



Training the Trainers, 15 December 2017

Introduction

Xavier Carcopino - Obstetrician Gynecologist, Head of department of colposcopy and cervico-vaginal pathologies North University Hospital of Marseille, France

Training in colposcopy is a genuine challenge for both trainees and trainers. Trainees should be provided with basic knowledge regarding cervical pathology, natural history of HPV infection, colposcopic examination and patients information and management.

Additionally, trainees should be offered practical supervised and thereafter unsupervised training. In the training the trainers sessions, we offer all the people involved in training of colposcopy the opportunity to meet and exchange about their training experience in order to improve their skills and provide trainees the best they can offer.

In these sessions, we also present the up to date optimal training strategies. This includes the use of simulating models that should nowadays being systematically used as the initial step before patients examination and management.

Xavier Carcopino





Welcome to the course

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This is the 1st EFC TTT session, we need clear objectives for training over and above imparting theoretical and practical knowledge, we also need to optimize training and communication from trainees to patients. Why do we need a TTT session? We need to discuss and strive to improve training and feedback.

Identify likely difficulties for trainees. Trainer should be present throughout training and so constructively take time to report how to improve practice. Aim to make a TTT session interactive.

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International terminology and EFC quality standards in colposcopy

Pekka Nieminen - President-elect of the European Federation for Colposcopy, Department of Obstetrics and Gynaecology, Helsinki University Hospital, Finland

Terminology and valid standards are needed for high quality services is a relevant matter because all information including visual patterns need to be communicated in a standardised format since this helps communication with colposcopists, cytologists and pathologists. If there is confusion then quality is impaired, the IFCCP international terminology is a useful example and is recommended. Adequacy of colposcopy, and TZ type are important and must be clearly understand, also squamous metaplasia must be understood. Trainees must understand basic principles before understanding cervical pathology, trainees must be trained at a pace which is not too fast. Identification of the scj in its entirety is critical to colposcopy and there is disagreement amongst experienced colposcopists between TZ types 2 and 3. The scj must be seen for all 360o to not be type 3, Swedescor or Reid index aids reporting of visualised findings in a structured way. Both the Swedescor and the IFCCP classification are recommended as template for training and are to be used on EFC approved colposcopy courses. Feedback should be always supportive but honest with supportive points for improvement where needed. Recommendations for trainer skills support trainers to provide critique of colleagues/ trainees, and it is important to see how trainees explain management to patients and how patients feel afterwards (Ameli Trope suggested should ask patients what they felt about the trainee). In conclusion guidelines for training should be developed. Communication to patients and other health professionals is critical, and is considered the development of a group of trainers to assist training in countries across Europe.

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EFC Certification of colposcopy courses

Xavier Carcopino - Obstetrician Gynecologist, Head of department of colposcopy and cervico-vaginal pathologies North University Hospital of Marseille, France

Prof Carcopino leads on approval via efcopolposcopy website, where the criteria are listed. At least 1 day long with 360 min of teaching, and content is determined by EFC core competencies. Local organiser is required for local administration, and the programme must be sent to the EFC. Basic courses don't need to include practical procedures except how to take cervical biopsies and control bleeding following biopsy. The basic course (100 Euro and valid for 3 years) should tell students how to set up and position a colposcope.

The advanced course, which is relevant to senior colposcopists, has to be approved annually and programme is required to be sent to Prof Carcopino. 2 days each for 6 hours for 100 Euro. Evaluation forms for both courses are on the efcopolposcopy website.

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Who can be a trainer and what the role is

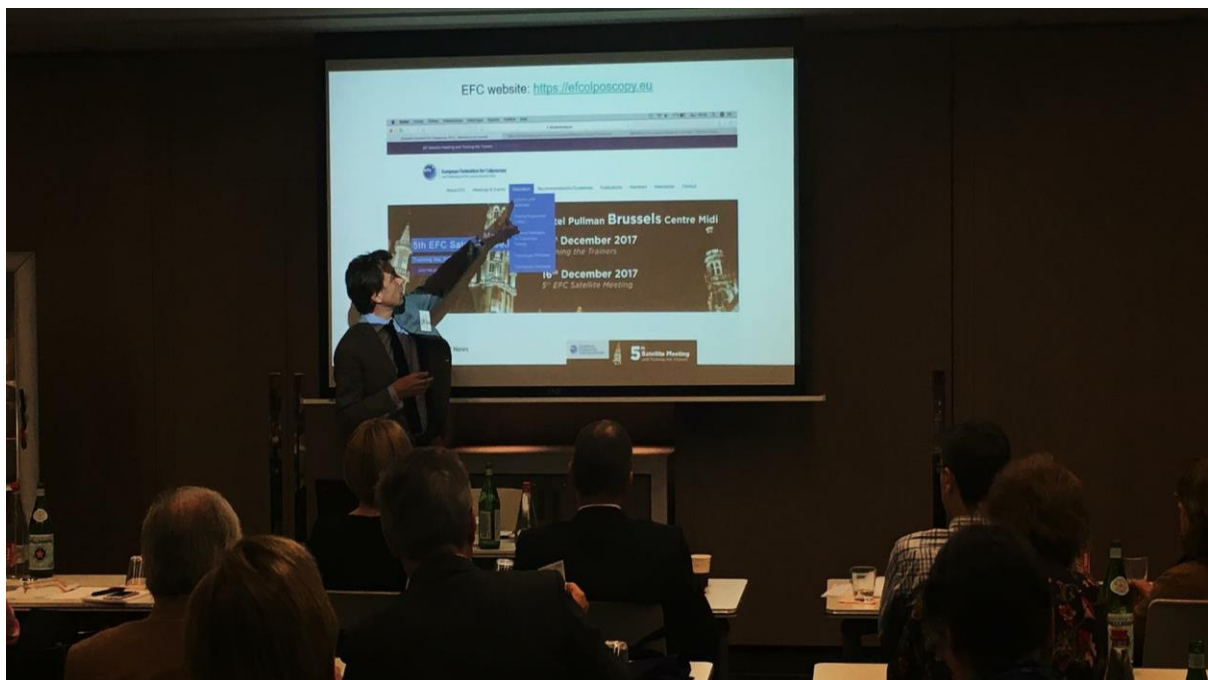
Nick Myerson - Obstetrician & Gynaecologist in Bradford Chair of the Certification and Training Committee of the BSCCP

High quality trainers are needed for future high quality colposcopists, which is way trainers must be accountable to official regulatory bodies such as national societies. There are responsibilities for poor trainees in colposcopy would be reflected in poor quality of care elsewhere from these poor trainees. There is a responsibility to ensure the best possible standard of care for colposcopy patients and other patients exposed to poor trainees.

Success as a trainer requires tools. A trainer provides an environment which allows the trainee to learn, and sometimes despite best efforts a trainee may not learn and so a new approach may be required. Insight into how people may learn provides further strategies to learn via knowledge, skills and attitudes. Experiential Learning (Kolb) involves planning before the clinical exposure, reflect on the experience and make sense of the experience to plan what to do next. Keep it simple (KISS), establish credibility, establish the trainers' credibility, teaching is not learning and remember that all is said may not be absorbed, and the trainee is the focus of the process. Fail to prepare, prepare to fail!

Feedback must be specific, measurable, achievable, relevant time-bound (SMART). It must be agreed beforehand and not just done at the trainees' request because a particular intervention went well.

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Common difficulties in colposcopic practical training

Nick Myerson - Obstetrician & Gynaecologist in Bradford Chair of the Certification and Training Committee of the BSCCP

How to deliver good training even if you are good trainer? Theoretical knowledge is essential. The trainer must understand the task, analyse the task, provide an orderly plan to teach, be able to build skills, have a plan for training and acknowledge that not all trainees are the same. Trainees have differing motivations, capabilities, learning styles and expectations. Teachers usually teach the way they learn (3 ways can be audio, visual or a combination as kinaesthetic). Trainers must understand this but it can be difficult to determine which trainees are which. Can visit NLP website for further information. Miller's pyramid is a schema for learning and professional authenticity from knows, knows how, shows how and finally does. Also there is 'Peyton's 4 step technique':

- 1 - do procedure (demonstration useful for visual learner)
- 2 - then describe each step (deconstruction useful for the audio learner)
- 3 - the teacher demonstrates the skill whilst the learner describes the steps (comprehension)
- 4 - finally the learner performs the skill whilst describing the steps (performance useful for kinaesthetic learners).

Works well when adapted to the chosen task.

The '1 minute preceptor' focusses discussion (ie short and therefore SMART feedback ideal). Another concept is merging these as 'blended learning'.

Simulation training is useful particularly for treatment. Colposcopy is suited to a blended approach but some theoretical knowledge is useful. Pre-learning with watching in clinic, have a skills lab environment, use simple aids, break the task down to build skills, a 4 step approach and plan before you start. If the task is not analysed in advance, then success in that episode is less likely.

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Optional work place assessment of training

Maggie Cruickshank - Professor MB ChB MD FRCOG Division of Medical and Dental Education and Medical Sciences.

Effective assessment should provide feedback and clarify action plans. Should be valid (does a test measure what it is supposed to measure) and reliable (does the test measure the same thing which varies for 0-1). However, validity is not easy to demonstrate. The top of Miller's pyramid has competency and performance with competency what is being done in a controlled environment and performance is what is done in practice. OSCEs or examinations cannot demonstrate performance, perhaps 'knows how' or 'shows' from Miller's pyramid at best. Practical skill simulation, OSCEs, long cases or work based assessments provide best all round reliability, validity, feasibility and acceptability. Work based assessments focusses on all round clinical performance. Formal assessment has a significant influence on achievement. Feedback has the largest effect on learning or training (70% contribution to overall learning and more benefit than attending teaching). Work based assessments provide structured review and feedback of performance – including min-CEX (mini clinical examination); DOPS (direct observation of procedural skills) and CbD (case-based discussion).

A mini-CEX are very focused activities such as taking a history or explaining results, feedback is included and the whole procedure takes about 5 minutes. Feedback includes 'is there anything that was good', 'is there anything that could be done better' and 'what is the future learning plan'. Assessments are continuous as the trainee learns. It is not summative at the end of training. A DOPS is a record of an activity and takes as long as that procedure takes. There is a standard check list to record all activities such as a colposcopy. CbDs provide a dialogue with structured record of the discussion. Together these can sample expertise widely across the curriculum with multiple raters. The trainee can have dynamic formative feedback and summative feedback on completion of that particular skill. More formal assessments are required to provide a final sign off for training. Work-based assessments can pick up the failing trainee to provide an action plan or to abandon training at an early stage to avoid wasting time. In general, weaker trainees are less likely to seek feedback. There needs to be enough trainers to have work-based assessments.

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Providing feedback and make an action plan

Maggie Cruickshank - Professor MB ChB MD FRCOG Division of Medical and Dental Education and Medical Sciences.

How am I doing, where am I going and how do I get there? This is trainees' view for feedback. Focus on process not behaviour (attempting changing behaviour is rarely successful and changing process encourages deeper learning and improved performance). Feedback should be credible, useful, accurate and the trainer should understand the trainee's culture and level of achievement. Ask the trainee to give their view, be non-judgemental, choose a suitably quiet location, be specific and know when to stop. It must not be a monologue. Recreate the events being reviewed, remember non-verbal cues help communication with feedback and an action plan is useful in that goals to be achieved can make the change.

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How to help the trainee in difficulty

Maggie Cruickshank - Professor MB ChB MD FRCOG Division of Medical and Dental Education and Medical Sciences.

Group discussion for 4 scenarios:

- 1- Trainee gives an instant answer and is not confident when challenged. Process problem.
How is that decision made? Knowledge or understanding to be considered.
- 2- Poor quality loop excisions. Retraining to be considered.
- 3- Trainee disagrees with recommended management. Check the information to see why there is a difference. This can be difficult to resolve but a consensus may be required. Quote guidelines if there is a difference of opinion.
- 4- Trainee feels not ready for independent practice but trainers feels differently. See what reasons there are. Provide practical solution.

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Use of training models for treatment of CIN

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There is no standardised method of teaching loop excision, trainees generally learn on the job which is not ideal. Laparoscopic training boxes improve trainee surgical performance, and vaginal models allow colposcopists to develop dexterity skills. This must be performed under colposcopic vision. The training can be recorded as an OSATS (objective structured assessment of technical skills) on standardised sheets, publications have shown improved colposcopic performance. A speculum should be inserted into the vaginal model, LLETZlearn is an alternative device which uses modelling clay rather than a sausage. The clay must have some moisture to allow an electrical current to work.

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E-learning and distance learning. How we supervise it

Albert Singer - He is Professor Emeritus at UCL and holds Honorary Consultant appointments at University College Hospital and the Whittington Hospital in London.

Training can be provided by apprentice system with teachers or coaches, courses and e-courses to allow remote learning. Remote learning is accessible where there are no trainers but with use of the internet, and mobile colposcopy can be linked to e-learning. Mobile ODT weighs 400g, is the only mobile device in production, and with Mobile ODT the colposcopist can be thousands of km away. Correlation with local colposcopic opinion appears excellent, data is encrypted and stored in the cloud. Trainees still need to be reviewed in person with patients, it is ideal for 3rd world and remote regions

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Thanks for coming! We wish to see you all again next year!



With the support of



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