Mentoring
(& avoiding bullying)

Mrs Scarlett McNally BSc MB BChir FRCS(Tr&Orth) MA MBA FAcadMEd

Consultant Orthopaedic Surgeon, ESHT

Council member, Royal College of Surgeons of England

Previously: Director of Medical Education, ESHT

A mentor is

"Someone to talk to off-line…"

Tim Terry, RCS Council member, 13.10.16

- Mentoring is for everyone and anyone
- It is NOT just to be invoked for the failing trainee

- It takes time

Mentoring: New RCS guide

www.rcseng.ac.uk "publications"

This is a simple guide about being a mentor or mentee, basic ground rules

NB Tables in this talk come from this booklet https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/gsp-mentoring/

Mentor	Help another with their beliefs and values in a +ve way
Coach	Must be trained. Often specific. May involve “telling”
Perceptor	Guiding newly-qualified (eg nursing)
Teacher	Info (etc)
Educational supervisor	Directing trainee
Clinical supervisor	Help with training/feedback in clinical setting
Session supervisor	(eg in ISCP may be another team member)
Appraiser	Trained – formulate PDP, check on progress
Counsellor	Helping improve by resolving situations from past
Clinical supervisor for a Dr in difficulty	‘targeted’
Patron	Giving advice. Junior under your wing

Mentoring

- Formal or informal
- Short-term or long-term
- Face-to-face or otherwise (Skype/ email/ phone)

- Need boundaries
- Need to agree (shared understanding)

Toolkit for a mentor

Listening skills	
Resist urge to give advice	
Communication skills	- Interpret and reflect back - Remove barriers and negativity - Avoid judging
Rapport building	- Focus on mentee - Have an intrinsic desire to help them
Motivating and inspiring	
Curiosity flexibility and challenge	- People's needs are different

One model for behaviour change or changing mindset:

The GROW model

This is another model encouraging a step-by-step identification of goals and realistic assessment of how to achieve them.

Goal	Clarify and agree a realistic and motivating outcome
Reality	Work through the reality of what is happening now and where blocks might be
Options	Stimulate ideas and choices about new ways of doing things
What next	What is the first step? And then?

SAMPLE MENTORING CONTRACT

*Mentor:*_____

*Mentee:*_____

*Frequency of meetings:*_____

*Duration of meetings:*_____

*End date/ Duration of mentoring:*_____

*Cancelling meetings:*_____

_____

_____

*Communication between meetings :*_____

_____

_____

*Purposes of relationship, including mentee goals:*_____

_____

_____

_____

_____

Content and boundaries:

- *Confidentiality*_____
- *Will clinical advice be given? Yes/ No*
- *Will mentor act as referee? Yes / No / Not yet certain*

Agreement and contact details			
Mentor name:		*Mentee name:*	
Job role:		*Job role:*	
email address:		*email address:*	
Telephone:		*Telephone:*	
Other telephone:		*Other telephone:*	
Other contact:		*Other contact:*	
Signature:		*Signature:*	
Date:		*Date:*	

Benefits

- To the mentee
- To the patients
- To the mentor
- To the organisation

And now for something a bit similar…

All people are different

We select surgeons from the teeny minority that are alpha

- Bullying is how the victim FEELS. It is not what you meant
- Be nice
- Be clear

Clare Marx – now PRESIDENT

me

ANY Member or Fellow can stand for Council:
- 6 Thursdays /year
- write 100 words
- apply any JANUARY

VACANCY NOW
- DPA = College rep for South East Coast
BY 30 Nov 2016

The Royal College of Surgeons - Council April 2012

Being accused of bullying…

- Can be devastating
- “The second victim”

- Medical Women’s Federation:

  “the perpetrators of domestic violence need help too”

But behaviour change is possible

Being accused of bullying…

- Often a sub-optimal trainee
- Often a stressful environment
- Often a trigger

Bullying

- Behaviour that could be interpreted as bullying is very common in the NHS.
- In the 2014 **GMC trainee survey**:
  - 8% of doctors in training experienced bullying
  - 14% witnessed it
  - surgery and Obstetrics & Gynaecology a particular area of focus
- 48% Australian surgical trainees
- 54% Less Than Full Time Trainees in surgery experienced undermining behaviour as a result of undertaking LTFT from Consultants and other staff http://bmjopen.bmj.com/content/6/4/e010136.full.pdf

- There is a body of literature on this topic and on modification of behaviour.

thebmj

BMJ 2016;354:i4682 doi: 10.1136/bmj.i4682 (Published 1 September 2016)

FEATURE

COMMENTARY

Sexual harassment and bullying in UK surgery: no room for complacency

All surgeons need to guard against the effects of unconscious bias

Scarlett McNally *consultant trauma and orthopaedic surgeon, Eastbourne, and council member, Royal College of Surgeons*

A 2014 General Medical Council survey of 50 000 junior doctors in the United Kingdom found that about 8% had experienced

We all need to make it absolutely clear that any type of bullying is unacceptable. There are four aspects to eliminating bullying.

RCS

TACKLING BULLYING & HARASSMENT in the *NHS*

WHAT IS BULLYING?

Characterised as offensive, intimidating or insulting behaviour, which includes an abuse or misuse of power through means that undermine, humiliate or injure the recipient. Bullying can be verbal, physical, hidden or covert and cyber.

WHAT IS HARASSMENT?

Unwanted and unlawful conduct related to a relevant characteristic concerning age, disability, gender reassignment, race, religion or belief, sex, and sexual orientation, which has the purpose or effect of violating an individual's dignity or creating an offensive environment for that individual.

20% of staff in the NHS report they have been bullied by other staff.[1]

51% of staff who reported bullying perceived supervisors/managers to be the most common source.[1]

80% of staff believe the state of their health affects patient care.[2]

29.9% of all UK NHS staff indicated experience of psychological distress due to bullying behaviours.[1]

WHAT IMPACT COULD THIS HAVE?

ON THE ORGANISATION:

- poorer patient care
- reduced productivity
- low morale
- increased absenteeism.

WHAT CAN MY ORGANISATION DO?

- Create jointly agreed policies that help to develop a shared understanding and positive culture
- Promote supportive line management
- Identify early warning signs and challenge inappropriate behaviours
- Respond quickly to complaints
- Promote a culture where bullying and harassment is not tolerated
- Appoint a board lead to work closely with your Freedom to Speak Up Guardian on tackling bullying and harassment

WHAT CAN I DO?

- Ask the individual to stop
- Speak up!
- Keep a record or diary and document
- Speak to your manager, senior colleague and/or union rep

THE NHS STAFF COUNCIL
WORKING IN PARTNERSHIP

HEALTH, SAFETY AND WELLBEING PARTNERSHIP GROUP

The HSWPG has produced this infographic along with guidance on bullying and harassment to help both employers and staff. The group recognises the importance of managers and trade union representatives working in partnership and taking a proactive approach. Joint training, jointly agreed policies and early identification of problems can help promote trust, a shared understanding and create a positive culture.

HSWPG@nhsemployers.org www.nhsemployers.org/hswpg

NHS Employers

Who is most at risk of being accused of bullying?

- Is a doctor who qualified in a time of teaching by humiliation
- Is very dedicated to patient care
- Is very irritated by cases of failure in patient care
- Is personally very detailed
- Is highly intelligent
- Has had plaudits from many trainees
- Is poor at coping with below-average trainees or staff
- Expects too much of trainees at a junior level
- May not have insight into the effects of their actions and behaviours

There is a fantastic e-learning package on bullying, 50 minutes on BMJ learning LINK

http://learning.bmj.com/learning/module-intro/tackling-bullying-in-medicine.html?moduleId=44

Expert Advisory Group

on discrimination, bullying and sexual harassment

Advising the Royal Australasian College of Surgeons

Report to RACS

RCS

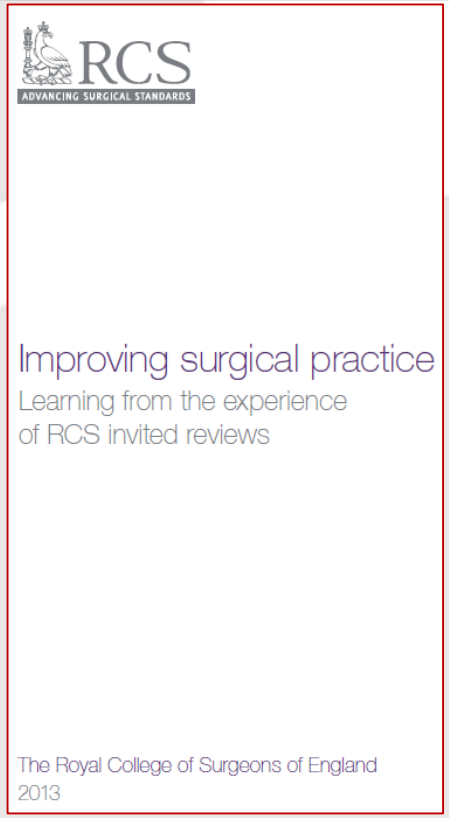
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

www.surgeons.org/respect Australasian

- Characteristics linked to discrimination, bullying and sexual harassment include that surgeons may have a strong sense of entitlement and may lack impulse control; many would benefit from more skills in managing stress and developing emotional intelligence.

- Supervisors were frequently reported to have poor interpersonal skills or leadership capability, which leads to both deliberate and unintentional bullying and ineffective teamwork. There was a general sense that badly behaved surgeons were unaware of – or dismissed – the link between effective teams and quality patient care.

Learning from invited reviews (patient care)



https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/improving-surgical-practice-learning-from-the-experience-of-rcs-invited-reviews/

INDIVIDUAL BEHAVIOUR

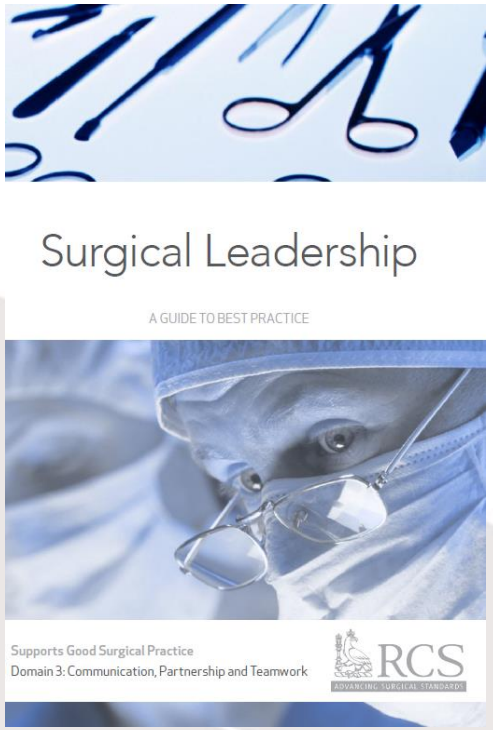
A regular feature of our experience is that the insight that an individual surgeon has into the strengths and weaknesses of his or her own surgical practice, and the impact of his or her own behaviour on the people around them, are crucial to enabling concerns about performance to be addressed. In particular, individuals about whom concerns are raised often demonstrate little self-awareness or appreciation of the significance of the situation they are in and the seriousness of the concerns raised. They can often be unwilling or unable to accept challenge and criticism of their performance and find it extremely difficult to be dispassionate about their circumstances and see them from the perspective of those raising concerns (or indeed from the point of view of an objective, neutral observer). They can be highly dismissive of the concerns that are raised about them and often will seek to challenge the individual or organisation that are raising concerns rather than engaging with a process of clarifying them and giving assurance about the quality of the care they are providing. They are poor at accepting feedback and become increasingly entrenched in their position. During this process they can come across as being 'difficult to manage', 'controlling', or arrogant in their approach.

It is also our experience that individuals experiencing difficulty can become isolated within their surgical team. They may respond defensively when concerns are raised, and data to judge the quality of the individual's surgical outcomes may be difficult to find. Without appropriate reflective practice, some of the qualities an individual will have relied on to become a highly trained autonomous surgical professional (such as strong, independent decision-making) can be magnified and manifest themselves in personality traits that make the individual difficult to engage with. Individuals may become arrogant and dismissive of other healthcare professionals. Their behaviour can become highly variable, and range from being compliant and non-confrontational to being difficult and demanding.

Individuals may also be reluctant to accept and deal with complications in their surgical practice, and may attempt to explain these complications away without acknowledging their significance. A tendency to blame other staff emerges and relationships with other colleagues can be affected.

Common attributes of the disruptive leader

- Dominant, arrogant, aggressive, egocentric, impersonal and autocratic – being outspoken and often intimidating to other team members (eg in theatre; in MDTs).
- Inhibiting the learning and development of other team members and trainees by dismissing their questions or challenges.
- Neglecting to share important information.
- Promoting the existence of factions/ rivalries within the team.
- Inhibiting constructive feedback or identification of patient risks
- Treating other non-clinical staff (eg management or administrative colleagues) without due courtesy or respect.
- Passive disruption such as:
  - persistent non-attendance at key meetings (eg MDTs; directorate meetings);
  - refusal to abide by decisions agreed by the team;
  - undermining colleagues by criticising them in public;
  - refusal to delegate;
  - failure to carry out proper patient handovers
- https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/surgical-leadership-guide/



The problems

- Trainee in difficulty / sub-optimal / trigger moments
- Protected characteristic:
  - Race / culture
  - Pregnancy / gender
  - Not fitting in
  - Not wanting to say something for fear of making it worse
- Different lines of command:
  - (Deanery/ regional / training / hospital)
  - Nursing hierarchy
- Not having clear expectations

When is it performance management and when is it bullying.

When it is going wrong...

- Everyone needs clarity
- We need rules!
- We need induction
- We need tick-boxes
- We need reflection

Start…

By saying hello
By knowing the student
Look nice
And/or be nice

#hello my name is…

Hello, my name is Dr Kate Granger & I'm the founder of the #hellomynameis campaign.

I'm a doctor & a terminally ill cancer patient. During a hospital stay in Summer 2013 I made the stark observation that many staff did not introduce themselves.

I firmly believe a friendly introduction is much more than common courtesy. It is about making a human connection, beginning a therapeutic relationship and building trust.

Introduce yourself to every patient you meet & encourage your peers to do the same

Consider launching your own local campaign

What Can I do?

Tweet using #hellomynameis

Visit my blog & pledge your support drkategranger.wordpress.com/hellomynameis

www.hellomynameis.org.uk

May 2016

https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/avoiding-unconscious-bias/

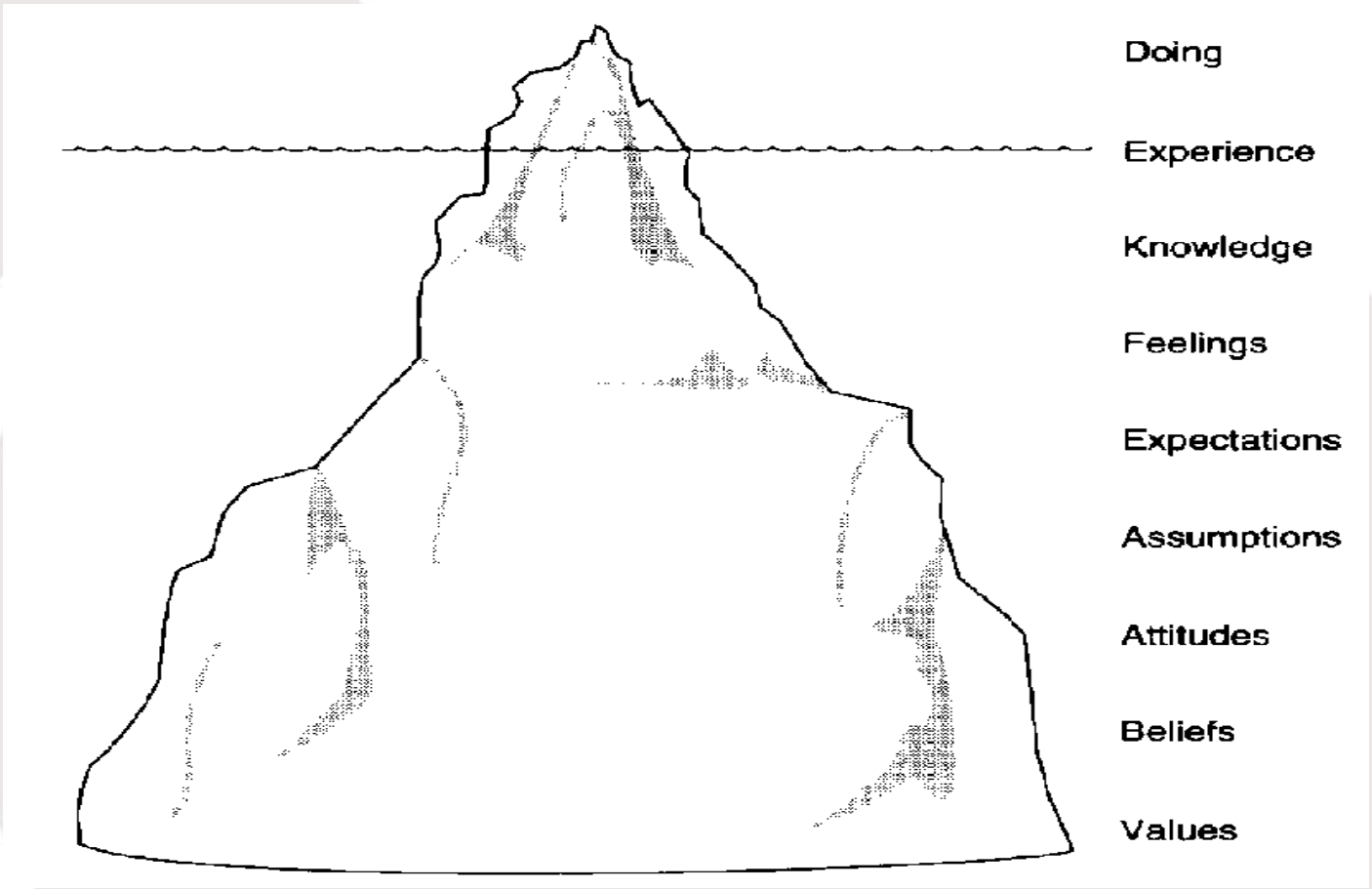
- We all have unconscious bias
- Start by NOT saying the first thing that comes into your head
- Start by saying hello and looking welcoming
- Try to find common ground
- Focus on the task not the individual
- Have systems to reduce your stress

Thiedeman's (2008) Seven Steps for defeating bias in the workplace

1. Become mindful of your biases
2. Put your biases through triage
3. Identify the secondary gains of your biases
4. Dissect your biases
5. Identify common kinship groups
6. Shove your biases aside
7. Fake it till you make it (what we say can become what we believe)

https://www.amazon.co.uk/Making-Diversity-Work-Defeating-Workplace/dp/0793177634

The Iceberg of Professional Practice - Fish & Coles, 1998



The trainee can't see: - What you are thinking

- Why you did something

“The Iceberg of Practice” (Fish & Coles, 2008)

- People can’t see:
  - why you do something
  - nor what other alternatives you considered
  - what you meant
- Behaviour change is possible
- Re-setting the culture of what is normal is also possible

Non-technical skills…
Getting your team to feel like a team
Concepts from the aviation industry

- "Below 10,000 feet" *(plane is taking off landing or crashing, people have to work with you at that time, no distractions, nothing taken personally)*

- "I have concerns" *(something is about to go wrong)*
  - Anyone is allowed to say this

With thanks to Mr Jamie Buchanan, Ortho Consultant, ESHT

The operating theatre – reduce difficult behaviour

- Use the team briefing well
  - To ensure that everyone knows who everyone else is
  - To explain any particularly tricky step or patient i.e. when tension
  - To think in advance who should assist, scrub, etc. for the whole list
- Getting new staff and students to understand the possibilities & expectations:
  - Be clear about what you expect – eg where to meet?
  - Send them the RCS guidance: “learning in operating theatres”
  - Try very hard not to make assumptions. For example, there are still some surgeons who assume that the male student/trainee will want to scrub and the female trainee/student will not. Treat everyone as their role requires.
- Be aware that you may be a few decades out of date about career-planning and know where you can refer trainees to, for example, the RCS.
- Be polite. If you are distracted from the operation in hand, find a polite way.

UNACCEPTABLE BEHAVIOURS

- Persistent attempts to belittle and undermine work / undervaluing efforts
- Persistent and unjustified criticism and monitoring of work
- Intimidating use of discipline or competence procedures
- Destructive innuendo and sarcasm / persistent teasing / threats / inappropriate jokes
    - Withholding necessary information from individual
    - Freezing out, ignoring or excluding
    - Unreasonable refusal for applications for leave/training
    - Setting impossible deadlines/ Undue pressure to produce work
    - Shifting goalposts / removal of responsibilities without telling the individual
    - Persistent attempts to demoralise individual
    - Persistent attempts to humiliate individual in front of colleagues

Work style

- Physical violence / Violence to property
- Discrimination based on racial, gender, sexual orientation and disability
- Unwelcome sexual advances

TRAINERS SHOULD:

- Provide support, guidance and fair treatment to trainees irrespective of gender/race/
- Avoid demonstrating favouritism to the exclusion of individuals or groups, allowing all trainees equity of access to the appropriate training opportunities
- Offer prompt, timely and constructive feedback that links feedback to performance
- Work with trainees in a constructive and professional manner
- Avoid giving feedback in such a way as to belittle, humiliate, threaten or undermine
- Provide feedback which highlights observed behaviours and helps the trainee to find alternative strategies to overcome problems
- Highlight areas of good performance
- Avoid behaviour that intimidates/bullies trainees, seeking to deal with problems in an appropriate manner for a professional practice which aims to encourage positive approaches to practice
- Avoid inappropriate behaviours: shouting/swearing/public outbursts about trainees Make time
- Focus on the tasks, not the individual

SET the RULES:

so ALL operating theatre staff help students / trainees

If you are invited to scrub:

- Try to meet the patient first. Aim to follow them up, in recovery and back on the ward.
- Practice scrubbing and gowning in advance, before you have to do it for real
- If given instruments to pull, pull with exactly the tension you are given
- Say if you are going to move.
- Keep a logbook if training (you should not keep confidential information unless registered)

https://www.rcseng.ac.uk/-/media/files/rcs/careers-in-surgery/learning-in-operating-theatres-2016-v3.pdf?la=en

It is like a party invitation…

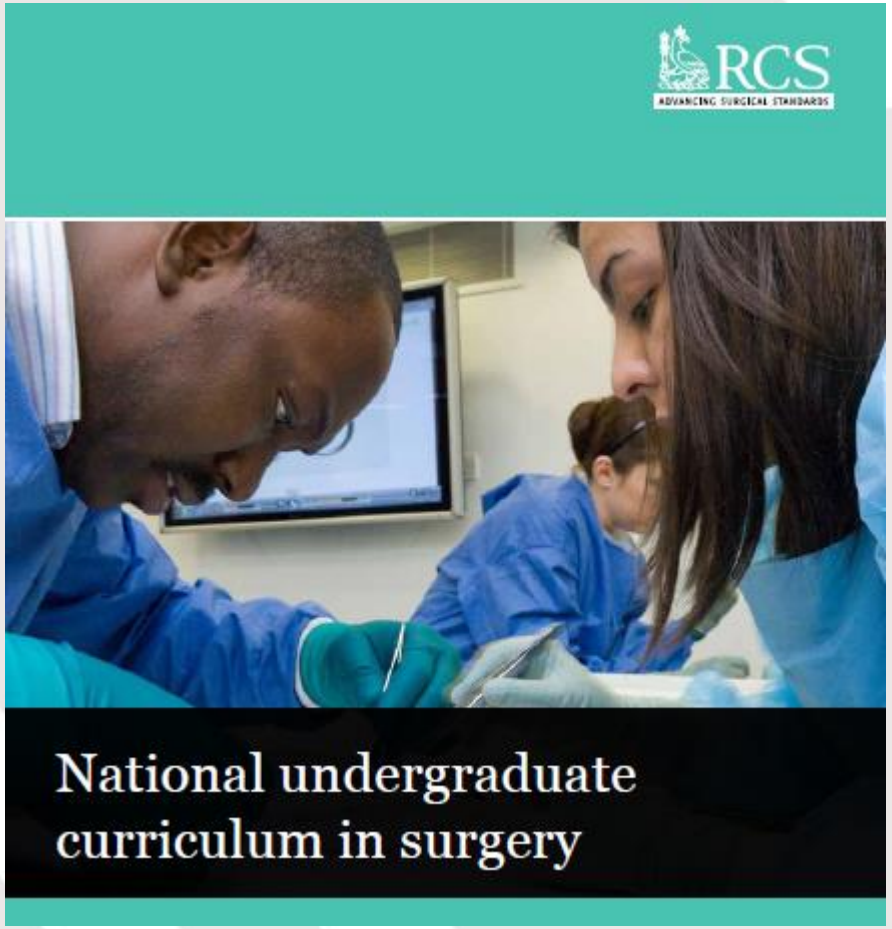
- Unless you say what the rules are, you can't penalise them for not adhering

- Start time
- Expectations
- Dress code
- Leave policy
- Set clear rules
- Induction
- Write it down

"It's another one of your tick-box forms, Scarlett"

- Knowledge is power
- A curriculum = knowledge + skills + attitudes

For EVERY future doctor

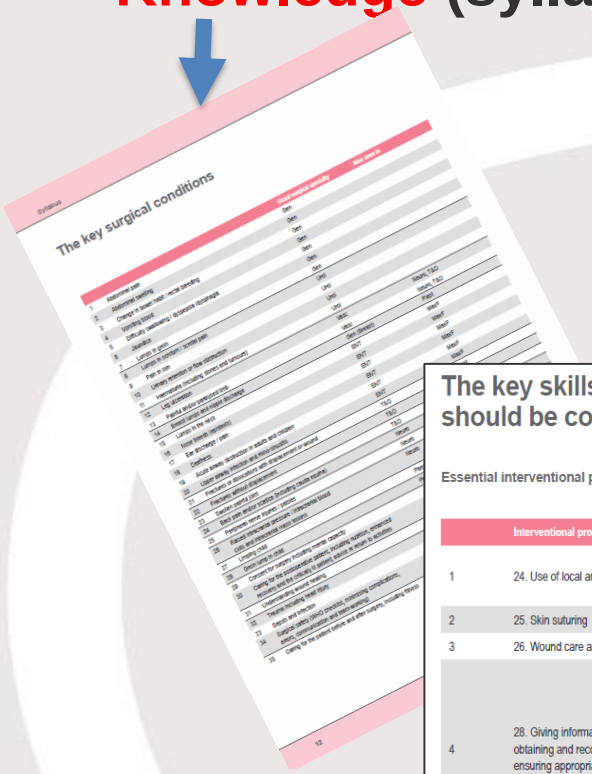


- To feel confident in considering surgical diagnoses
- To be able to manage conditions
- To refer appropriately
- To manage complications
- To be able to talk to patients

https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/national-undergraduate-curriculum-in-surgery/ 2015 version 1 !

Curriculum Contents = 3 sections:

Knowledge (syllabus) + Skills + attitudes/ ways of learning


The key surgical conditions

The key skills and interventional procedures that should be covered

Essential interventional procedures, as mandated by the GMC

	Interventional procedure and GMC – learning objectives 24–31 from *Tomorrow's Doctors*	
1	24. Use of local anaesthetics	Safe use of drugs that produce numbness and prevent pain, either applied directly to the skin or injected into skin or body tissues. Awareness of toxic doses. Ability to deal with anaphylaxis. Understanding of allergy, including to latex.
2	25. Skin suturing	Closing wounds in the skin by inserting stitches.
3	26. Wound care and basic wound dressing	Providing basic care of surgical or traumatic wounds and applying dressings appropriately.
4	28. Giving information about the procedure, obtaining and recording consent, and ensuring appropriate aftercare procedure.	Awareness of the risks and benefits of procedures and possible alternatives. Ability to communicate in a variety of ways to individualise the discussion with the patient or their supporters. Recognition of the barriers to communication inherent in a hospital/ clinic setting with which patients are not familiar, including heightened stress levels for the patient, which often impedes communication. Understanding of the importance of written documentation. Being clear in the observations required and communicating with those involved in aftercare, including handover.
5	29. Hand washing (including surgical 'scrubbing up')	Following a sequence to ensure clean hands and gloving without contamination.
6	30. Use of personal protective equipment (gloves, gowns, masks)	Following a sequence to fit mask, scrub, gown and gloves without contamination. Behaviour while using equipment. Appropriate doffing procedures to avoid contamination of self or environment.
7	31. Infection control in relation to procedures	Understanding the importance of minimising infection risk. This includes understanding team dynamics, avoiding contamination, commanding respect and adhering to local protocols.
8	32. Safe disposal of clinical waste, needles and other 'sharps'	Ensuring that these materials are handled carefully and placed in a suitable container for disposal.

Examination and other es

	Other skills an undergraduate should master, includin
9.	Removal of stitches and staples
10.	Applications of dressings and bandages
11.	Examination of a lump (eg its size, consistency, locatio
12.	Assessment of a wound
13.	Examination for fitness for surgery (chest, heart, neck
14.	Examination of the abdomen
15.	Digital rectal examination
16.	Examination of the groin
17.	Examination of the scrotum
18.	Examination of the soft tissues of the neck
19.	Examination of pulses
20.	Examination of the breast
21.	Examination of the hip
22.	Examination of the knee
23.	Examination of the back
24.	Examination of the ear
25.	Examination of the nose
26.	Examination of the throat

Ways of teaching and learning in surgery

Concepts of surgery

The practicalities of operations include removing tissue, releasing collections of fluid, unblocking vessels or other tubes, repairing tissue and rearranging anatomy. Every doctor must be able to discuss, in general terms, the risks and benefits of different courses of action and understand complications. For example, obstruction of the ureter may be treated by radiologically guided percutaneous drainage or by surgical endoscopic placement of a stent. There is overlap with other interventional specialties, and surgery is linked with anaesthesia, interventional radiology and emergency medicine.

Surgical placements should provide experience with explanation and/or reflection. The students should understand the clarity of each surgical condition, as listed in the syllabus. They should also understand the discussion behind each decision. The unique role of every doctor is as 'diagnostician […] and handler of uncertainty'.[22]

We encourage surgical trainers to verbalise the options and explanations to their students as well as to their patient, so they understand the 'iceberg of practice'.[23] 'Surgical thinking' is helpful to any future career; this gives the future doctor the ability to explore options and uncertainties, including at which level to investigate or undertake screening depending on possible intervention.[24] A good understanding of surgery encourages a more holistic view of healthcare. This includes placing the fundamental importance of the social determinants of health and the preventable aspects of ill-health across the range of conditions.[14]

Types of conditions

We realise that there has to be a realistic number of conditions in the curriculum for it have a practical application. We prioritise conditions according to the following criteria:

1. Important – ie will have a significant detrimental effect on a patient;
2. Frequency – ie how likely will the undergraduate medic come across these conditions.

We are all busy

- We all get 168 hours a week
- Plan ahead
- Move the talking / reading / deciding to a sensible time
- Be nice

We need to make training better

A question of balance

The extended surgical team

Extended surgical team (May 2016)
https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/question-of-balance/

Administrative support

In this report, we give attention to practitioners who provide clinical expertise to the surgical team. It should also be noted, however, that administrative staff play a crucial role in supporting the surgical team.

Other work conducted by the RCS has identified units that have introduced a model whereby several 'Doctors' support workers' undertake administrative tasks 8am–9pm, 7 days per week. These workers are Band 3 or Band 4, and usually working towards an NVQ (National Vocational Qualification) or apprenticeship. Other units have a hybrid clinical and administrative role at Band 3 or Band 4. These staff usually come from a healthcare assistant background and perform basic clinical duties and administration. The benefits include helping doctors in training.

The mid-point on the pay-scale for Band 3 is £17,000 and for Band 4, £20,000. So these roles are significantly cheaper to the service than the clinical roles featured elsewhere in this report.

A further advantage is that recruitment can often be achieved at a local level without depleting senior clinical staff from the team. Staff starting on Band 3 or Band 4 are limited to simple tasks, but require only a few weeks' initial induction and thereafter development on an NVQ or apprenticeship basis (with training days, for example). These staff can only ever act as assistants. They cannot work at night, be on call or deal with uncertainty or risk.

- I am leading a new scheme in East Sussex
- Six “Doctors’ Assistants” (Band 3 £18,000 pa)
- To do paperwork/ simple clinical eg looking up results / dementia screenings, from 7.30am Monday – 9pm Sunday (Days only) Short training
- By Christmas
- NB “Physicians Associates” are Band 7 £45,000 with degrees +/- experience

Equality is VERY DIFFERENT FROM Diversity

Equality

Being equal at the point of selection/ exam

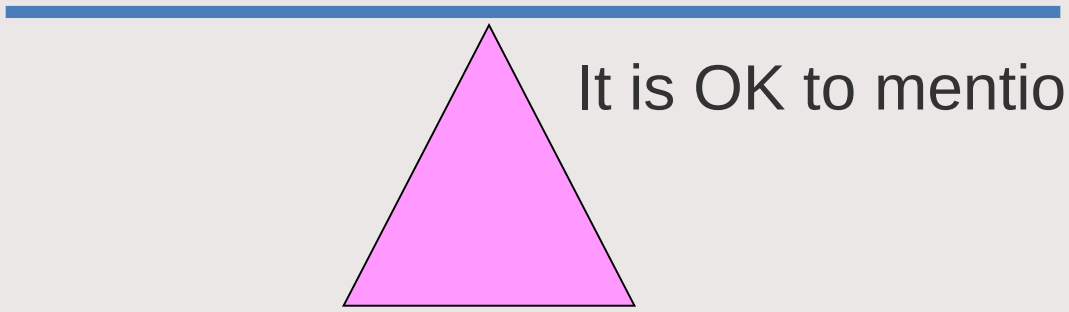
Diversity

Embracing difference;

asking what else is needed;

how to get the individual to be the best that they can be.

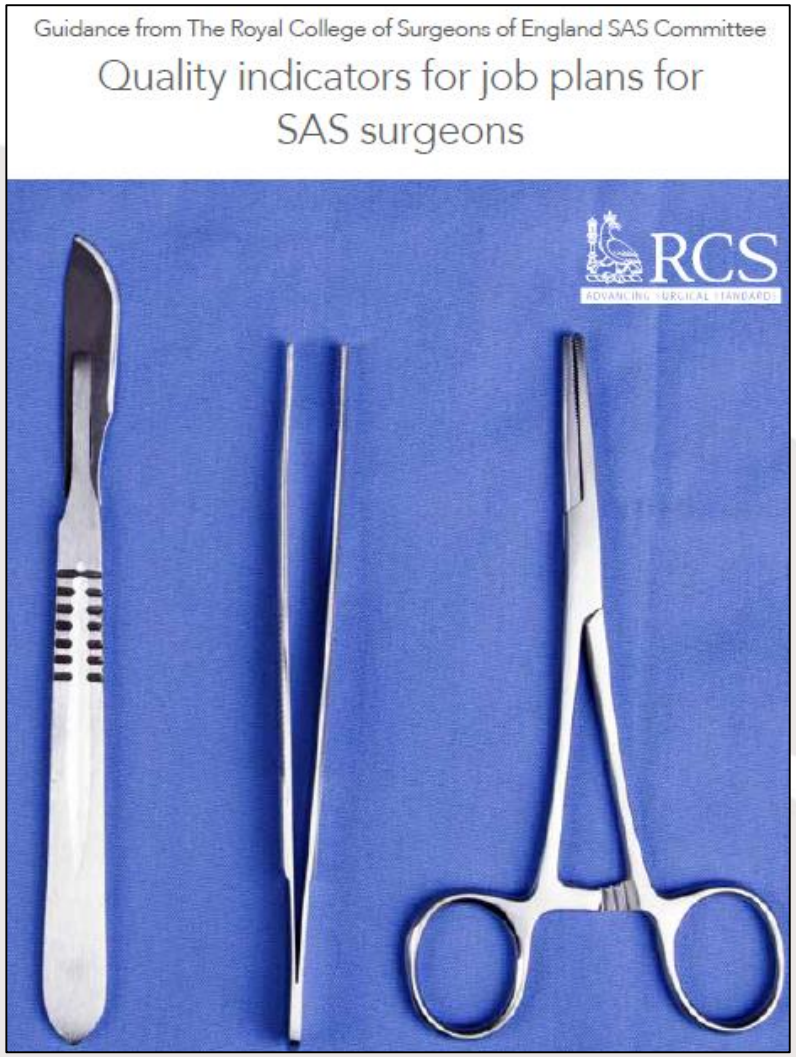
Eg if you are their supervisor

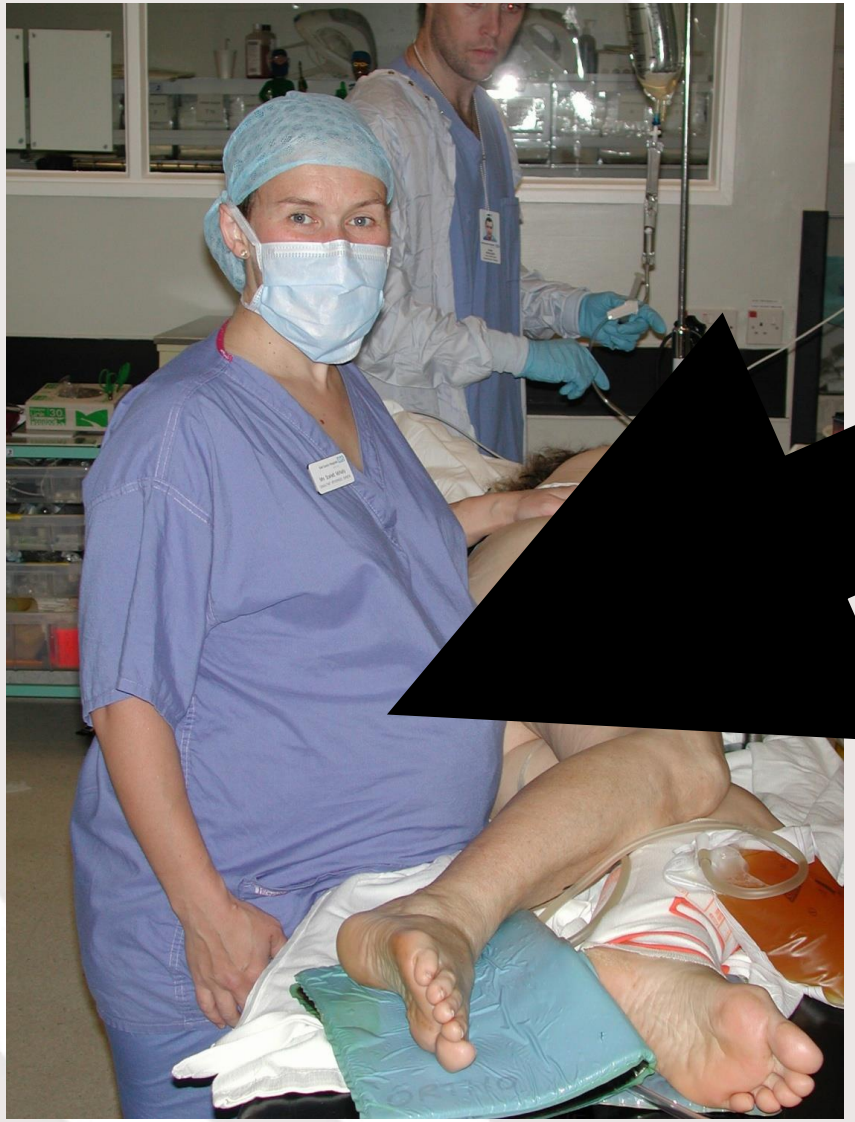


It is OK to mention they are different!

Everyone needs to realise that we need the best possible surgeons for the changing future care our patients need. This may mean changing our attitudes about what is normal and what is needed to do the job.


Charter for SAS Doctors
RCPE Royal College of Physicians of Edinburgh
Representing physicians, maintaining standards.


Guidance from The Royal College of Surgeons of England SAS Committee
Quality indicators for job plans for SAS surgeons
RCS



RCS
ADVANCING SURGICAL STANDARDS

http://surgicalcareers.rcseng.ac.uk

Pregnancy and Maternity

Many surgeons successfully combined motherhood with a rewarding surgical career. Surgery benefits from a diverse workforce.

Remember the months of pregnancy are a short time in a surgical career

www.rcseng.ac.uk look in "careers" section

JUST KNOW – there is a way

ACADEMY OF
MEDICAL ROYAL
COLLEGES

RETURN TO PRACTICE GUIDANCE

APRIL 2012

“Attracting” surgeons also means:

1. Attracting medical students into surgery
2. Attracting doctors into surgery
3. Supporting medical students considering surgery
4. Supporting doctors considering surgery
5. Stopping medical students being put off surgery
6. Stopping doctors being put off surgery
7. Changing society so that surgery is seen as a possible career

Supporting More Future Surgeons

- Surgery is now less competitive. We need to be more attractive to non-traditional applicants
- Some women report being put off surgery due to perceptions of work-life balance.
- All future surgeons want /need a good work-life balance.
- Unless we pick from all trainees, we fish in a small pool
- Medical students and junior doctors are more likely to stick at a career goal of surgery if they see:
  - surgeons having fun and
  - that the topics are achievable

What motivates (or de-motivates...)?

- 76% motivated by personal contact / senior
- 34% “clinical placement actively discouraged them from surgery”
- 65% identified their specialty at medical school

Attitudes, Motivators, and Barriers to a Career in Surgery: A National Study of UK Undergraduate Medical Students

Paul A. Sutton, BMBS,[*,†] *John Mason, BMBS,*[*] *Dale Vimalachandran, BMBS,*[*,†] *and Scarlett McNally, BMBS*[*,‡]

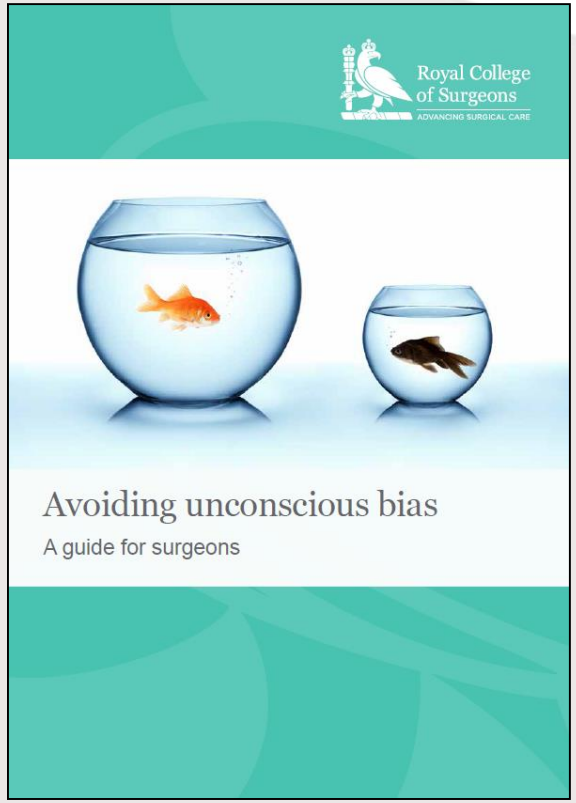
[*]Royal College of Surgeons of England, London, United Kingdom; [†]Countess of Chester Hospital NHS Foundation Trust, Chester, United Kingdom; and [‡]East Sussex Healthcare NHS Trust, Sussex, United Kingdom

We are not all perfect every day. Help us value good enough

- 42% of marriages end in divorce (www.ons.gov.uk)
- 9% of over-65s are living with dementia – my mum + exercise as prevention
- 34% of marriages are expected to end in divorce by the 20th wedding anniversary (www.relate.org.uk)
- 20% of known pregnancies end in miscarriage (www.tommys.org)
- IVF has only 14% success rate aged 40 (www.hefa.gov.uk)
- 10% of operations will have a complication
- There are only 168 hours in a week

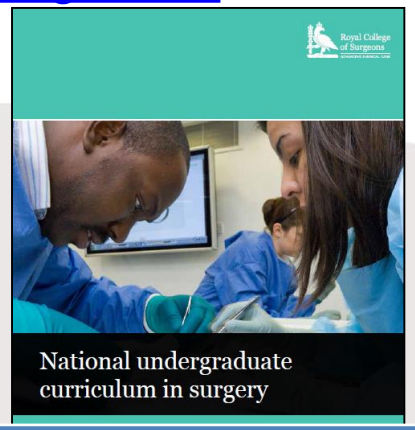
Supporting More Future Surgeons

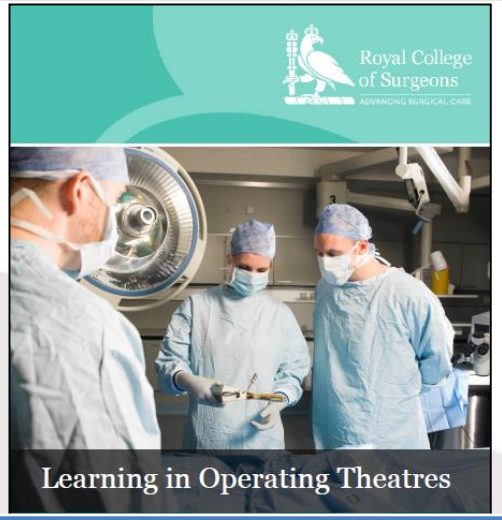
- There are documents to support training:
- Mentoring (support outside any training programme)
- Avoiding unconscious bias (how to treat people better)



Contact

- University surgical societies - www.rcseng.ac.uk “career”
- Or contact :
  - careers@rcseng.ac.uk
  - 0207 869 6227
  - www.rcseng.ac.uk





Learning in op theatres	https://www.rcseng.ac.uk/careers-in-surgery/careers-support/careers-events-and-resources/resources-and-links/
Undergrad curriculum	https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/**national-undergraduate-curriculum-in-surgery/**
Avoiding unconscious bias	https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/**avoiding-unconscious-bias/**
Mentoring	https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/**mentoring-good-practice/**

RCOG – advice to trainees who think they are being bullied…

- **Be assertive:** We all need to learn from our mistakes, even if the rebuke was unreasonable. If your supervisor isn't being supportive, spell out what you want them to do and why.
- **Talk it over:** with someone you can trust. Sometimes, what seems like undermining might not be.
- **Take no further action:** If an isolated event, perhaps. On the understanding that it doesn't happen again. The underminer must realise their actions, explain their point of view and offer an apology.
- **Speak to the perpetrator:** If the behaviour does happen again, speaking to the perpetrator can be very effective. Some undermining isn't deliberate. Arrange a meeting in private and take along a trusted companion. Plan what you're going to say beforehand to explain how their actions made you feel. Stay calm and polite. Afterwards, make a written record of the date, time, venue, persons present and what was discussed at the meeting.
- **Write it down:** Make a note of each episode of undermining and any associated meetings. Collect any documents that may back this up, especially emails. This will be valuable evidence if the undermining persists, and will also allow you to reflect on the events.
- **Speak to a senior colleague:** Before pursuing a formal complaint, try talking to a senior colleague. This can be any of the following, depending on where the undermining occurs: Educational Supervisor, Clinical Supervisor, College Tutor, Clinical Director, Medical HR, Training Programme Director, Postgraduate Dean. You may also wish to involve occupational health, the BMA or a Trainees' representative. Extra support can be found through counselling.

What if the undermining persists? NUCLEAR OPTION = make a formal complaint in writing with evidence

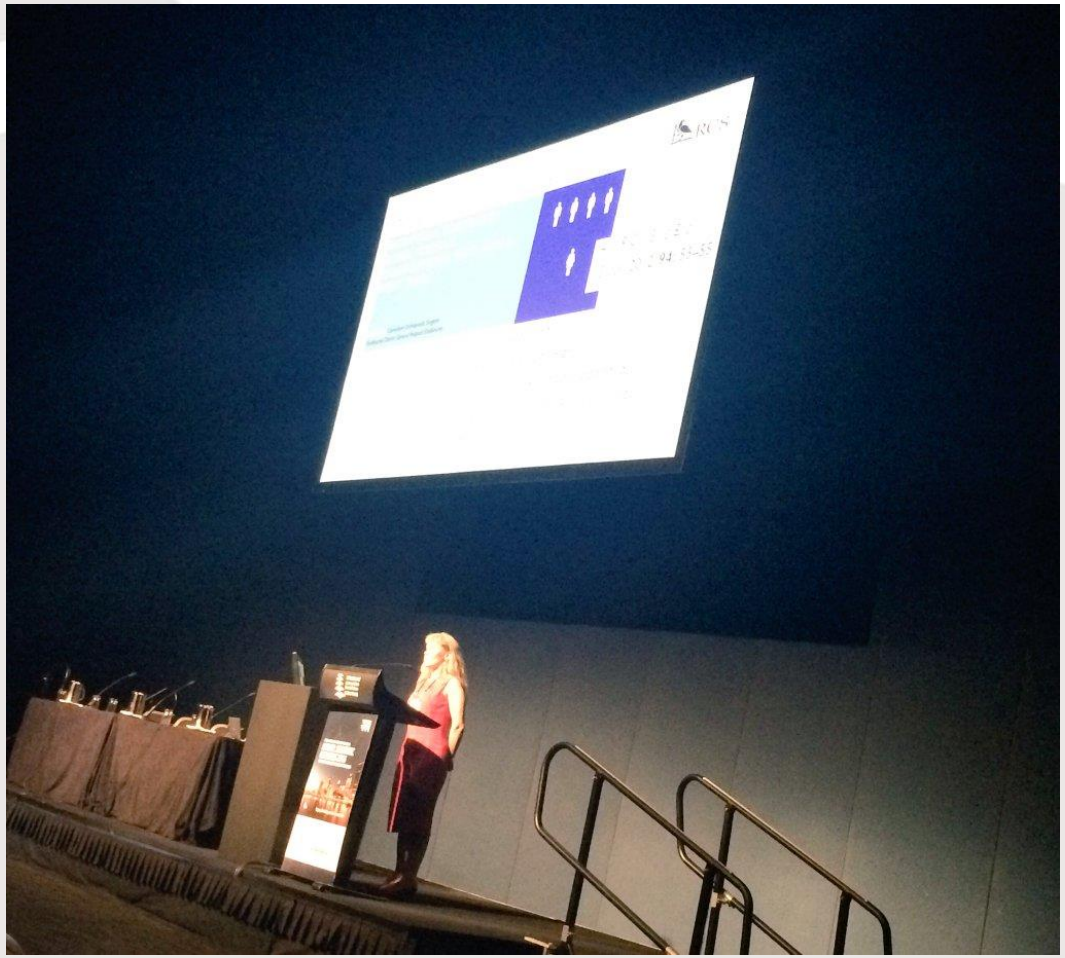
Very destructive and, like resigning, can be done only once. It effectively ends the relationship.

The underminer will know this too and will be just as anxious to avoid it.

http://www.rcog.org.uk/education-and-exams/postgraduate-training/advice-and-support-trainees/assertiveness-work

RCS Australia trip May 2016

Talking in Australia



The next few slides are from the Royal Australasian College of Surgeons new campaign to reduce bullying

www.surgeons.org/respect

Let’s Operate With Respect

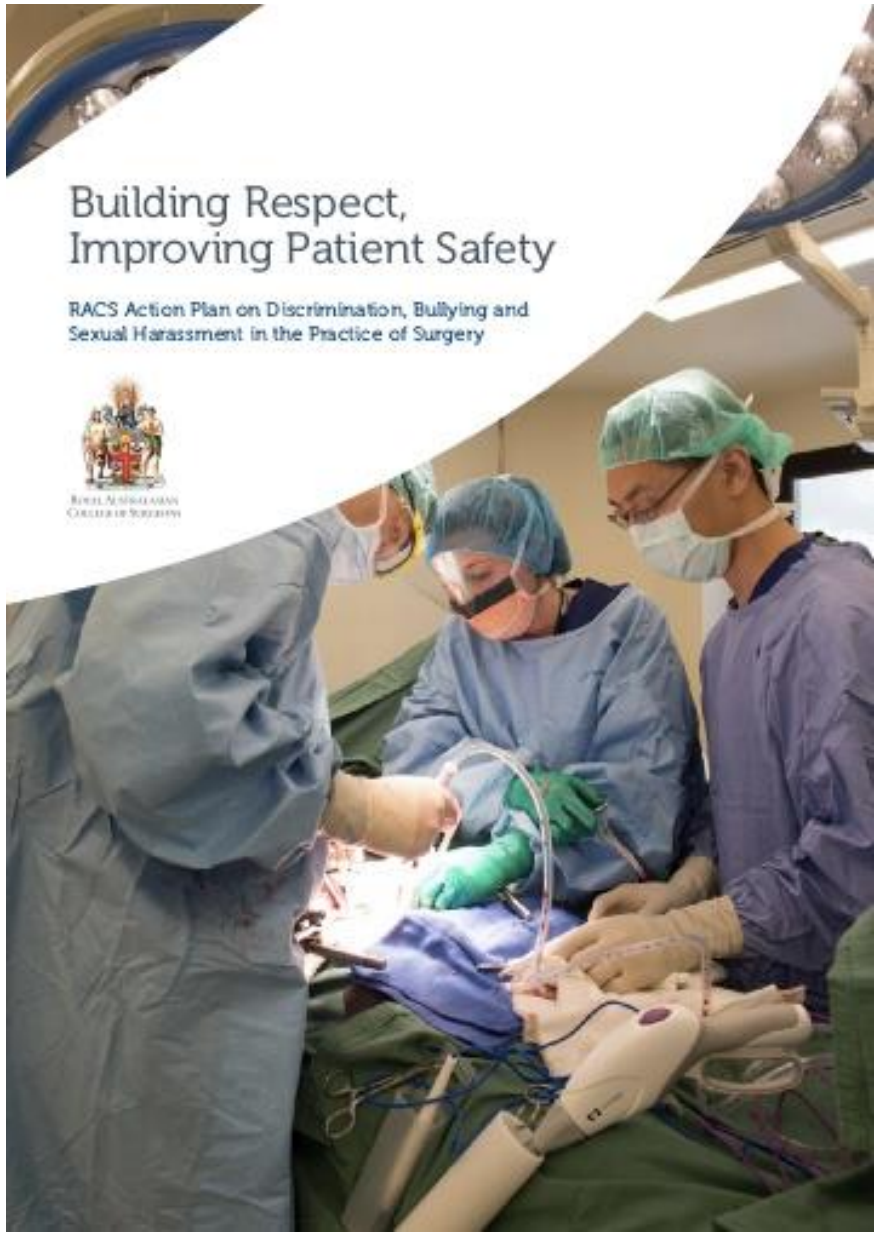
Campaign to Build Respect
Improve Patient Safety

RACS

LET’S OPERATE WITH RESPECT

ACTION PLAN

- Cultural Change and Leadership
- Education
- Complaint Handling



Published November 30th 2015

RACS
LET'S OPERATE WITH RESPECT

Let’s Operate With Respect…

- Three-year campaign to:
  - bring together all parts of the Action Plan
  - support cultural change and
  - deal effectively with discrimination, bullying and sexual harassment in surgery in Australia and New Zealand.
- Awareness, conversations, education
- Ownership of the problem, surgeons being part of the solution

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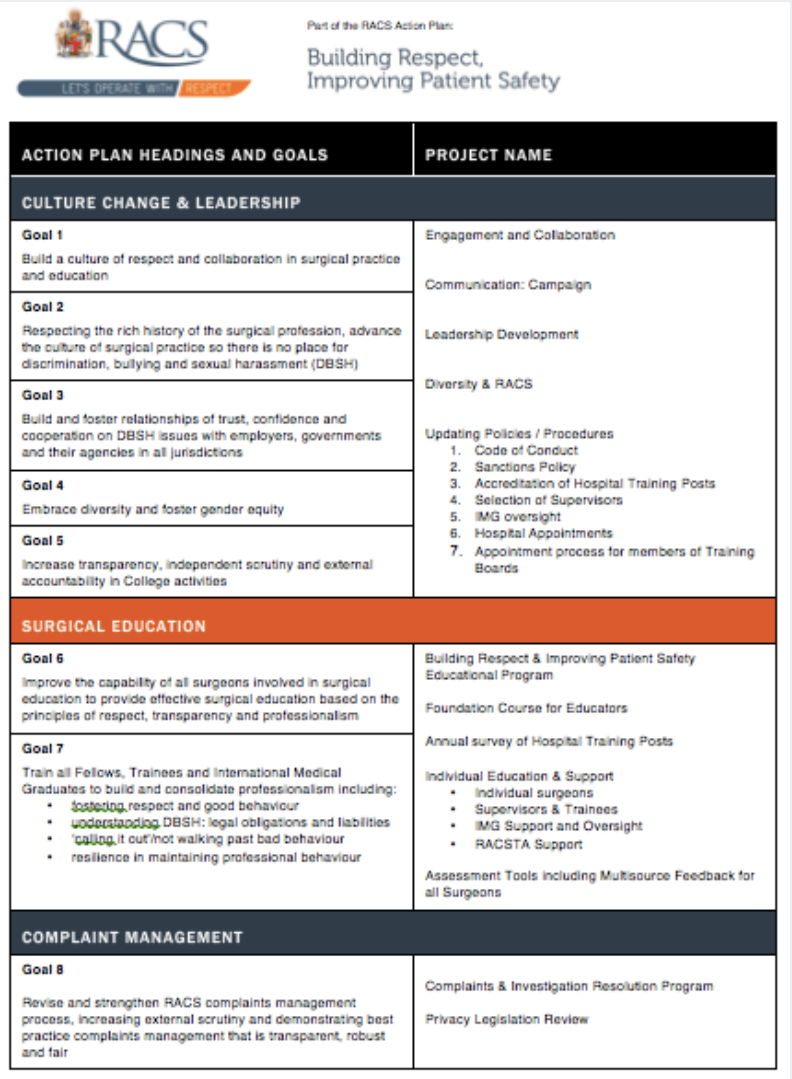
LET’S OPERATE WITH RESPECT

Let’s Operate With Respect…

- We’re not the only ones, but…
- It’s up to us to build a culture of respect in surgery
- Campaign for and from the profession:
  - Personal, direct
  - About us, for us



RACS

Part of the RACS Action Plan:

Building Respect, Improving Patient Safety

ACTION PLAN HEADINGS AND GOALS	PROJECT NAME
CULTURE CHANGE & LEADERSHIP	
Goal 1 Build a culture of respect and collaboration in surgical practice and education	Engagement and Collaboration Communication: Campaign
Goal 2 Respecting the rich history of the surgical profession, advance the culture of surgical practice so there is no place for discrimination, bullying and sexual harassment (DBSH)	Leadership Development Diversity & RACS
Goal 3 Build and foster relationships of trust, confidence and cooperation on DBSH issues with employers, governments and their agencies in all jurisdictions	Updating Policies / Procedures 1. Code of Conduct 2. Sanctions Policy 3. Accreditation of Hospital Training Posts 4. Selection of Supervisors 5. IMG oversight 6. Hospital Appointments 7. Appointment process for members of Training Boards
Goal 4 Embrace diversity and foster gender equity	
Goal 5 Increase transparency, independent scrutiny and external accountability in College activities	
SURGICAL EDUCATION	
Goal 6 Improve the capability of all surgeons involved in surgical education to provide effective surgical education based on the principles of respect, transparency and professionalism	Building Respect & Improving Patient Safety Educational Program Foundation Course for Educators Annual survey of Hospital Training Posts
Goal 7 Train all Fellows, Trainees and International Medical Graduates to build and consolidate professionalism including: • fostering respect and good behaviour • understanding DBSH: legal obligations and liabilities • ‘calling it out’/not walking past bad behaviour • resilience in maintaining professional behaviour	Individual Education & Support • Individual surgeons • Supervisors & Trainees • IMG Support and Oversight • RACSTA Support Assessment Tools including Multisource Feedback for all Surgeons
COMPLAINT MANAGEMENT	
Goal 8 Revise and strengthen RACS complaints management process, increasing external scrutiny and demonstrating best practice complaints management that is transparent, robust and fair	Complaints & Investigation Resolution Program Privacy Legislation Review

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LET'S OPERATE WITH RESPECT

WE ALL RELY ON OUR SURGICAL TEAMS.

WHEN WE SHOW THEM RESPECT, WE BRING OUT THEIR BEST PERFORMANCE.

RACS

LET'S OPERATE WITH RESPECT

Find out more: www.surgeons.org/respect

RACS

LET'S OPERATE WITH RESPECT

WHEN WE SEE BAD BEHAVIOUR,

IT'S UP TO US TO CALL IT OUT.

RACS

LET'S OPERATE WITH RESPECT

Find out more: www.surgeons.org/respect

Let’s Operate With Respect

Now is the time to deal with discrimination, bullying and sexual harassment and how it affects the surgical profession.

Prof. David Watters

RACS

LET'S OPERATE WITH RESPECT

Let’s Operate with Respect

Phil Truskett

Bullying is a real problem for our profession. Most of us have seen or experienced it.

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Let’s Operate with Respect

Being a surgeon takes more than technical excellence. How we behave shapes our culture and profession.

Spencer Beasley

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LET’S OPERATE WITH RESPECT

Let’s Operate with Respect

Dr Cathy Ferguson
Chair Professional Standards

Bullying and harassment. When teams suffer, patients suffer.

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Let’s Operate with Respect

We all rely on our surgical teams.

When we show them respect, we bring out their best performance.

A/Prof Marianne Vonau
Treasurer

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Let’s Operate with Respect

John Batten
Chair Court of Examiners
In-coming Censor in Chief

Leadership.
It’s about
doing the right
thing.

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Stress is part of our work, but is no excuse for unacceptable behaviour.

Laurie Malisano
In-coming chair
Professional Standards

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Let’s Operate With Respect

Richard Lander
Executive Director Surgical Affairs NZ

When we see bad behaviour, it’s up to us to call it out.

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Let’s Operate With Respect

- You will see:

  - On all the activities in the Action Plan:
    - New section of the RACS website
    - Posters in hospitals
    - Conversation starters
    - Social media
    - In education and training
    - On ppt presentations / templates you can give and use
- ASC survey
- Show your support

RACS
LET'S OPERATE WITH RESPECT

RACS

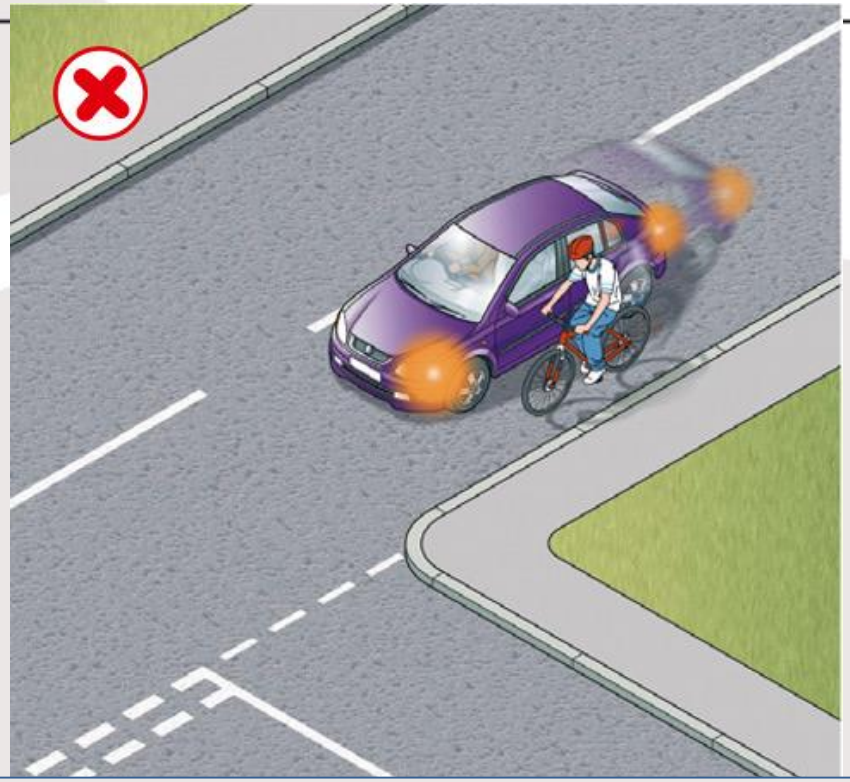
LET'S OPERATE WITH RESPECT

Find out more: www.surgeons.org/respect

www.surgeons.org/respect Australasian report & action plan

When am I bullied, every day?

On my bike… so where are the rules?



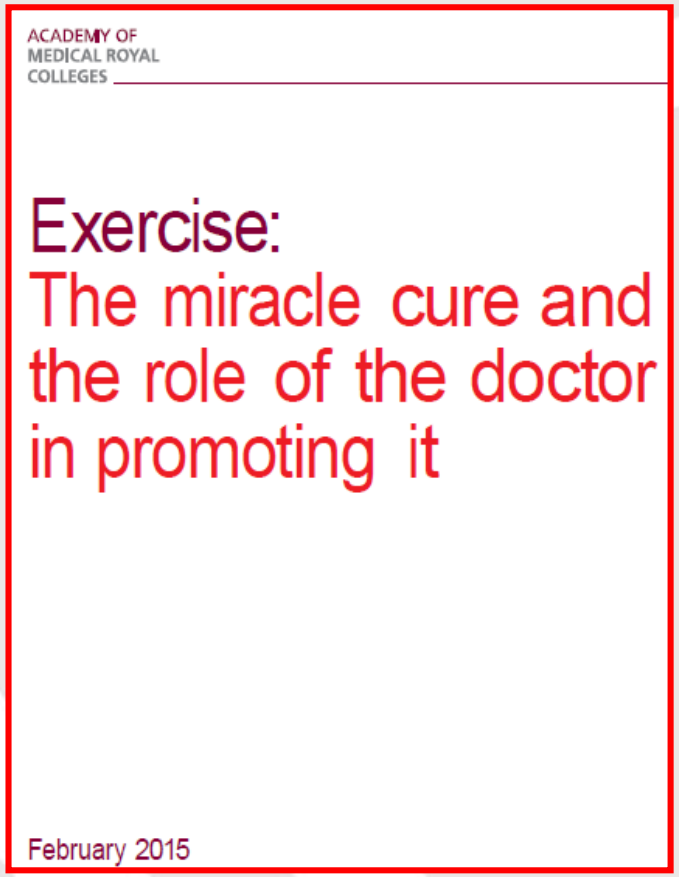
Rule 163 Give cyclists as much room as you would when overtaking a car

Rule 182 Do not overtake just before you turn left

Rule 178 Advanced stop lines – stop at first line

Allow cyclists time and space

It's personal AND it's surgical

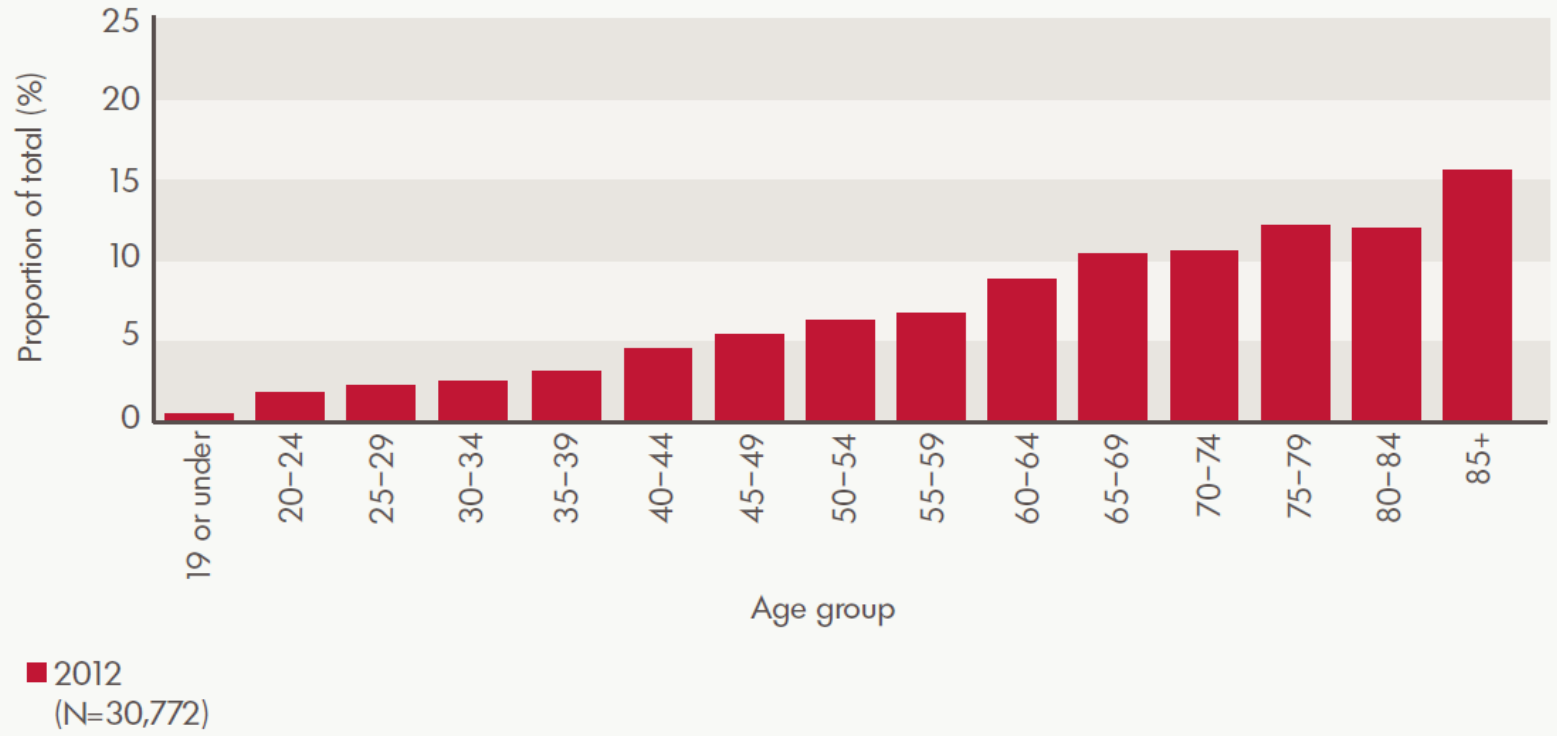


- Exercise 5-times-a-week for 30 minutes a time reduces a person's risk of:
  - dementia 30%
  - hip fracture 50%
  - breast cancer 25%
  - Bowel cancer 45%
- 30% of UK adults do NO physical activity
  - This cohort has highest later use of NHS beds
  - Suffer highest complication rates
- The best forms of exercise are scheduled (eg active travel)
- Best interventions are: planning and culture change (WHO,2016)

http://www.aomrc.org.uk/publications/reports-guidance/exercise-the-miracle-cure-0215/

That's why our surgical beds are full…

Figure 2.4: Age distribution of patients presenting with high-risk emergency general surgery diagnoses, 2012



2016 http://www.nuffieldtrust.org.uk/publications/emergency-general-surgery-challenges-and-opportunities

Mentoring: New RCS guide

www.rcseng.ac.uk "publications"

This is a simple guide about being a mentor or mentee, basic ground rules

https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/gsp-mentoring/

Mentor	Help another with their beliefs and values in a +ve way
Coach	Must be trained. Often specific. May involve “telling”
Perceptor	Guiding newly-qualified
Teacher	Info (etc)
Educational supervisor	Directing trainee
Clinical supervisor	Help with training/feedback in clinical setting
Session supervisor	(eg in ISCP may be another team member)
Appraiser	Trained – formulate PDP, check on progress
Counsellor	Helping improve by resolving situations from past
Clinical supervisor for a Dr in difficulty	‘targeted’
Patron	Giving advice. Junior under your wing

The GROW model

This is another model encouraging a step-by-step identification of goals and realistic assessment of how to achieve them.

Goal	Clarify and agree a realistic and motivating outcome
Reality	Work through the reality of what is happening now and where blocks might be
Options	Stimulate ideas and choices about new ways of doing things
What next	What is the first step? And then?

Toolkit for mentor (see booklet for toolkit for mentee)

Listening skills	
Resist urge to give advice	
Communication skills	- Interpret and reflect back - Remove barriers and negativity - Avoid judging
Rapport building	- Focus on mentee - Have an intrinsic desire to help them
Motivating and inspiring	
Curiosity flexibility and challenge	- People's needs are different

Thank you

- Value each person:
  - staff, student, patient, yourself, cyclists
- 150 minutes/week “Exercise: miracle cure”

www.rcseng.ac.uk Publications and Careers Use search function

- Avoiding unconscious bias
- Learning in operating theatres
- Mentoring guide
- Undergrad curriculum
- Careers pages: GET STUDENTS & FOUNDATION DOCTORS TO JOIN AFFILIATES