10. Dunnington GL. The art of mentoring. Am J Surg 1996;171:604-7.
11. Feudtner C, Christakis DA, Christakis NA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. Acad Med 1994;69:670-9.
12. Foucault M. The Hermeneutics of the Subject: Lectures at the Collège de France 1981-1982: Macmillan; 2005.
13. Jain S. So you want to be a neurosurgeon: A career resource guide for successful navigation. Am J Surg 2011;202:360-3.
14. Paice E. Identification and management of the underperforming surgical trainee. ANZ J Surg 2009;79:180-4.
15. Paice E. The role of education and training. Understanding Doctors' Performance. Oxford: Radcliffe Publishing; 2006. p. 78-90.
16. Paice E, Heard S, Moss F. How important are role models in making good doctors? BMJ 2002;325:707.
17. Papadimos TJ, Murray SJ. Foucault's. Philos Ethics Humanit Med 2008;3:12.
18. Ramani S, Gruppen L, Kachur EK. Twelve tips for developing effective mentors. Med Teach 2006;28:404-8.
19. Rosseau G. The role of the World Federation of Neurosurgical Societies in the development of world neurosurgery. Practical Handbook of Neurosurgery. Springer; 2009. p. 1656-61.
20. Shamim MS. Mentoring programme for faculty in medical education: South-Asian perspective. J Pak Med Assoc 2013;63:619-23.
21. Shamim MS, Tahir MZ, Godil SS, Kumar R, Siddiqui AA. A critical analysis of the current state of neurosurgery training in Pakistan. Surg Neurol Int 2011;2:183.
22. Sohn H. Intercultural Communication in Cognitive Values: American and Koreans. University of Hawaii Press.
23. Walter AJ. Surgical education for the twenty-first century: Beyond the apprentice model. Obstet Gynecol Clin North Am 2006;33:233-6, vii.
24. Zafar SN, McQueen KK. Surgery, public health, and Pakistan. World journal of surgery 2011;35(12):2625-34.