Surgeon Educators Day at RCS England

May 20 2016

Report by Stephen Walsh. BAOMS Chair CPD and Revalidation Committee

The RCS is running a course :

Training and Assessment in the Clinical Environment (TrACE)

aimed at surgical educators (educational and clinical supervisors) : This course is specifically mapped to meet the GMCs competencies for registration as an approved trainer.

Details can be found here:

<https://www.rcseng.ac.uk/courses/course-search/training-and-assessment-in-the-clinical-environment-trace>.

Also run an educational leadership programme for surgeons: for more senior surgical roles:

<https://www.rcseng.ac.uk/courses/course-search/educational-leadership-programme-for-surgeons/>

Opening theme: Failure / Success

Failure to get something right, increases chance dramatically of getting same thing right next time.

Suggestion that trainees chose feedback from doves instead of Hawks (although there would be better feedback) because they get a better WBA mark from the doves. Are you a dove or a hawk ?

Most organisations don't value failure as a learning point but see it as a negative. (Despite the lip service). Admitting mistakes - attracts blame. Error is associated with poor ability and blame. Therefore powerful incentive to cover up errors. Errors ARE NOT the same as misconduct - we need to understand this in the NHS. Blame helps us cope with uncertainty. Can be stigmatisation following an adverse event - therefore barrier to reporting events - as people "punished" for mistakes.

All wrapped up in our "blame Culture". Need to move to a "learning culture".

'Success is going from failure to failure without the loss of enthusiasm" (Winston Churchill).

David Nott - Emotional Resilience.

"Ones ability to adapt to difficulties or crises"

Complex interplay between the individual, the individuals environment and socioeconomic / cultural factors.

Mental health problems in junior doctors increasing. Today's doctors not as tough as their predecessors? Is this a function of the change in the regime of training?. Can emotional resilience be taught?

Positive inputs for trainees very important to help develop resilience - good mentor ship from resilient mentor, open door access to trainer. Good work life balance and good social and work team support.

Theatre team training- Craig McIlhenny

The majority of surgical adverse events are teamwork or communication failures not technical skills failures.

'National safety standards for invasive procures" - NHS England document - teams that work together should train together.

Evidence that poor team working relates to poor outcomes (correlation is stronger than for example ASA index).

RCS document - "The high performing surgical team" - worth reading.

<https://www.rcseng.ac.uk/surgeons/surgical-standards/professionalism-surgery/gsp/documents/the-high-performing-surgical-team-2013-a-guide-to-best-practice>

What is good teamworking?

(Sales) - a good team shows:

Strong leadership

Clear roles and responsibilities

Practice close loop communication

Hold shared mental models

Engage in regular feedback

And many more .........

Train teams in/as teams is a key message. How many of us still have regular teams ?

Current standards of medical education to see if you meet guidance for educational revalidation.

AoME Core values. <http://www.medicaleducators.org/Professional-Standards>

Faculty of surgical trainers: Surgical specific.

<https://fst.rcsed.ac.uk/media/9403/surgical-trainers-lr.pdf>

Inevitable discussion about aviation analogy / training /reporting followed.

Maria Busey - ISCP feedback

Reinforced the importance of written feedback to the trainee on ISCP. This allows reflection by the trainee over time.

Looked at all feedback on ISCP. Assessors are being overwhelmingly positive - little constructive criticism, almost universally praising, feedback almost "administrative" as opposed to being useful or constructive, often not really tailored to that trainee either. More training for trainers to improve feedback, redesign of WBAs to encourage feedback. Less single word feedback like "good" please !

Standards for surgical trainers:

GMC recognition and approval for secondary care is on the horizon (July 2016). See gmc website for further details and standards as highlighted above, these will have to be met to be a recognised trainer.

Meeting standards: "Trainers Journal" will be incorporated into ISCP. This will allow trainers to collect evidence of their educational activity, and may rate this activity from a quality point of view.  This will be done by addition of a trainer TAB to help collect that data, some automatically as ISCP is used and some data can be uploaded.

There will be a trainer profile, trainee feedback questionnaire about quality of feedback / training, trainer peer feedback questionnaire, assessment record, reflective notes section, a document library to upload to and ISCP will produce a PDF file to output for appraisal. This should be easy to do and make trainers reflect more on their educational practice.

Integration of simulation into curriculum - William Allum, Chair JCST

Simulation becoming more important in training because of:

Patient safety (Competency achieved before operating on a patient)

Gain clinical experience for limited access areas

Change in working practices and EWTR.

Advantages in technology is helping make simulation more realistic and therefore useful.

Evidence of efficacy now emerging to support simulation use.

Simulation shouldn't be a one off event - but an ongoing process of practice.

RCS presented their PG Cert in surgery - about to launch very soon :more details below

60 credits approx equal to 600 hrs of study: Total estimated cost approx £2,000 - £2,500.

<https://www.rcseng.ac.uk/courses/course-search/pg-cert-in-surgery>

Interesting presentation on 3D printing of pathology (e.g. Aneurysms) to practice pathology surgery and how it improves outcomes by anticipating difficulties.

Selection for a career in surgery (Philip mostyn)

Are we selecting our future surgeons appropriately :

Don't want to select based  on knowledge, as knowledge can be imparted or learned, but you do want those with the aptitude and inclination for desired behaviour. Described as like a driving test passed on knowledge alone having never been out on the road in a car.

What to look for when selecting trainees:

Task aptitude; technical, physical practical and cognitive

Robust personality, coping under pressure

Ability to work in a team and communicate

Ability to relate individually and build rapport

Low propensity for emotional reactions

High self control

Capacity to lead ' influence

Natural inclination to behave as desired

Conscience to self monitor and improve

Openness to feedback and acting on it.

Watch and continue to monitor and assess though, as changes can happen with time:

Desirable values on the left change with time and pressures to those on the right !

Selection suggestions:

(Best indicator of future behaviour is past behaviour)

A battery of group and individual practical exercises under pressure, assessed by 2 professional assessor so who stay with the group during assessment

Biographic data analysis interpreted through a long professional interview supported by good psychometrics

Particular focus on aptitude for emotional resilience (low anxiety, high self control ..... Under pressure)

Training Overview:

Costs £198,000 per year per surgical trainee !!!!

Therefore about £1.5 million to train a surgeon to consultant level !

Greater use of non medical workforce - to support (and not replace!) junior doctors on call too as Up to 35% of time spent doing non clinical admin.

Should we have super trainers who like academics have a large part of their job plan designated to training ? The concept of the professional trainer - improves quality and trainees happier and maybe progress more quickly ?

There is work going on to reshape general surgery training with a view to a pilot starting in 2018 and this model may roll to other specialties - vascular have already shown interest and urology may also follow.

There may well be a model where in the future there are "training centres" and centres with no trainees despite doing the same workload and case mix.

HEE - going from 13 to 4 LETBs - geographically based again.

Flexible training soon likely to be open to all who want to train that way.

Very positive feedback for bootcamps (accelerated learning opportunities) - specialty focused training time - out of service - multifaceted (e.g simulation /regulation /radiology / education/ etc etc.

Stephen Walsh