AGL 2022

51st GLOBAL CONGRESS ON MIGS

December 1–4, 2022 | Gaylord Rockies Resort and Convention Center | Aurora, Colorado

SYLLABUS

SURG-621: Surgical Coaching

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Table of Contents

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Caprice Greenberg, MD, MPH – Consultant: Johnson & Johnson
Cara R. King, DO, MS*

SURG-621: Surgical Coaching

Co-Chairs: *Caprice C. Greenberg, MD, MPH*

Faculty: *Cara R. King, DO, MS, Janet Donbrowski, MHSA*

Course Description

Join the Academy for Surgical Coaching for a Surgical Coach Training Session. You will learn the mindset and skillset necessary to be a great surgical coach. Hands-on practice and interactive conversation guide the training. The Surgical Coach Training Course consists of a 6-hour, full-group session that involves a didactic component, interactive reflection, and small group breakouts to apply coaching skills.

All participants will become certified coaches through the Academy for Surgical Coaching and will be eligible for future coach-coachee pairing if interested.

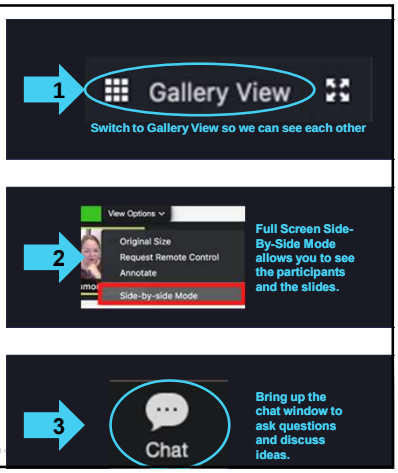
Learning Objectives

At the conclusion of this course, the participants will be able to: 1) Describe the current performance gap that can be met by Surgical Coaching; 2) Identify core principles of the coaching mindset; 3) Identify the key skills of surgical coaching; 4) List three aspects that are critical for adult experiential learning and 5) Apply skills of Surgical Coaching within practice coaching sessions.

Course Outline

9:00 am	Fundamentals of Surgical Coaching	C. Greenberg/J. Dombrowski/C.R. King
10:30 am	Break	
10:45 am	Operationalizing Surgical Coaching	C. Greenberg/J. Dombrowski/C.R. King
12:30 pm	Lunch	
1:45 pm	Practice Coaching Sessions	C. Greenberg/J. Dombrowski/C.R. King
2:45 pm	Break	
3:00 pm	Effective Coaching and Wrap-up	C. Greenberg/J. Dombrowski/C.R. King
4:00 pm	Adjourn	

THE Academy FOR Surgical Coaching



THE Academy FOR Surgical Coaching

Surgical Coach Training Course

December 1, 2022

www.SurgicalCoaching.org @SurgeonCoaching

Conflict of Interest Disclosures

ACADEMY FOR SURGICAL COACHING – SURGICAL COACH TRAINING
DECEMBER 01, 2022
DENVER, CO

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Kristine Lombardozzi	X			

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Julie Clanahan	X			

Agenda

- Welcome and Introductions
- Introduction to Surgical Coaching
- Operationalizing Surgical Coaching
- 15 min break
- The Peer Coach Tool
- 60 min break
- Practice Coaching
- 10 min break
- Wrap Up and Finish

Meet Our Faculty & Participants

1. What is your name?
2. Where are you from?
3. What is one fact about you that is *not* on your CV?

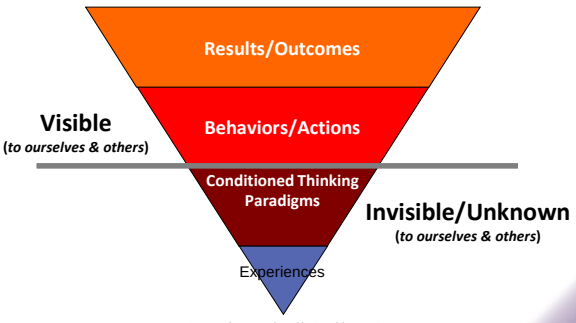
Opening Reflection

- What do you have to do to get the most out of today's training?

Opening Reflection

- What do you have to do to get the most out of today's training?
- What might get in your way of achieving this?

Shifting Behaviors Isn't Enough for Achieving Different Results



Courtesy of Janet Dombrowski, JCD Advisors, LLC

Getting the Most Out of Today

*Practicing the **culture** we want to create for surgical coaching*

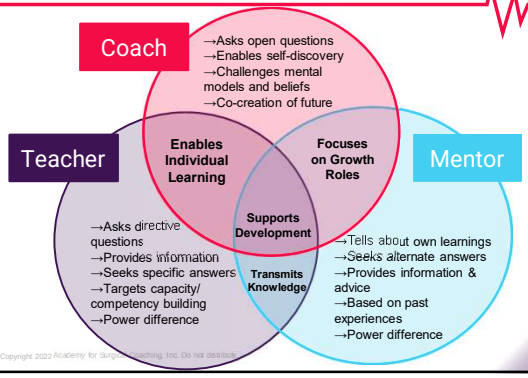
- Support engagement - videos on
- Promote mutual learning - mute off, engage freely
- Interact as equals - use first names
- Value each other's time - start/end promptly
- Practice curiosity - balance advocacy & inquiry
- Practice compassion - acceptance, not judgment
- Others?

Introduction to Surgical Coaching

What is Coaching?

- In your mind, what is coaching?
- What are 3-4 important activities in which you think coaches should engage?
- How does coaching differ from traditional educational activities?

How is a Coach Different?



Video: Teaching, Mentoring and Coaching

Definition of Coaching

- Unlocking a person's **potential** to maximize their own performance.
- It is helping them to **learn** rather than **teaching** them.
- Providing objective and constructive feedback to help someone recognize what works and what can be improved and inspire them to maximize their potential.

1. Palmer and Whybrow (ed.) Handbook of Coaching Psychology (2008)
2. International Coaching Federation (http://coachfederation.org/)
3. Whitmore. Coaching for Performance (1992)

Peer Coaching

A distinctive type of coaching in which peers, who are often at a similar level of knowledge engage in an **equal non-competitive relationship** that involves:

- Establishing goals
- Self-evaluation
- Observation, feedback
- Establishing next steps

→ To improve task performance and support in the implementation of changes.

1. Schwellnus and Carnahan. Peer-coaching with healthcare professionals…Medical Teacher (2014)l 36: 38- 46.
2. Grant, Passmore, Cavanaugh, Parker. The state of play in coaching today: A comprehensive review of the field. Inter Rev Ind Organ Psych. (2010); 25: 125-167.

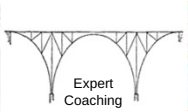
Peer Coaching

- **Power balance** – by nature a **collaborative** relationship where neither participant takes a superior role
- **Self-directed/responsible** – enhances intrinsic motivation and enables people to follow self-concordant goals
- **Develops capacity** – monitor progress until the surgeon starts to develop the habit of self-monitoring

1. Wang. Structure and characteristics of effective coaching practice. The Coaching Psychologist. (2013); 9(1): 7 – 17.
2. O'Broin and Palmer. Co-creating an optimal coaching alliance. International Coaching Psychology Review. (2009); 4(2): 184-94.
3. Burke and Linley. Enhancing goal self-concordance through coaching. International Coaching Psychology Review. (2007); 2(1): 62-9.

Peer Coaching as an Expert

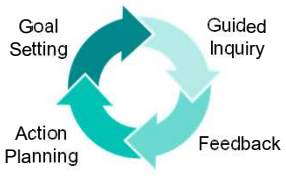
- Expert coaching employs these same principles but in a situation where a surgeon aims to acquire a *new skill* or learn a *new procedure*.
- There is an implicit acknowledgement that the coach will have more experience and knowledge than the participating surgeon.
- Expert coaching serves as an adjunct to other types of learning. **It is a bridge to independence.**



Adult Learners

Individualized Learning

- ➔ Goal-driven
- ➔ Active Participation
- ➔ Tailored to Experience
- ➔ Iterative and longitudinal



1. Kaufman. Applying educational theory in practice. BMJ (2003); 326:213-16
2. Boonyasai et al. Effectiveness of teaching quality improvement to clinicians: a systematic review. JAMA (2007); 298: 1023-37.

Discussion

- How is peer coaching different from what you've experienced in the past?

Discussion

- How is peer coaching different from what you've experienced in the past?
- What might be the challenges of shifting from/between expert coaching and peer coaching?

Why aren't we already doing this?

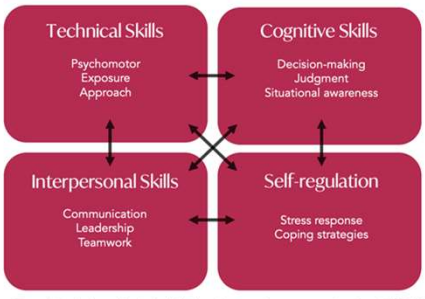
Operationalizing Surgical Coaching

Video-Based Surgical Coaching

- Allows one to view own performance
- More successful in sustaining behavior change
- Confers a time savings of 50-80%
- Removes concurrent responsibilities to allow full concentration on performance assessment
- Mitigates medico-legal and credentialing complexities

1. Ward. Resident self-assessment of operative performance. Am J Surg (2003); 185(6): 521
2. Scherer. Videotape review leads to rapid and sustained learning. Am J Surg (2003); 185(6): 516.
3. Beard. Assessing technical skills of surgical trainees. Br J Surg (2005); 92(6): 778.
4. Dath. Toward reliable operative assessment: the reliability and feasibility of videotaped assessment of laparoscopic technical skills. Surg Endosc. (2004); 18(12): 1800.

Surgical Performance Domains



Greenberg CC, et al. Surgical coaching for individual performance improvement. Ann Surg. 2015;261(1):32-4.
Yule S, et al. Non-technical skills for surgeons in the operating room: A review of the literature. Surg. 2006;139(2):140-9.

Getting Started: Rapport Building

- Stress that you look forward to learning together
- Explore the surgeon's professional background and interests
  - Identify areas of shared interest and common experiences
  - Surgical "camaraderie" and short, pertinent "war stories" can be helpful here
- Share a little about yourself relevant to the coaching program
- Elicit the surgeon's motivation for participating in the program and what he/she hopes to achieve
- Explain your motivation for serving as a coach

Mindsets and Skill Sets of Coaches

- Active participation based on equality and choice
- Role of experience of surgeon
- Co-learner, not expert
- Responsibility, not rescue

MINDSETS to foster adult learning

- Facilitate goal setting
- Guide inquiry / ask good questions
- Observe and give constructive feedback
- Facilitate action planning and follow up

SKILL SETS for effective coaching

The Peer Coach Tool

❑ FACILITATE GOAL-SETTING & REVIEW
- Press for clarity, specificity
- Ask for progress update, identify barriers, and commend effort
- Ask how current case relates to goals and where surgeon would like to focus

❑ GUIDE INQUIRY
- Understand parameters of the case and identify key contextual factors
- Listen for opportunities for inquiry (i.e., surgeon insights, concerns, questions)
- Press for deeper analysis, using multiple questions, esp. "Why?"
- Explore alternative interpretations, staying objective re. surgeon's framing of events
- Problematize situations, with hypotheticals and "what ifs"

❑ PROVIDE CONSTRUCTIVE FEEDBACK that is
- Focused on surgeon's goals & responsive to issues they raise
- Descriptive of specific behaviors and observed or potential consequences
- Respectfully offered, i.e., attentive to tone, style, and amount
- In the service of further inquiry & action planning
- Allows surgeon to respond

❑ FACILITATE ACTION-PLANNING
- Engage surgeon in identifying specific strategies for implementing changes
- Press surgeon to identify potential barriers and possible solutions

❑ ATTEND to the COACHING PROCESS
- Solicit surgeon feedback re. your coaching approach, session structure, content, etc.

MINDSET REMINDERS

Who is driving the learning agenda?
The surgeon.

Which hat are you wearing?
An expert gives advice. A colearner is curious and supports exploration of a range of possibilities with a colleague.

Are you in service to the surgeon?
Attentive to the surgeon's style, needs, and goals, not your own

Who has responsibility?
Surgeon For committing to and implementing changes / solutions
You For improving your coaching

❑ FACILITATE GOAL-SETTING & REVIEW

Key Mindset Shift

Who is **driving** the learning agenda?

The Coach → **Surgeon/ participant**

*"At the core of this role is the assumption that [surgeons] must be encouraged to remain **proactive**, in the sense of retaining both the diagnostic and remedial initiative, because only they own the problems identified, only they know the true complexity of their situation, and only they know what will work for them in the culture in which they live."*

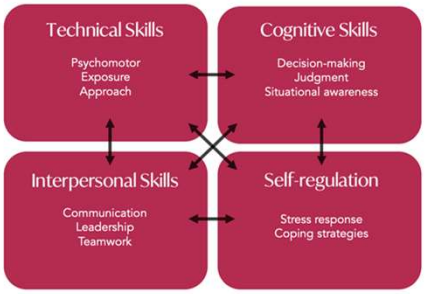
Schein, E. (2011). Helping: How to offer, give, and receive help.

Skill Set for Goal-Setting

- Press for clarity, specificity
  - Metrics
  - Action steps
- Ask for progress update, identify barriers, commend effort
- Ask how current case relates to goals and where surgeon would like to focus
- Be able to distill goals into concise, written form

❑ FACILITATE GOAL-SETTING & REVIEW

Recall the Performance Domains



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Yule S, et al. Non-technical skills for surgeons in the operating room: A review of the literature. Surg. 2006;139(2):140-9.

❑ FACILITATE GOAL-SETTING & REVIEW

Goal-Setting Exercise

❑ FACILITATE GOAL-SETTING & REVIEW

Challenges and Opportunities

- Not just “jumping in” and skipping this key step
- Results in “conversation”, but not directed learning or shifting behaviors
- Not coming back to this at the end of a session

Agenda

- Welcome and Introductions
- Introduction to Surgical Coaching
- Operationalizing Surgical Coaching
- 15 min break
- The Peer Coach Tool
- 60 min break
- Practice Coaching
- 10 min break
- Wrap Up and Finish

We Are Here

Break

15:00

❑GUIDE INQUIRY

GUIDE INQUIRY

Key Mindset Shift

Which hat are you wearing?

Expert & Advice-giver & Critic → **Co-learner & Curious Supporter**

GUIDE INQUIRY

Coaching Mindset Shift

Expert	Learner
• Knows the answers	• Wonders about answers
• Shows little curiosity	• Shows great openness
• Relies on habits, routines/rules	• Challenges assumptions and beliefs
• Feels competent, complete, comfortable	• Continuously tests competence, accepts discomfort, tolerates conflict

 Courtesy of Janet Dombrowski, President JCD Advisors, LLC

GUIDE INQUIRY

Balancing Advocating vs Inquiring

➔ What is the balance of these two components in Western conversations?

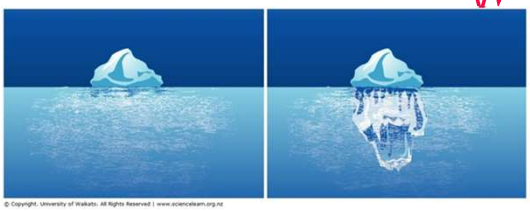
➔ How about in your own conversations?

➔ Real dialogue happens when advocacy and inquiry are in balance

➔ "Seek first to understand, then to be understood"

GUIDE INQUIRY

Skill Set: Different Types of Inquiry



Process Inquiry	Deeper Inquiry
• Warming up • Focused on the "WHAT"	• Uncovering thinking processes • Focused on the "WHY"

Schein, E. (2011). Helping: How to offer, give, and receive help.

GUIDE INQUIRY

Process vs Deeper Inquiry

Process	Deeper
• Develop a full picture of the surgeon's situation	• Engage the participant in reflection and diagnosis through guided questioning related to:
• Demonstrate commitment to listening carefully in order to understand	- Personal reactions and thinking
- Eliciting details of what occurred	- Causes & motives
- What the surgeon has tried	- Actions taken or contemplated
- What kind of help is expected and would be useful	- Systemic considerations

GUIDE INQUIRY

Inquiry Examples

Process	Deeper
Prompt case description • "Tell me what's going on…" • "What brings you here?" • "How can I support you?"	**Personal reactions** • "Why do think this is an issue now?" • "Why do you think you reacted that way here?"
Ask clarification questions • What do you mean by…?" • "Could you tell me more about…?"	**Causes & motives** • "What conditions might have contributed to X occurring?" • "Are there other possible explanations for Y?"
Check your own understanding • "What I hear you saying is…" • "So, what you are wondering about is…"	**Actions taken or contemplated** • "What have you tried so far? Why?" • "Can you imagine another approach to this?" • "What is another way this might have played out?"

Slide 42

1 Push inquiry example handout

Addi Faerber, 7/13/2020

❑ GUIDE INQUIRY

After the Inquiry: Levels of Listening

For Understanding
- of the entire message; beyond the words
- generative, full of possibilities

For Application

To Agree/Disagree

To Tell My Story

Non-listening

PRESENCE MAKES THE DIFFERENCE

Courtesy of Janet Dombrowski, President JCD Advisors, LLC

"Most people do not listen with the intent to understand. They listen with the intent to reply."

– Stephen R. Covey

❑ GUIDE INQUIRY

Challenges & Opportunities

- Biggest mindset shift is from telling to asking
- Be alert for "feeling" words as indicator to go "deeper"
- When in doubt, ask a question - less about process, more about thinking
- Remember to listen to responses

❑PROVIDE CONSTRUCTIVE FEEDBACK

❑ PROVIDE CONSTRUCTIVE FEEDBACK

Key Mindset Shift

Are you in service to the surgeon participant?

YOUR perspective, views, needs → **THEIR needs, style, goals**

❑ PROVIDE CONSTRUCTIVE FEEDBACK

Shift from "Rescue to Responsibility"

	Rescue	Responsibility
Mindset	• They can't do this without you • You fear they are not capable • Coach takes the blame	• Other person has the wisdom and ability that you bring out • The other person has choice about how to react/respond • The surgeon will need to live with results
Feedback Qualities	• Weakness focused • Makes decisions, gives directions • Results oriented • Fosters dependence	• Strength based • Stimulates thinking with great questions • Learning oriented • Builds capacity

 Courtesy of Janet Dombrowski, President JCD Advisors, LLC

PROVIDE CONSTRUCTIVE FEEDBACK

Skill Set for Constructive Feedback

- Be descriptive, specific, and non-judgmental
- Focus on observations of behaviors and the impact of those behaviors, rather than on assumptions or inferences
- Follow with an opportunity for the surgeon to consider the feedback and respond
- Be mindful of:
  - Tone
  - Timing of the feedback
  - Amount so as not to overwhelm

PROVIDE CONSTRUCTIVE FEEDBACK

Examples of Constructive Feedback

Instead of… "You shouldn't stand like that."	**You might try…** "Here I noticed that your arm position was tight to your chest. This looks like it made it difficult for you to…"
Instead of… "The resident was too timid. I don't like how he hesitated when…"	**You might try…** "The resident paused here for a couple of seconds before he… This led to… "
Instead of… "Don't do that again before checking with the anesthesiologist."	**You might try…** "At this point, you started closing before you checked in with the anesthesiologist."
Instead of… "Nice job there."	**You might try…** "Your movements looked very fluid and natural. The extra time you spent positioning the retractor seems to have made it much easier to see."

PROVIDE CONSTRUCTIVE FEEDBACK

Example "Script": 3-Part Technique

1 Your Observation

Tell the surgeon what you saw. It is important to be specific, clear, and objective.

- "I saw"
- "I observed"
- "I watched"
- "The team did"
- "The team didn't"
- "I noticed"

2 Your Opinion

State why you think what you saw is important to talk about, and explain why you pointed out what you did.

- "I think…"
- "I believe…"
- "It is really important to…"
- "I am pleased because…"
- "I am concerned because…"

3 Your Question

Ask a question to help the team reflect on what happened.

- "Can you help me understand?"
- "I am curious, what do you think happened?"
- "How did that make you feel?"
- "What is your point of view?"
- "How did you experience that?"
- "I wonder what you think happened?"
- "Where do you think your team was coming from?"

Coaching Clinical Teams Module: Facilitator Notes. Content last reviewed October 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/teamstepps/instructor/index.html

PROVIDE CONSTRUCTIVE FEEDBACK

Alternate "Script" for Feedback

What I appreciate is...

AND

I feel you could be even more effective if...

PROVIDE CONSTRUCTIVE FEEDBACK

Roleplay: Surgical Coaching

2

PROVIDE CONSTRUCTIVE FEEDBACK

Challenges & Opportunities

- Tough skill for physicians to put into practice
- Need to shift from just observation to feedback
- Make sure to invite surgeon to respond/react
- Commit to using a "script"

Slide 53

2 @addi@surgicalcoaching.org insert Cara's myometomy video.
Assigned to Addi Faerber
Addi Faerber, 4/20/2022

❑ PROVIDE CONSTRUCTIVE FEEDBACK

Skill Set for Effective Feedback

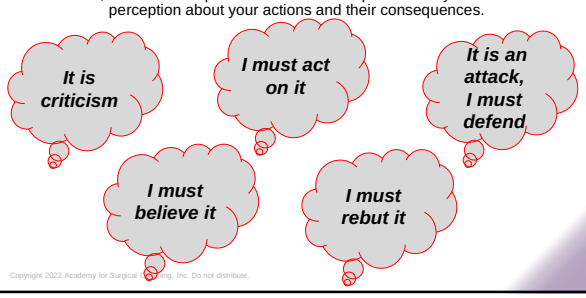
Credible & Skilled Giver ⟷ Willing & Prepared Receiver

Courtesy of Janet Dombrowski, President JCD Advisors, LLC

❑ PROVIDE CONSTRUCTIVE FEEDBACK

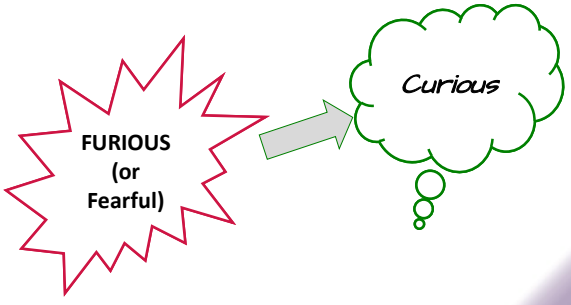
RECEIVING Feedback Can Be Tough

A **mental model** is an explanation of your thought process about how something works in the real world. It is a representation of the surrounding world, the relationships between its various parts and a your intuitive perception about your actions and their consequences.



❑ PROVIDE CONSTRUCTIVE FEEDBACK

Encourage Shift in Yourself & Others



 Courtesy of Janet Dombrowski, President JCD Advisors, LLC

❑ FACILITATE ACTION-PLANNING

❑ FACILITATE ACTION-PLANNING

Key Mindset Shift

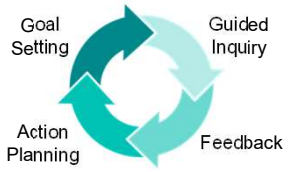
Who has responsibility?

YOU tell them what to work on → **THEY choose & commit to implementing change**

❑ FACILITATE ACTION-PLANNING

Skill Set for Action Planning

- Support adult learning
- Engage surgeon in identifying specific strategies for implementing changes
- Press surgeon to identify potential barriers and possible solutions



❑ FACILITATE ACTION-PLANNING

Challenges & Opportunities

- Similar to goal setting – needs focused attention
- Attend to timing, use end of session wisely
- Intentionally wrap up
- Document planned changes/actions

❑ ATTEND to the COACHING PROCESS

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Take the Opportunity to Improve

- Solicit surgeon feedback regarding:
  - Coaching approach
  - Session structure
  - Content
  - Pace
- Go back and review these training materials
- The Academy is here to support you and provide feedback

❑ ATTEND to the COACHING PROCESS

Create Momentum & Accountability

- Coach helps hold the structure for the surgeon to be accountable to him/herself
- Ensure goals, action plans are documented
- Schedule future sessions at the time of the current session
- Discuss expectations for ongoing communication between coach and surgeon from session to session

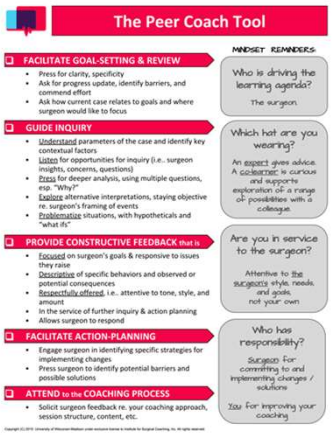
How Coaching Goes Wrong

Common Coach De-Railers and Their Effects

Break Confidentiality	→	Lose trust
Lack of clear goals and process	→	Just “chatting” /sub-optimizes learning opportunity
Acting in ”rescue mode”	→	Reduce surgeon responsibility
Reverting to expert/mentor	→	“It’s all about me”/Lose focus on surgeon needs
Interrogation vs Inquiry	→	Defensiveness/withdrawal

Sometimes the Surgeon Can Create Challenges to Coaching

- Lack of commitment (time, effort, enthusiasm, preparation)
- Technical problems (no videos, problems with Zoom, scheduling/time zone issues)
- Content/goals for coaching
  - Wants the focus of coaching be the adoption of an entirely new procedure
  - Wants to "be coached" or "told" what to do by "expert"
  - Can't see or commit to areas for improvement/pushes back/defensive



Preparing for Practice Sessions

Before Break

2 Volunteers needed for practice. Will serve as Surgeon to receive coaching from their peers. Will need to have an operative video available.

After Break (60 minutes)

Breakout into small groups and practice coaching.

Agenda

- Welcome and Introductions
- Introduction to Surgical Coaching
- Operationalizing Surgical Coaching
- 15 min break
- The Peer Coach Tool
- 60 min break
- Practice Coaching
- 10 min break
- Wrap Up and Finish

We Are Here

Break

Discussion

- *What will come naturally?*
- *What appeals to you?*
- *What are you worried about?*
- *What do you have to work on?*

Break Out: Practice Coaching Sessions

Agenda

- Welcome and Introductions
- Introduction to Surgical Coaching
- Operationalizing Surgical Coaching
- 15 min break
- The Peer Coach Tool
- 60 min break
- Practice Coaching
- 10 min break
- Wrap Up and Finish

We Are Here

Break

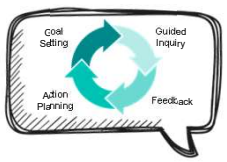
09:59

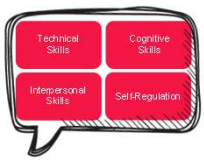
Self-Assessment: How'd You Do?

- Was I in the right "mindset" (co-learner, present, other-focused) entering the conversation?
- What mental models do I have that I might need to be aware of and manage?
- How did I do on employing the key coaching skill set?
  - Goal setting and action planning
  - Staying in inquiry mode rather than advocating
  - Giving constructive feedback
  - Attending to differences in style
- What was easy? What was hard?

Being the Most Effective Coach You Can Be

Surgical Coaching Interaction



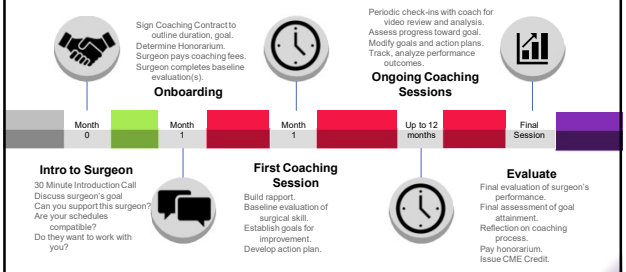


Peer-to-peer Coaching

Surgical Coach

Surgeon Partner

Longitudinal Coaching Relationships



What makes an effective coach?

- How important is surgical technical skill?
- How can great coaches be identified?
- What characteristics do you see in yourself that will help you in your role as a coach?

What makes an effective coach?

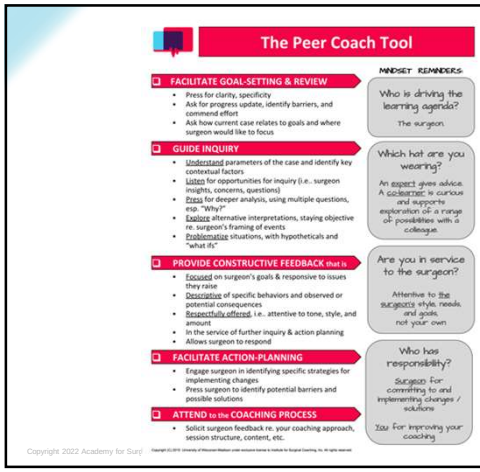
- "Successful coaches are **masterful communicators** and unsuccessful coaches often fail not because they lack knowledge of the sport but because of poor communication skills" - Athletics
- "So the ability to **adapt**, like I say, situational is 95% of being a good coach. Reading the situation and figuring out what each person needs" - Music
- "Good coaches speak with **credibility**, make a personal **connection**, and focus little on themselves" - Teaching

Traits of an Effective Coach

- Communication skills - two way
- Adaptability
- Can understand surgeon's needs and perspectives
- Ability to motivate
- Broad knowledge base
- Respected in the field
- Attention to detail/observation
- **Self awareness**

Effects on Coaching Interaction

People who prefer Extraversion tend to	People who prefer Introversion tend to
• Talk things through	• Think things through
• Take action, get going	• Reflect before acting
• Want to be involved	• Want to be informed
• Prefer face-to-face communication	• Prefer writing/one-on-one communication



Next Steps

Feedback and CME

To receive CME, you will need to complete the course feedback survey. Look for an email!

What else can you do following this Surgical Coach Training?

- Refer colleagues who you think would benefit from **receiving coaching** or **being a coach**
- Coaching program at your **home institution**
- Coaching program through your **professional society**
- Other creative partnership ideas? Let us know!

THE Academy FOR Surgical Coaching

Empowering surgeons through coaching

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. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), 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 CLC and IB standards page 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/