

IMPROVING SURGICAL TRAINING: ADDING NON-TECHNICAL SKILLS TO SIMULATION TRAINING FOR SURGEONS

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10.54531/UCUS4220

Background: The launch of the new Improving Surgical Training (IST) programme in 2020 introduced an exciting opportunity to develop a high-fidelity simulation course designed specifically with surgeons and their training in mind. Surgical simulation is often thought of as task-focussed training, with little emphasis on non-technical skills, especially in junior years of training. This created an opportunity for the formation of a bespoke high-fidelity course immersing IST trainees into surgical scenarios involving an extended surgical team and incorporating elements of technical and non-technical skills.

Methods: Following a review of the curriculum [1], core training areas were identified. Index procedures and critical conditions appropriate for core-level training were selected to create the scenarios. Furthermore, a surgical simulation faculty was developed whereby consultant surgeons conducted faculty development training, enabling them to support the core simulation faculty. Three scenarios were piloted in a half-day course which was subsequently rolled out to all current IST trainees at the Trust. Key elements incorporated include:

1. Environment – immersion within environments where surgeons work such as theatres, surgical wards, and emergency departments.
2. Surgical issues – each scenario centres around a surgical complaint.
3. Non-technical components – often overlooked in traditional surgical simulation [2] but pertinent to the working life of a surgeon.
4. Multidisciplinary Team – scenarios must incorporate surgeons working within extended teams.

To ensure high-fidelity, a combination of simulation manikins and faculty were used as patients and other characters, with all tasks being carried out in real-time.

Results: An initial pilot session ran with Deanery and non-Deanery trainees and a mixed simulation faculty including senior surgeons. Three sessions were delivered to a total of twelve trainees attending from a range of different surgical specialties. Feedback demonstrated satisfaction with the course given an average score of 4.67/5 and relevance of course content to current job role average of 4.5/5. 100% of trainees rated session content as either 'Good' or 'Excellent'. Trainees enjoyed how 'realistic' the scenarios were and appreciated that they 'gave a feel of real-life situations and a framework to resort to in difficult day-to-day situations'. Recommendations for improvement included wanting more scenarios and further opportunities to explore human factors.

Conclusion: Overall feedback was overwhelmingly positive with appreciation of the role of human factors and non-technical skills in surgical training. The results provide a convincing argument for continuing the programme and developing a programme for second year IST trainees to aid transition to registrar training.

REFERENCES

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2. Intercollegiate Surgical Curriculum Programme. Simulation training and core surgical training. 2017 <https://www.iscp.ac.uk/> [Accessed on 26/06/2022]

'DID THAT REALLY JUST HAPPEN?': USING SIMULATION TO IDENTIFY AND RESPOND TO MICROAGGRESSIONS IN THE CLINICAL ENVIRONMENT

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10.54531/KEFS4953

Background: In a recent survey of 80 final year medical students at The University of Edinburgh, 35% reported being the victim of, while 46% reported witnessing microaggression while on clinical placement. It has been established that microaggressions in the clinical environment have a negative impact on victims as well as patient care^[1]. It is therefore vital to educate our future clinicians to identify microaggressions and respond to them appropriately. Active Bystander Training (ABT) is a framework that has been designed for this purpose and has been successfully implemented in the clinical environment [2]. **Activity:** We delivered a 90-minute simulation-based session using the ABT framework for final year medical students. In the session, we used two real life examples of microaggressions from our local context. The first example involved racism while the second involved homophobia. We used a combination of shadow-box simulation and immersive simulation to recreate these scenarios. Prior to attending this session, students attended an online teaching session that covered the basic principles of ABT. We began the session with an emphasis on psychological safety and student wellbeing. Participants were then given a short reminder of the principles of ABT. They then watched a video re-enactment of the first scenario. This was followed by a structured debriefing in small groups. Next, in small groups participants were given scripts and assigned roles to take part in an immersive simulation for the second scenario. This was then followed by a second structured debriefing. At the end of the session, there was an opportunity for participants to share their own experiences of microaggressions in the clinical environment. We also signposted students to wellbeing services.

Results: 150 final year medical students participated in the session and gave feedback (Table 1). The session was well received with an average overall score of 4.67/5. 94% of participants reported that the workshop had a positive impact on them. Key themes that emerged from the free text feedback were that participants found the ABT framework useful, they found the session empowering, there was an appetite for more sessions like this during their medical training, and they identified the importance of allyship and victim support.

Conclusion: This intervention demonstrates that simulation can be used as an effective modality to empower clinicians to identify and respond to microaggressions in the clinical environment.

REFERENCES

1. Freeman L, Stewart H. Microaggressions in clinical medicine. Kennedy Institute of Ethics Journal. 2018;28(4):411-449.