THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH
1505
The Faculty of Surgical Trainers

ICOSET 2022
Parallel Session 3:
Why can't we eradicate bullying and harassment from surgical training?
Presenters: Adrian Anthony, Jason Frank

	Analyses	Solutions
macro	Encultured in medicine Normalised – not recognised or accepted as wrong Lack of data – prevalence and impact Predisposed by necessary hierarchy	Explicate 'zero tolerance' in policy Back up policies with processes Publicly report on effectiveness of processes Create culture of zero tolerance as well as forgiveness Ensure strong responses for recidivist or egregious behaviour
meso	Lack of effective processes to address Employer responsibility, not Colleges Unconscious biases 'Zero tolerance' not enforced, not enforceable Real vulnerability and real risk in 'calling out' Accept bad behaviour because surgeon is technically good Poor role models, no role models in championing change Trainees 'passing through' – not worth addressing	Set expectations – 'no banter' when power differences exist Implement reporting and responding processes Collect data – incidence, impact Educate using existing evidence base – 'boot camp' courses Behavioural training in 'cup of coffee' low level intervention Mandate supportive training culture in training post accreditation Withdraw training accreditation where culture does not improve Evaluate processes
micro	Not empowered – lack skills, confidence, support in calling out Fear of reprisals Power differential too great – hierarchy Micro-aggression more difficult to challenge	Teach students / trainees 'kickback' phrases … "did I hear you correctly" Teach skills in calling out, having 'cup of coffee' conversations Buddy trainees with mentors Flatten hierarchy through language and explicit permission to raise concerns

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If all surgeons learn at different rates, can we ever standardise training time?
[consistent answer is “no”. but there should be a time limit rather than CBT being time-invariant]

	Analyses	Solutions
macro	It takes time to become competent Depth of experience also time-dependent Limited evidence on reasonable timeframe to achieve competence Limited evidence on minimum training opportunities Training programs require ‘prevocational’ time (eg UK, ANZ) Disruptors (*eg* pandemic) impact on time to train	Define streamlined pathways – medical school to vocational training Collect data on time to develop competence Set ‘maximum time in training’ – informed by evidence Workforce planning to account for variable time to train
meso	Not all competencies may be assessed with WBAs Assessments that determine trainee progression too infrequent Flexible training impacts on time to train Learning and practice opportunities vary between rotations Feedback and coaching varies between rotations Mechanisms to accelerate training not always well defined Everyone still finishes at same time – does not reflect CBT WBAs often ‘tick box’ exercise Poorly defined milestones Services require trainee throughput – pressure to progress trainees	Define clear milestones aligned to training opportunities Monitor consistency of training opportunities across rotations Facilitate accelerated training based on milestone achievements Implement remedial programs to support slower learners Evaluate CBT against valid metrics
micro	Trainees seek flexible training arrangements Self-assessment not reliable – dependent on external assessment	Frequency of assessments adequate to inform trainee trajectory Assess for all competencies Individual progress referenced to milestones and graduate outcomes

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Why are there recurring concerns about poor or absent feedback or coaching from supervisors in surgical training?
[group discussion focused on feedback and did not address coaching to any extent]

	Analyses	Solutions
macro	Culture of ‘no news is good news’ Culture of judgmental, punitive feedback No formal training in feedback skills and literacy	Normalise feedback in training and learning culture Mandatory requirement – documented policies and procedures Expected educational skill set of supervisors – giving feedback Expected educational skill set of trainees – receiving feedback
meso	Lack of time – absent or delayed, ‘after the fact’ Supervisor-trainee relationship not sufficiently trusting No set expectations Unit culture not to provide feedback Fear that feedback perceived as bullying, harassment Changing rotations and supervisors – transferred accountability Differentiating variable performance No evaluation of feedback effectiveness	IT infra-structure to record feedback events Adopt consistent, standard feedback process Trainee-centred processes Sufficiently long rotations Nominated supervisor responsible for feedback Mandate as part of training post accreditation – monitor and evaluate Integrate feedback in programmatic assessment / WBAs Feedback as core part of faculty development
micro	Feedback not sign-posted Communication structure and language not recognised as feedback Ambiguous, too general, not specific enough Loss of objectivity – judgemental, emotive Avoidance in giving / receiving Too hard especially regarding underperformance	Training in feedback skills and literacy – supervisor & trainee Standardised feedback format including language to signpost Timetable (formally schedule) periodic feedback Evaluate supervisor feedback skills Include trainee self-reflection on feedback in training portfolio Start of rotation discussion to include requirements around feedback