Royal College of Obstetricians & Gynaecologists

Dual operating in obstetrics and gynaecology

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BRITISH GYNAECOLOGICAL CANCER SOCIETY

BSGE
BRITISH SOCIETY for GYNAECOLOGICAL ENDOSCOPY

BSUG
British Society of Urogynaecology

BIARGS

This guidance sets out the principles, models and best practices for dual operating in obstetrics and gynaecology. Its aim is to enhance surgical training, support professional development, and support clinicians to provide safe high-quality care by providing a practical framework that enables departments and clinicians to implement dual operating in a structured, equitable and sustainable way. It supports high-quality training opportunities for Specialty Trainees while fostering a culture of collaborative learning and shared professional responsibility.

Developed as part of Phase 2 of the Royal College of Obstetricians and Gynaecologists (RCOG) Surgical Skills Project, this document reflects a new, partnership-driven direction for the College. It demonstrates the RCOG working collaboratively with its specialty societies to co-produce guidance that is grounded in real-world clinical practice, responsive to workforce pressures, and aligned with the evolving needs of patients and services.
The guidance builds on emerging evidence, examples of good practice, and the lived experience of clinicians working across a wide range of clinical settings. Dual operating is positioned not solely as a training intervention, but as a mechanism to support lifelong learning, safe skill acquisition, peer support and shared decision-making across all career stages. In doing so, it aligns with the wider ambition of the Surgical Skills Project to normalise continued surgical development beyond completion of training.

Central to this work is recognition of the essential role of educators, supervisors and trainers in delivering safe and effective surgical care. By promoting structured approaches to dual operating, the guidance seeks to ensure that those who teach and support others are recognised, valued and enabled to fulfil their educational roles within modern service constraints. This reflects the College's commitment to embedding education, mentorship and collaborative practice within job planning and organisational structures, rather than relying on informal or ad hoc arrangements.

The RCOG is grateful to the Specialty Trainees and trainers who contributed their time, expertise and insight through the lifelong learning workstream that developed this guidance. Their engagement has been fundamental to ensuring that the document is grounded in contemporary practice and responsive to the needs of the workforce.

This guidance has been developed in close collaboration with, and is reviewed and endorsed by

- The British Society of Gynaecological Endoscopy
- The British Gynaecological Cancer Society
- The British Society of Urogynaecology
- The British and Irish Association of Robotic Gynaecological Surgeons.

Through shared leadership and partnership, the RCOG and its stakeholder societies continue to strengthen surgical training and professional development, supporting safe, high-quality care for patients now and in the future.

1. Introduction

Dual operating is a collaborative surgical approach in which two specialist surgeons operate together, either as co-surgeons or in a primary-supportive arrangement. This guidance outlines the rationale, structure, and best practices for dual operating in Obstetrics and Gynaecology (O&G) within the UK. It is intended to support lifelong learning, ensure patient safety, and foster a culture of reflective practice and surgical development.

2. Definition and models of dual operating

Dual operating is defined as the joint intra-operative practice between two consultant-level surgeons who share decision-making and operative responsibility. However, it is recommended for clarity that the listing surgeon take ownership of peri-operative care unless otherwise agreed between colleagues. It is distinct from trainer-trainee relationships and may be structured in the following formats:

- **Primary-supportive model**: One surgeon leads while the other supports, offering technical advice or observation.
- **Co-surgeon model**: Both surgeons perform key elements of the procedure jointly, often in prolonged or complex cases. This may also include inter-specialty operating which brings together surgeons from different specialties to address complex cases.
- **Parallel operating model**: An experienced consultant operates in one theatre while a less experienced consultant undertakes a case in an adjacent theatre. The expert surgeon provides oversight, mentorship, and is available to support decision-making or assist if needed. This model promotes autonomy for the less experienced consultant within a safe framework and enables simultaneous productivity and development.

3. Indications and purposes

Dual operating serves several functions:

- Accelerate skill acquisition and confidence for less experienced surgeons.
- Enhance patient safety by reducing peri-operative risk, enabling expert peer review, and supporting shared intra-operative decision-making.
- Facilitate learning of new surgical techniques (e.g. robotics).

- Support development of new services or complex procedures (e.g. HIPEC).
- Enable return-to-work support (e.g. post parental leave, illness).
- Assist international recruits in adapting to UK practice.
- Reduce cognitive overload and fatigue thereby promoting surgeon wellbeing
- Preventing surgeon musculoskeletal injury through shared workload
- Promote reflective and continuous surgical development.

Case Study 1: Primary-supportive accelerates skill acquisition (Bath)

At the Royal United Hospital in Bath, a monthly dual operating session is scheduled on Friday afternoons to coincide with Specialty Trainee governance activities, minimising impact on training. Two consultants—typically one more senior and one more junior, or a colleague needing specific support—work together on a short theatre list. The lead consultant is job-planned for the session, while the other attends using their own Supporting Professional Activity (SPA) time.

This model allows targeted skill development without the need for a formal business case. A shared spreadsheet tracks participation and learning objectives to ensure equity and consistency. The programme has been praised for its regularity, transparency, and low administrative burden. While it is best suited for refreshing skills or regaining confidence rather than acquiring entirely new ones, it offers a replicable, low-cost framework for peer learning.

Case Study 2: Primary-supportive model for targeted skill development: BSUG mentorship programme

The British Society of Urogynaecology (BSUG) established a national mentorship programme for stress incontinence {autologous fascial sling procedures and colposuspensions} following the restrictions placed on vaginal mesh procedures. This was launched in November 2018. This programme incorporates dual operating between experienced and less experienced consultants to ensure safe reintroduction and skill development for incontinence surgery. Through this scheme multiple consultants have acquired competence.

The mentorship scheme has subsequently been expanded to other surgical procedures that are complex and require more experience to gain competence i.e. laparoscopic sacrocolpopexy.

Consultants seeking to introduce or re-establish the procedure are paired with an experienced mentor for joint cases. They then make a plan to initially observe in theatre, assist in theatre and then create a list of their own cases for a BSUG mentor to assist and supervise their progression operating until deemed they have the appropriate skills to move to independent practice for this procedure.Dual operating allows for immediate feedback, shared intra-operative decisions, and reinforcement of anatomical technique. The programme has demonstrated a safe framework for skills transfer and supports BSUG's aim to standardise care and improve patient outcomes across centres. It sets clear standards for

practice, includes a defined pathway for completion of training, and provides evidence of validation for those completing the mentorship process.

Case Study 3 : Co-surgeon model improves patient outcomes in Gynaecological Oncology (Northern Ireland)

A retrospective cohort study conducted at the Northern Ireland Regional Cancer Centre assessed the impact of dual operating on outcomes in gynaecological oncology. The study compared hysterectomy outcomes across 2004 (pre-dual operating), 2014 (post-implementation), and 2017 (established practice).

Key findings included:

- A 41.4% reduction in postoperative haemoglobin drop (a marker of blood loss) for laparoscopic procedures between 2004 and 2017 ($p = 0.015$).
- A 56% reduction in mean hospital length of stay (LOS) from 2004 (12.1 days) to 2014 (6.1 days), which remained significant for both laparoscopic and open procedures.

The study concluded that dual operating in gynaecological oncology is associated with statistically significant improvements in blood loss and LOS, particularly in laparoscopic surgery. These findings support the wider adoption of dual operating to enhance patient outcomes in complex procedures.

Case Study 4: Dual and parallel operating supporting complex endometriosis surgery (Portsmouth Hospitals)

Portsmouth Hospitals NHS Trust developed a structured dual and parallel operating model within their complex endometriosis service. Initially, the model consisted of parallel lists, where a senior consultant supported junior colleagues operating in adjacent theatres. Over time, this evolved into a system where two junior consultants dual operate in one theatre, while the senior consultant runs a parallel list in a neighboring theatre.

Both junior consultants have these sessions formally included in their job plans. Careful case selection is a key component of this model's success: typically, a more complex case is scheduled in one theatre in the morning, with the less complex in the adjacent theatre, and roles swapped in the afternoon. This approach supports safe learning, optimises supervision, and enables real-time peer development while maintaining patient safety and service efficiency. The model has contributed to an increase in the number of complex surgeries performed each month. The junior consultants feel well supported in managing more complex cases, which, over time, enhances their confidence, skill set, and ability to operate independently.

This approach also aligns with recommendations in the NICE Endometriosis Guidelines (NG73), which advocate for multidisciplinary team working and appropriate surgical expertise in managing complex endometriosis. The Portsmouth model operationalises these

recommendations by fostering a structured, sustainable training and service delivery system that enhances surgical outcomes and meets national standards.

4. Best practice in dual operating

4.1 Principles of an effective dual operating partnership

- Mutual respect and voluntary participation.
- Recognition of skillsets and learning goals.
- Clear designation of roles and responsibilities.
- Shared understanding of situational awareness responsibilities.
- Respectful communication between both surgeons regardless of perceived experience.
- Clear documentation of roles in operative notes.

4.2 Pre-operative phase (Set)

- Case selection and joint planning.
- Alignment of learning and service objectives.
- Environmental preparation (equipment, team briefing).

4.3 Intra-operative phase (Dialogue)

- Shared decision-making and communication protocols (e.g. agreed stop word).
- Level-appropriate discussion and peer engagement.

4.4 Post-operative phase (Closure)

- Joint debrief and reflection.
- Use of feedback tools.
- Audit and documentation.
- Planning for future cases.

5. Integration with training

Dual operating should enhance, not replace, Specialty Trainee opportunities. It should be clear in the team brief how Specialty Trainees will be included. Key considerations:

- Avoid excluding Specialty Trainees due to perceived ‘extra hands.’
- Define Specialty Trainee involvement early.
- Use additional consultant capacity to enhance teaching.

- Improve teaching opportunities through reduced consultant cognitive load.

6. Organisational considerations

- Institutional support and policy development.
- Inclusion in job planning and appraisal.
- Structured incorporation into Continuous Surgical Development (CSD).
- Succession planning within departments.

7. Equality, Diversity and Inclusion (EDI)

Ensure that dual operating is underpinned by a respectful and supportive relationship between participants. Mutual trust and open communication are essential to ensure psychological safety and promote effective peer learning.

Ensure equal access to dual operating opportunities across demographics and specialties. Monitor uptake and address barriers to participation.

8. Evaluation and future development

- Incorporate regular audits and feedback mechanisms.
- Adapt models based on outcomes, Specialty Trainee input, and service needs.
- Encourage research into dual operating efficacy, including patient outcomes and training benefits.

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surgical practice. We would also like to sincerely thank Hologic for their generous support in helping to fund this work.

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3. National Institute for Health and Care Excellence (NICE). Endometriosis: diagnosis and management. NICE guideline [NG73]; Published September 2017.

Appendices

- Template for dual operating checklist.
- Suggested language for team briefing.
- Example Specialty Trainee inclusion plan.

Appendix A
Dual operating checklist template

Pre-operative

Task	Completed (✓/✗)	Notes
Define dual operating model (Primary-Supportive / Co-Surgeon / Parallel)		
Confirm roles and responsibilities for each surgeon		
Review patient case together (history, imaging, risks)		
Discuss surgical plan and contingency strategies		
Agree on communication protocols during surgery		
Ensure both surgeons are familiar with equipment and setup		

Task	Completed (✓/✗)	Notes
Confirm availability of necessary support staff		
Document dual operating arrangement in theatre list / notes Plan for debrief and feedback post-op		

Post-operative

Task	Completed (✓/✗)	Notes
Conduct joint debrief (clinical outcomes, teamwork)		
Reflect on learning points and areas for improvement		
Document feedback and follow-up actions		
Update training log / supervision records if applicable		

Appendix B

Team brief language

These are examples and will need to be adapted for each individual case considering the surgical team, the patient complexity and the skillsets/learning goals of both surgeons.

Primary–supportive model

"Today's case will be conducted using a *Primary–Supportive* dual operating model. I will be the primary surgeon, and [Name] will be in a supportive role.

[Name] (supportive role) will be supervising the procedure and is available to offer technical advice and support if needed. We've discussed the plan and potential challenges, and we'll communicate openly throughout.

The overall responsibility for the case remains with the [name] primary surgeon but we will communicate any changes to this plan as required.

Please feel free to speak up at any point if you have concerns or suggestions—this is a team effort."

Co-surgeon model

"For this case, we'll be operating as *co-surgeons*. Both [Name] and I will be performing key parts of the procedure jointly. This is a complex/prolonged case, and we've planned our approach collaboratively.

We'll be sharing responsibility for decision-making and will communicate clearly throughout.

As always, we welcome input from the whole team—please don't hesitate to raise any concerns or observations."

Parallel operating model

"Today we're using a *Parallel Operating* model. I'll be operating in Theatre A, and [Name], a (junior) consultant, will be leading the case in Theatre B.

I'll be available for oversight, support, or escalation if needed, and we've agreed on how to communicate between theatres.

The goal is to support autonomy while maintaining safety. Please ensure any concerns are escalated promptly—we're all here to support each other."

Appendix C

Strategies to ensure Specialty Trainee involvement in buddy operating

1. List planning

- Match the Specialty Trainee's level to the complexity of the case—ensure the tasks are challenging but achievable.

2. Team brief inclusion

- Explicitly introduce the Specialty Trainee and their role during the team brief.
- Assign a clear role to the Specialty Trainee (e.g., assisting, performing specific steps, observing decision-making).
- Use a structured learning objective (e.g., "Today, the Specialty Trainee will perform the abdominal entry and closure under supervision").
- Encourage the whole team to support the Specialty Trainee's learning.
- Use inclusive language:
- "[Name] is our Specialty Trainee today and will be performing key parts of the procedure under supervision. Please support their learning and speak up if you have any concerns."

3. Dual surgeon coordination

- Ensure both surgeons agree on how the Specialty Trainee will be involved.
- Avoid the Specialty Trainee being sidelined due to the presence of two senior surgeons—plan moments where the Specialty Trainee leads or is coached.

4. Intraoperative engagement

- Use real-time teaching: narrate decision-making, ask questions, and invite the Specialty Trainee to reflect.
- Allow the Specialty Trainee to perform supervised steps, even if minor, to build confidence and competence.
- Rotate roles if appropriate (e.g., Specialty Trainee assists one surgeon, then swaps).

5. Post-op debrief

- Include the Specialty Trainee in the debrief and ask for their reflections.

- Provide specific feedback on technical skills, communication, and decision-making.
- Encourage the Specialty Trainee to log the case and learning outcomes.