5/st GLOBAL CONGRESS ON MIGS

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SYLLABUS

Panel 1: Maximizing Surgical Coaching

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Asterisk (*) denotes no financial relationships to disclose.

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The following members of AAGL have been involved in the educational planning and/or review of this course (listed in alphabetical order by last name).

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FACULTY DISCLOSURE

The following have agreed to provide verbal disclosure of their relationships prior to their presentations. They have also agreed to support their presentations and clinical recommendations with the "best available evidence" from medical literature (in alphabetical order by last name).

Angela Chaudhari, MD – Educational Consultant and Advisory Board: Johnson and Johnson; Consultant Surgical Coach: Academy of Surgical Coaching; Co-Founder: Premier Surgical Insights, LLC

Chris DeStephano, MD, MPH – Stock: Eli Lily (bought and sold to <u>assess</u> conflict of interest process)

Cara R. King, DO*

Veronica Lerner, MD -Consultant: Applied Medical

Panel 1: Maximizing Surgical Coaching

Chair: Cara R. King, DO, MS

Faculty: Angela Chaudhari, MD, Christopher DeStephano, MD, MPH, Veronica Lerner

Course Description

Dedicated and deliberate surgical education is critical for propagating our field and training the next generation of surgeons. A unique set of skills and knowledge are needed to take surgical education initiatives to the next level for our medical students, residents, and fellows. Critical aspects of surgical education include how to give and receive feedback, competency assessment, understanding learning styles, and integration of simulation. Surgical coaching also presents an actionable approach to enhance surgical education and promote continuous professional development throughout one's career. This panel will provide insight on the philosophy of surgical coaching and how to provide high impact feedback. It will provide evidence for components of internal motivation through application of a growth mindset and discuss available resources for simulation as a teaching method through assessment and technology integration.

Learning Objectives

At the conclusion of this course, the participants will be able to: 1) Illustrate techniques to provide high impact feedback and competency assessment 2) Recognize the impact of surgical coaching in continuous professional development and trainee education to elevate technical and non-technical skills 3) Discover resources to enhance surgical simulation and deliberate practice through integration of technology.

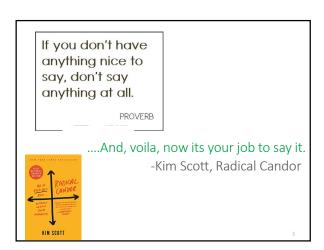
This panel will include minimal formal presentations or PowerPoint slides to enhance a robust discussion amongst the panelists and audience surrounding feedback, competency assessment, surgical coaching, learning styles, and surgical simulation.

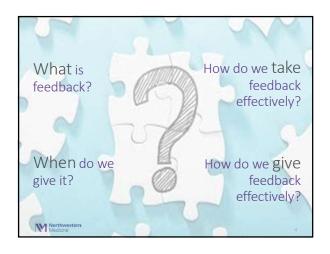
Course Outline

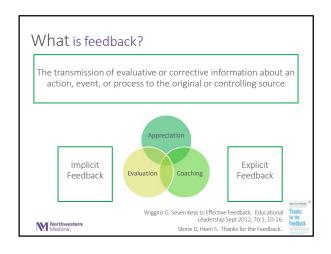
11:30 am	Welcome, Introduction and Course Overview	C.R. King
	Talks from Faculty (listed in Alpha order):	
	Giving Feedback Isn't Rocket ScienceIt's Harder!	A. Chaudhari
11:35 am	Everything is a Test: Assessment to Optimize Gynecologic	C. DeStephano
	Surgery Learning	V. Lerner
	Can We Teach and Assess Proficiency Before OR?	
12:25 pm	Questions & Answers	All Faculty
12:35 pm	Adjourn	

Giving Feedback Isn't Rocket Science.... It's Harder! Angela Chaudhari MD Associate Professor, Vice Chair Faculty Development, ObGyn Chief of Gynecology and Gynecologic Surgery System Director of the P2P Support Network Northwestern University Feinberg School of Medicine

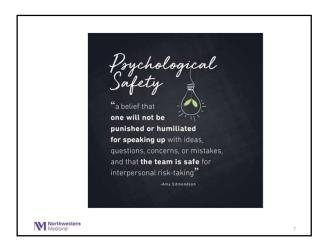


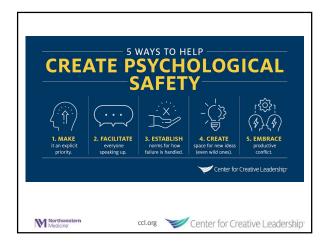












How should we take feedback?

DON'T

Take a defensive position regarding the feedback

DO

Find a simple, default response to feedback

DO

Let people know that you are open to feedback

Northwestern

Bregman P. 13 ways we justify, rationalize or ignore regative feedback. HRR. Feb 14, 2019.







How should we give feedback? Get your intentions right before opening your mouth.

Deal with your own emotions before giving feedback.

Ask permission.

Control is central to creating safety. Wait for the invitation to give the feedback is important

Share intent before content.

Ensure that intent is positive and not malicious.

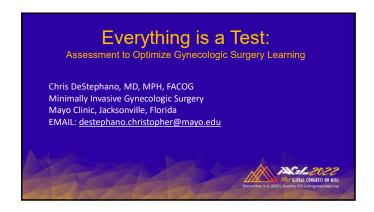
Ask for Clarification

Morthwestern Medicine

Greeny J. The Key to Giving and Receiving Negative Feedback, Aug 2015.









Learning objectives

- Encourage a shift from teaching what I want audiences to learn (outcomes) to learning how to learn (process)
- Audience members (silent reflection):
 - What do you want to learn?
 - · What brought you to this session?

Question

Is the majority of the responsibility for learning/assessment on the teacher/training program/hospital/board or is it the responsibility of the learner?

- In Medical School?
- In Residency?
- · In Fellowship?
- As a Surgeon?



Assessment

- Definition: The evaluation or estimation of the nature, quality, or ability of someone or something
 - Formative [Process]: "Planned, ongoing process used by all students and teachers during learning and teaching to elicit and use evidence of learning to improve student understanding of intended learning outcomes and support students to become self-directed learners."
 - Summative [Outcome]: "Evaluate student learning, skill acquisition, and academic achievement at the conclusion of a defined instructional period"

Why understanding consequences of assessment is important (and a political process)

This is an excellent opportunity for someone who is interested in a leadership role in founding our upcoming MiGS Fellowship program. Highlights include state of the art facilities, access to robotics, a procedural center only open for OBGYNs, and protected time for research.

We are open to considering AAGL Fellowship trained and those with the ABOG Practice Designation.

False equivalence is an informal fallacy in which an equivalence is drawn between two subjects based on flawed or false reasoning

How much weight to assessment?

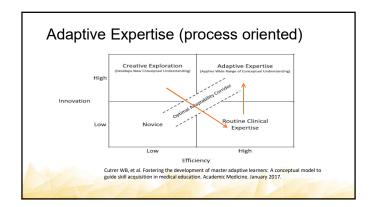
How much weight to 2 year fellowship?

Published in final edited form as: Ann Surg. 2015 August; 262(2): 217–219. doi:10.1097/SLA.000000000001290.

The Continuum of Coaching: Opportunities for Surgical Improvement at all Levels

Caprice C Greenberg, MD, MPH1 and Mary E. Klingensmith, MD2

- "Surgeons tend to conceptualize 'mastery' or 'expertise' as having conquered a specific set of skills [Outcomes], while in other disciplines these terms are equated with a continual learning state or perpetual devotion to improvement[Process]."
- Process: "In medicine, we tend to prioritize and strive for competence [Outcomes] rather than continued improvement [Process] regardless of level. This is a cultural difference and one that we will need to sort through in the upcoming years."



Anders Ericsson: Deliberate Practice (process oriented)

- "Special type of practice that is purposeful and systematic" (process)
- Misrepresented as "10,000 hours" (outcomes oriented)



Stock market: "Past performance is no guarantee of future results"

- Humbling realization
 - Bias and noise are part of all assessments
- Performance during medical school, residency, fellowship, boards, etc may or may not predict future performance
- Therefore, the weight and significance we put on individual outcome assessments needs to decrease



THOUGHTS ABOUT THIS PICTURE/ASSESSMENT?

"It is the illusion of knowledge, not ignorance, that keeps one from growing" --Jerry Uelsmann



What decision should we make about the fellow who did this?



Assessment

- Often has unintended consequences if not used deliberately with selection of appropriate outcome
- Formative, repeated assessments over time that assess the process of learning over high-stakes end of training assessments should be prioritized
 - Self-reflection
 - Self-directedness

 - Adaptability to change
 Initiative (did they seek out mentorship and coaching?)

 - Work ethicWillingness to speak up

References

Leon MG, Dinh TA, Heckman MG, Weaver SE, Chase LA, DeStephano CC. Correcting the Fundaments of Laparoscopic Surgery "Illusion of Validity" in Laparoscopic Vaginal Cuff Suturing.

Lerner V, DeStephano C, Ulrich A, Han ES, LeClaire E, Chen CCG. A Systematic Review of Validity Evidence for the Fundaments of Laparoscopic Surgery Examination in Gynecology, JMIG. 2021 LeClaire EL, DeStephano CC, Lerner VT, Chen CCG. Decision and consequences: Validation of High-Stakes Simulation-Based Assessments in Gynecologic Surgery. JMIG. 2021.

Greenberg CC, Klingensmith ME. The continuum of Coaching: Opportunities for Surgical Improvement at all Levels. Ann Surg. 2015.
Ericsson A, Pool R. Peak: Secrets from the New Science of Expertise. 2016

Cutrer WB, et al. Fostering the development of master adaptive learners: A conceptual model to guide skill acquisition in medical education. Academic Medicine. January 2017.



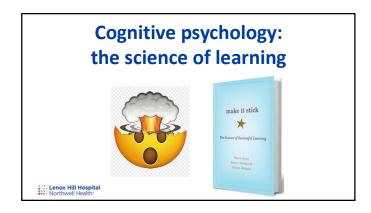




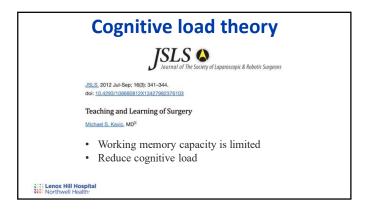


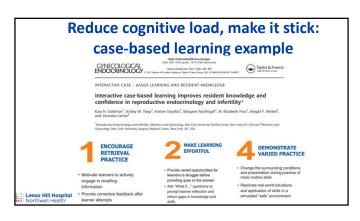


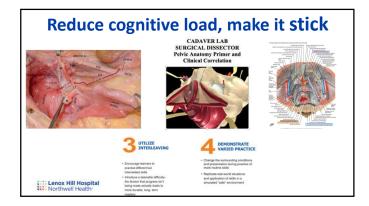


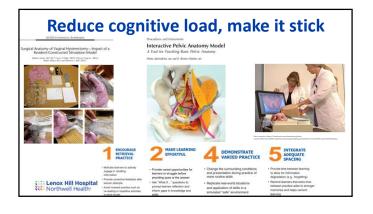


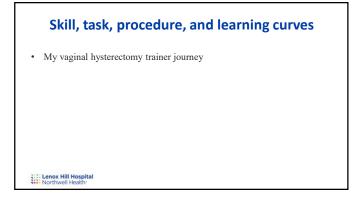






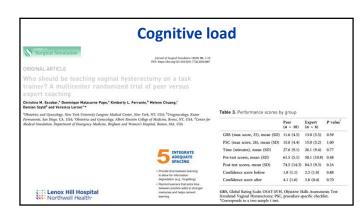
















CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) announced new standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. <u>AAGL is ACCME-accredited and headquartered in California.</u>

CMA developed the standards in response to California legislation (<u>Business and Professions (B&P) Code Section 2190.1</u>), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations beginning January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the <u>CLC and IB standards page</u> on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities and behaviors, in order to meet social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – The attitudes, stereotypes and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.

Bill Text – AB-241 Implicit bias: continuing education: requirements.

Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)

Cultural Competence In Health and Human Services | NPIN (cdc.gov)

Cultural Competency – The Office of Minority Health (hhs.gov)

Implicit Bias, Microaggressions, and Stereotypes Resources | NEA

Unconscious Bias Resources | diversity.ucsf.edu

Act, Communicating, Implicit Bias (racialequitytools.org)

https://kirwaninstitute.osu.edu/implicit-bias-training

https://www.uptodate.com/contents/racial-and-ethnic-disparities-in-obstetric-and-gynecologic-care-and-role-of-implicitbiases

https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn

https://pubmed.ncbi.nlm.nih.gov/34016820/