International Urogynecology Journal (2018) 29:323–325
https://doi.org/10.1007/s00192-017-3549-3

EDITORIAL

How to attract talented juniors to urogynaecology

Kim W. M. van Delft[1] · Robert A. de Leeuw[2,3]

Received: 26 September 2017 / Accepted: 20 December 2017 / Published online: 13 January 2018
© The International Urogynecological Association 2018

Attracting talented juniors to the subspecialty of Urogynaecology is important to continuing the great work we are doing. We believe that urogynaecology is often underexposed during residency training, where the initial focus is on obstetrics and general gynaecology. The key question is: how to attract top-talent to urogynaecology? Subsequently, we suggest practical tips for attracting junior doctors to our field.

A survey conducted amongst 258 Dutch obstetrics and gynaecology residents in 2015 revealed that half of the residents have chosen perinatology as their area of interest [1]. Sixty of them expressed an interest in urogynaecology. However, only 21 residents decided to choose urogynaecology as their subspecialism, which is only 8%. Given the aging of the population and the need for competent and skilled urogynaecologists, it is worth shining a light on the recruitment of obstetrics and gynaecology residents into the subspecialty of urogynaecology.

Before suggesting some practical tips, we briefly cover how to motivate and encourage people, and the importance of being a role model.

Motivate

Currently, people continue to believe that we can motivate people by offering higher financial rewards. However, back in 1962, Glucksberg demonstrated the candle problem [2]. His studies repeatedly showed that difficult cognitive tasks are decreasingly effective at engaging learners when they offer a higher reward. This is counterintuitive, and still a widely misunderstood concept, which we gained decades ago. If offering higher financial rewards does not work, what does? Scott Geller is a motivation guru and tried to answer that question. He summed up motivation in three different values: competence, consequence, and choice [3]. However, he admits that motivation is a complex topic and every model chosen oversimplifies reality. According to Geller, competence follows education and asks the question: can you do it? This is usually taught at medical school or theoretically at the beginning of a residency. The next step is consequence: will it work? By doing the things you were taught, you begin to experience the effect by seeing your results. Is the patient satisfied following a procedure? The final step is choice. Is it worth it? By choosing a direction and receiving a positive response from the people around them, such as recognition and feedback, a person is motivated in the long term. Usually, residents are stuck at the consequence part; they are searching for self-efficacy and are perhaps held back by their supervisor. This can lead to doubt for the resident. They may ask themselves: “is it worth it”? Supervisors not only have an important task in teaching and educating, but should be motivators as well. They could achieve this by being a role model to the resident.

Role models

By using the foundations of motivation, a role model may be the key in workplace learning [4]. We think that the best person to inspire and motivate junior doctors is the consultant urogynaecologist. Thus, to persuade a talent, the first step is to realize for yourself in what way you can be a role model. Simon Sinek, a British/American author, motivational speaker, and marketing consultant stated: “People don't buy what you do, but why you do it” [5]. He uses his golden circle, which is a simple, but powerful model for stimulating inspiring leadership (Fig. 1). By showing the junior doctor why you do something, you can “sell” your expertise. However, being

✉ Kim W. M. van Delft
kim.vandelft@radboudumc.nl

[1] Obstetrics and Gynaecology, Radboud University Medical Centre, Geert Grooteplein Zuid 10 (route 791), Postbox 9101, 6500 HB Nijmegen, The Netherlands

[2] Department of Obstetrics and Gynaecology, VU Medical Centre, Amsterdam, The Netherlands

[3] Amsterdam Reproduction & Development, VU Medical Centre and Amsterdam Medical Centre, Amsterdam, The Netherlands

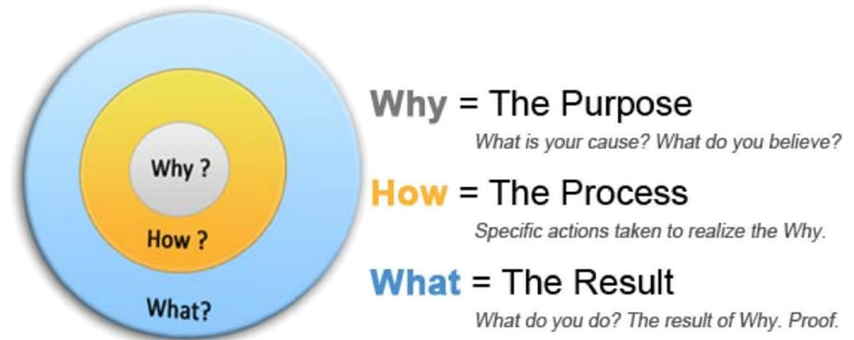

Fig. 1 Golden circle by Simon Sinek

a role model is rather complex. According to van der Leeuw, a role model is "in the mind of the beholder" [6]. However, there are some guidelines for a role model in medicine. Van der Leeuw distinguished three ways in which a medical professional is viewed as a role model. First, excellence in his/her patient care by showing mastery of the craft. Urogynaecology is rather a craft or an art than many other specialties in medicine. Each surgery is unique, problems and solutions are diverse, and are frequently influenced by the patients' cognition and behavior. This requires exemplary mastery. Second, their teaching abilities, which can be difficult to demonstrate when performing "keyhole" surgery. Third, personal qualities, which are very individual. Be aware that even personal stories or events are still part of being a role model.

When we combine motivational theory and role models (Fig. 2), we have the key ingredients. Residents should have the autonomy to know whether they can do what they want to do. Furthermore, they should explore mastery and find mastery in their consultant as role model. Last, they should find their purpose by choosing urogynaecology as a subspecialty.

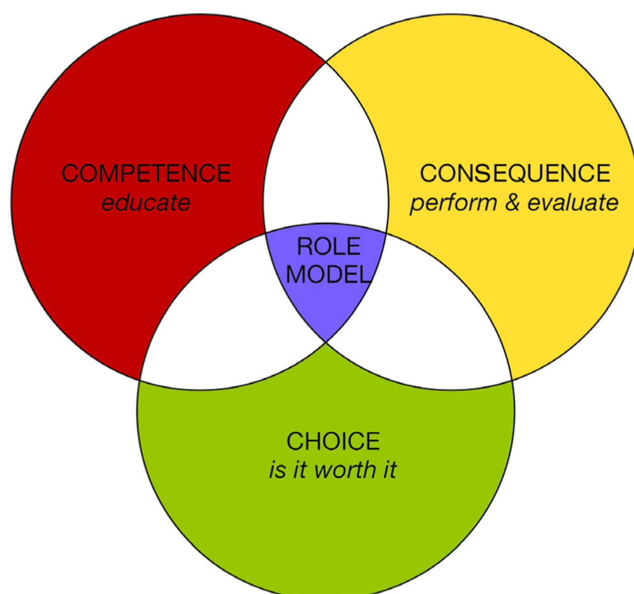

Fig. 2 The place of a role model within motivation

Practical tips

After discussing the theory of how to motivate junior doctors to choose urogynaecology, we return to our clinic. We believe that small details in daily practice can be of great help, for which we provide five practical suggestions:

1. Urogynaecology as a subspecialty should be *more visible* earlier during the residency in obstetrics and gynaecology. We could schedule junior doctors for a urogynaecology apprenticeship for a month's rotation. During this month, the junior could attend (multidisciplinary) urogynaecology clinics, operating theatre, urodynamics, multidiscplinary meetings, and pelvic floor physiotherapy. This allows consultants to act as role models and start providing the resident with autonomy.
2. A *basic urogynaecology course* could be implemented in the first part of the training. In this course, basic knowledge about anatomy, prolapse, bladder problems, and surgical skills could be taught. After having obtained this basic knowledge, confidence could be increased early in residency.
3. When performing a surgical intervention, such as a vaginal hysterectomy, the consultant can place a camera in front of him/her (for example, using the VITOM by Storz) [7]. This gives the resident the opportunity to see the entire procedure on a screen, rather than having the procedure obscured because the clamps are being held in a difficult position. It would also be much easier to supervise the procedure in this way and allow the resident more autonomy. Furthermore, this method could be used to review the procedure and to explain questions.
4. Juniors could be inspired if there were still much to discover in the field, if innovations were possible, such as technical skills or developments in tissue engineering. This is the case in the field of urogynaecology, which

previous authorities have described as a "perfect storm" [8]. Consultants could therefore try to engage junior doctors in new and exciting research subjects.

5. It is important to provide juniors with the latest urogynaecology *knowledge* and innovation by providing access to our international urogynaecology journal. Exploring surgical videos on the internet, such as websurg.com, can also be very motivational by showing the mastery of others.

Conclusion

We provided an overview of how to attract junior doctors to the subspecialty of urogynaecology. By providing autonomy, showing mastery, and illustrating the purpose, the choosing of urogynaecology as a subspecialty will follow. The practical tips suggested here can be used in our clinics.

References

1. Musters AM, Vermeij R, Oom DMJ, Hofman LN, Buist MR. Cijfers over de periode 2015-2020. De in- en uitstroom van gynaecologen. Ned Tijdschr Obstet Gynaecol. 2015;128:500–4.
2. Glucksberg S, Weisberg RW. Verbal behavior and problem solving: some effects of labeling in a functional fixedness problem. J Exp Psychol. 1966;71(5):659–64.
3. Geller ES. The psychology of self-motivation. Appl Psychol. 2016;1:83.
4. Van der Zwet J, Zwietering PJ, Teunissen PW, van der Vleuten CP, Scherpbier AJ. Workplace learning from a socio-cultural perspective: creating developmental space during the general practice clerkship. Adv Health Sci Educ Theory Pract. 2011;16(3):359–73.
5. Sinek S. Star with why, vol. 1. London: Penguin Group; 2009.
6. Jochemsen-van der Leeuw HG, van Dijk N, Wieringa-de Waard M. Assessment of the clinical trainer as a role model: a role model apperception tool (RoMAT). Acad Med. 2014;89(4):671–7.
7. Taylor GB, Myers EM. Imaging system for vaginal surgery. Obstet Gynecol. 2015;126(6):1170–3.
8. Brubaker L, Shull B. A perfect storm. Int Urogynecol J. 2012;23(1): 3–4.