



6th EFC Satellite meeting, Saturday 1st December 2018

Training the trainers

Introduction Xavier Carcopino

Optimizing training: What should be the ideal training nowadays

Maggie Cruickshank - Professor MB ChB MD FRCOG, Division of Medical and Dental Education and Medical Sciences, School of Medicine University of Aberdeen, UK (TBC)

What is ideal training. How should the EFC go about this?

Trainees need to understand equipment, their national programme but also professional behaviour, communication and problem solving skills. Reading and courses needed (both basic and advanced). Discussion is important and also then there can be remote access to a colposcopy expert. Most member societies offer basic, advanced courses and mentorship.

Need a training curriculum with the ability to deliver that knowledge to the trainees.

The above largely transmits theoretical knowledge.

Image recognition is important but there is variability. Some reasoning needed. Practical skills with simulation has limited problem solving but is resource heavy. Observation in clinic is resource heavy but the trainee is passive. An apprenticeship is authentic clinically with the development of all the competencies needed to practice. Needs knowledgeable trainers providing adequate supervision. Knows, knows how, shows how and does are the 4 steps of Millar's pyramid which illustrates how training can lead to competence.

Moss's paper (2015) in a survey of colposcopy training in Europe suggests that a training committee should oversee the programme. 1/3 looked to the EFC for guidance for that programme and that there should be some sort of quality assurance of training programmes.

There are differences across Europe with differing screening programmes as well as colposcopy is part of training for all obstetricians and gynaecologists (as recommended by EBCOG) or recommended just for a those that wish to do colposcopy. TTT sessions are crucial to lead and review training programmes. Assessments must have quality assistance. Of course, future trainees will progress to become trainers of the future. The EFC has a role in supporting training across Europe.

A question was asked whether all gynaecologists should be colposcopists? Prof Cruickshank said that each country has a different environment to deal with but Prof Petry the numbers of CIN3 will be small per colposcopist. Colposcopists must be adequately trained.

Who can be a trainer and what does the role entail?

Ameli Tropé – MD, PhD, Head of the Norwegian Cervical Cancer Screening Programme, Norway (TBC)

. Cannot be assumed that just because you are doctor you will be a good trainer. Specialist training is required. To be a trainer you should be a trained colposcopist, progress to a TTT programme and have sufficient clinical activity for the trainee.

Students value enthusiasm from trainers, a +ve attitude, availability, competent and an expert in your field.

A training course needs preparation, an agenda, an environment conducive to learning and be safe to practice, de-brief (eg a Norwegian model for colonoscopy training - Debriefing Assessment for Simulation in Healthcare (DASH)). Prepare well, as proper preparation prevents poor performance.

In order to teach then adhere to Knowles' 7 principles of adult learning:

1. establish a safe learning climate
2. involve learners in planning their learning
3. diagnosing their needs
4. develop their own learning objectives
5. ask trainees decide what resources they need
6. carry out their own plans
7. and evaluate their own learning.

How do you like to learn? Are there any any teaching methods that you find particularly helpful or unhelpful?

Can be an activist – like to do, reflectors like to watch, theorists need the theory and the pragmatists need to know to put into action but like to experiment.

Can be visual, auditory or kinaesthetic (the last being a learner by touching and doing). Tell the learner what you are going to say, say it and summarize what you have said.

Feedback requires dialogue.

Professional colposcopy trainers are needed and their practice and evaluation is needed. Kahoot use of surveys demonstrated which a free service from Norway.

A question was asked whether the shy trainee could be encouraged to participate with Kahoot? Also Dr Trope said that Kahoot also demonstrates the level of disagreement amongst experts.



Providing feedback and making an action plan

**Maggie Cruickshank – Professor MB ChB MD FRCOG,
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Aberdeen, UK (TBC)**

Feedback informs development. This is useful not only to the trainee, but also to the trainer and healthcare provider. According to Millar's pyramid the trainee has to 'show how' before they 'do' (ie are competent). Feedback has to be reliable – is the same result achieved with the same intervention time and again, and has to be valid – does it do what it is supposed to do. What have I learnt, what new do I need to do and what plans are there going forward? Should be non-judgemental, comments are specific and that it is not too verbose.

Bad feedback can bewilder the trainee and it does evoke an emotional response. It needs to be positive and interactive with the trainee. Ask the trainee to reflect on the observations in a chronological manner. Be supportive and summarise the findings. There is no point on commenting on what cannot be changed. Focus of process and not personality.

Don't generalise and don't be inappropriately kind.

Pendleton's rules of feedback are that; check the learner know they are ready, let the learner comment on the action, what they have done well, what could be improved and the trainer to comment. An example was given.

BOOST for feedback – balance, observed, objective, specific and timely.

A question was asked whether feedback should be in isolation? Prof Cruickshank said that should be in isolation. Another question was that feedback may not be given or is inadequate and wondered if it could be online? Prof Cruickshank agreed that sequential feedback can see progress in training. A further question was where is the time burden on the training? Prof Cruickshank is the there should be time in clinic for the trainee to see the patients and for discussion outside clinic time.

Use of new image capturing and sharing systems in colposcopy training

**Ameli Tropé – MD, PhD, Head of the Norwegian Cervical Cancer Screening Programme,
Norway (TBC)**

There are options for learning with colposcopy courses nationally and overseas, e-learning and invited lectures, writing easy read articles for magazines and asking students having attended courses to teach at clinic.

But there are not enough colposcopy trainers and colposcopy accreditation for training is difficult. There will be a low incidence of CIN2+ in the HPV-based screened post HPV-vaccinated population. In Norway where HPV-based screening was implemented stepwise but the biopsy rate was x2 in the HPV-screened group although cancer rate increased by 50% in the same group. Do colposcopists trust return to 3 year screening if colposcopy normal with low grade cytology with an HPV +ve test if TZ normal? Training has to be as thorough as possible.

Are there further options? Smartphone images can work as well as real time colposcopy (iEXAMINER, mobile ODT are options). These data have to be secure and the phones hygienically cased. The software



must be easy to update. Data transfer to hospital databases needs careful discussion with local IT departments. The training log can be maintained and accessed on a smart phone.

Another approach is Extension for Community Healthcare Outcomes – Project ECHO looks at telementoring underdeveloped countries. The Moonshot project uses a supercomputer in the US for civil defence but by neural networking can use screening histories of cases that develop cervical cancer following screening. This sort of work can improve pattern recognition and risk reporting.

Can women take pictures of their own cervix (see 'Love my cervix' website).

A question was asked whether this is the future for screening. Dr Trope said that if the images are in focus they can be for non-responders. Is the mobile colposcope used in Norway? Dr Trope said she was planning to set this up with Dr Cruickshank.

Building a training model for treatment of CIN

**Xavier Carcopino – Chair Education Committee of EFC,
Head of department of colposcopy and cervico-vaginal pathologies North University Hospital of
Marseille, France**

Dr Carcopino discussed how to build your own LLETZ trainer. A patient should not have a LLETZ done by a colposcopist doing a LLETZ for the first time. Various self-build models can be constructed which have been published or available on You-tube.

A model trainer is useful to see the trainee knows how to use the colposcope. It is important to use the rest of the equipment you would use during treatment with the generator, smoke extractor, tubing, speculum and loops. The model should be on the examination couch.

A delegate asked if a 3D printer could be used as a cheaper option. Prof Carcopino felt this was a good idea. Another delegate asked if industry could bring models to clinic. A third question was that is there a limitation for colposcopists if they only have experience with monocular colposcopy? Prof Carcopino felt that expertise with binocular colposcopy is essential for treatment. The delegates were divided on this point but treatment should be performed under colposcopic vision

Demonstration and use of training models for the treatment of CIN

**Xavier Carcopino – Chair Education Committee of EFC,
Head of department of colposcopy and cervico-vaginal pathologies North University Hospital of
Marseille, France**

3 models were available for the delegates to use. Many LLETZ procedures using sausages were performed by the group.

