# **UK Conference for Clinical Communication in Undergraduate Medical Education**

# **‘Developing the clinical communication curriculum’**

## UKCCC – UK Council for Clinical Communication

## **Abstract Book**

## **Thursday 23 March 2023: Day 1**

## **Clinical communication innovations in teaching**

## **The Dalton Room 09.30-10.40**

**Keynote, Profession Lorraine Noble**

Lorraine Noble is Professor of Clinical Communication at UCL Medical School in London. She has a background in clinical psychology and has specialised in doctor-patient communication and its education for over a quarter of a century. She has been a member of EACH: International Association for Communication in Healthcare since its creation in 2001, served as the elected UK National Representative of EACH from 2014-2020, and is currently serving as President. Lorraine has been a founding member of the UK Council of Clinical Communication in Undergraduate Medical Education since its creation in 2005.

To preface the topic for Day 1 of the conference, innovation in clinical communication teaching, this talk will discuss *clinical communication education: where are we now?*

**Opening Poem, Emmanuel Oladipo**

# **The Dalton Room 11.00-12.30**

# **Oral presentations – Broadening the Curriculum**

1. **Title: The development of scholarly simulated patient roles: the experience in Cardiff of developing Lead Actors.  Author name: Dr Lucy Morris, Lead for Communication Skills, Cardiff University School of Medicine**

Three years ago we created a new role in Cardiff of a ‘Lead Actor’. In part, this was simply to create a line management pathway for our pool of actors. Our experience since has demonstrated that actors add a huge amount of value to the communication skills delivery when given the opportunity. We had five successful candidates who were each allocated teams of actors. Primarily, their role was as a point of contact for queries, to undertake annual Performance Development Reviews and to liaise with the academic team, providing feedback from the actors perspective. Over time, their roles have developed to broadly cover five main topics:

1. Mentorship and peer review
2. Contribution to planning and delivery of assessments, including actor calibration
3. Contribution to ‘story telling’ – the development and characterisation of simulated roles
4. Research and training of actors
5. ‘Human Resources’ role acting as a point of contact for contract negotiations etc

I feel that the development of the Lead Actors in this way has had far reaching benefits for our delivery of communication skills and assessment processes. This oral presentation will share our experiences in more detail.

1. **Title: The recruitment and selection of Clinical Communication Skills (CCS) Peer Tutors: a values-based approach. Authors: Clinical Communication Section, St George’s, University of London Oral Presentation by Ms Angela Kubacki, Dr Laura Yalley-Ogunro, Dr Jenny Collom and Dr Leo Hudson**

Peer tutoring and Peer Assisted Learning (PAL) have become invaluable tools in pre-clinical years medical education and authors have begun to formalise its implementation and design. Existing programmes have enlisted Peer Tutors (PTs) on a predominantly voluntary basis and with little documented evidence or description of the recruitment procedure.

A new CCS Peer Tutor (PT) programme was developed, aiming to hire PTs using a skills and experience-based selection process rather than considering exam scores alone for selection. Writing a well-defined job description and person specification to match the values and attributes to which PTs would be selected was paramount.  With the desirable characteristics of a CCS PT in mind, a three-stage assessment approach including a written application, a three-station MMI-style assessment, and a training day for successful candidates was designed and implemented.

One year on after piloting and evaluating the programme, we will present our carefully considered recruitment and selection process and the lessons learned.  We will discuss the benefits of a values-based approach for selection and why feedback, empathy and facilitation skills are so important when selecting PTs to teach early years students. A robust recruitment and selection process for PTs in CCS teaching is essential for maintaining teaching standards and quality in medical education.

We will share our methods for establishing a CCS PT programme, with a step-by-step detailed design explanation, which can be adapted by any educational healthcare institution.  We hope the lessons learned from our experience will help other institutions to effectively implement CCS PT programmes.

1. **Title: Student as Teacher: Ideas, concerns and expectations of Clinical Communication Skills Peer Tutors.**Affiliation: Clinical Communication Section, St George’s, University of London Oral Presentation: Dr Annabel Ilves, Dr Julie Evans, Mr Noor Haddad, Ms Neve Lawrence, Dr Laura Yalley-Ogunro and Ms Angela Kubacki

Peer tutoring has long been implemented with success and its benefits to the tutee, peer tutor (PT) and university are unequivocal. Most commonly, PTs teach clinical and examination skills, often assisted by detailed step-by-step instructions. Clinical Communication Skills (CCS) teaching, however, involves creativity, complexity and nuanced facilitation. The aim of this presentation is to describe the findings from one London medical school and promote discussion on the impact of implementing such a programme.

A novel PT CCS programme was piloted in which penultimate and final year medical students were selected, trained and employed as PTs to facilitate CCS sessions for early years medical students. Feedback was collated via Microsoft Forms from qualified CCS tutors (QTs), PTs and tutees.

Initial qualitative analysis from QTs [n=10], PTs [n=21] and tutees [n=182] reveals that the programme has been positively received overall. Early years students benefit from access to a peer role model who they can relate to and trust, whilst the PTs are learning to work effectively and appropriately as mentors and teachers to meet GMC Outcomes (2018). Results suggest the university will benefit from a more satisfied and integrated student body. However, risks identified include PT preparedness, consistency, and ability to manage challenging scenarios.

When implementing Peer Tutoring into a CCS curriculum, considering appropriate methods for recruitment and selection are paramount and identifying training needs and levels of preparedness of PTs must be prioritised. Co-tutoring with CCS QTs is vital for building confidence and enhancing the facilitation skills of the PTs.

# **Title**: **Developing clinical communication skills of international students to achieve standards expected within UK medical curriculum. Authors**: Dr. Dhruva Somasundara, Dr. Yvonne Wedekind, University of Dundee School of Medicine.

## **Aim**: To present ongoing work supporting international students to help improve their clinical communication skills (CCS).

## **Overview:** University of Dundee (UoD) School of medicine follows a spiral curriculum. By the end of Year 2, students can complete a simple consultation in a variety of clinical scenarios. In year 3, these skills are applied to more complex consultations.

A set of students, mostly from the International Medical University of Malaysia, transfer to the UoD in Year 3. Though they have been introduced to Calgary-Cambridge model of consultation, there has been an observed gap in the ability to effectively apply these skills within a patient-centred consultation. Though tutors are excellent at identifying students who would benefit from additional support, the only formal process of assessing CCS is the end-of-year Objective Structured Clinical Examination (OSCE). Differential attainment of these international students in OSCE prompted introduction of consolidation sessions based on observed gaps in these skills.

The sessions have been well-received by students, evidenced by near 100% attendance rates and positive feedback. This presentation discusses strategies used to identify areas of support need in clinical communication skills among this group of students to create appropriately targeted teaching content and how these sessions have evolved since introduction in 2020-21. The presentation intends to share ideas and suggestions on supporting students arriving from out with the UK.

1. **Title: Medical student vs Student doctor. What’s in a name? Rachel Lindley, Ella Norgaard Morton, University of Manchester**

The first words in a conversation are fundamental to shape the interpersonal interaction

which follows. Traditionally in the UK, learners who are studying towards becoming a

qualified doctor have been called medical students. The lived experience of these learners

suggests that patients and family frequently misunderstand what role they have in the

healthcare environment. Students often go on to explain what they actually are, i.e. that

they are in training to become doctors, or later have to manage the confusion of realising

they have been assumed to be a pharmacy, nursing or generic healthcare student. An

alternative name of ‘student doctor’ is used by some settings across in the UK. With this

term, patients may not hear the word student, and presume the person before them is a

doctor. Students may feel the title is too scary and others may use it to take advantage of

patients thinking they are a qualified doctor. Have we all been encultured into medical talk

that we can’t remember a time when we didn’t know what a medical student was? Which is

better or worse?

Many issues are considered in this presentation, such as minimising cognitive load for the

patient in the precious first few minutes, matching language complexity for the listener,

building rapport by ensuring immediate understanding, professional use of language to

influence the power dynamic of the conversation, risks of abuse of power by students and,

most importantly, patient safety.

1. **Abstract title** Development of an interactive platform to facilitate communication skills OSCE preparation, Dr Lewis Potter (Sunderland Medical School) & Dr Chris Jefferies (UCLan)

**Background:** The Objective Structured Clinical Examination (OSCE) is a practical assessment tool used to assess performance within a simulated clinical environment. As an assessment method, OSCEs cause significant test anxiety among healthcare students. Various methods of OSCE preparation exist, including participation in peer-led ‘mock’ formative OSCEs.

**Methods:** A custom web-based OSCE platform was developed to assist students in organising and facilitating mock OSCEs. Key features of the platform include the ability to create OSCE stations (including student, patient and examiner instructions), embed rich media (pictures, audio and video), and create an interactive examiner checklist. The platform also allowed OSCE stations to be organised into circuits which could then be shared easily to facilitate mock OSCEs. The platform is designed to be used in small groups of three students, and accessed via a mobile device or laptop.

**Results:** The platform was launched in March 2022. Since launching, users have created 1,660 OSCE stations on the platform. These OSCE stations have had a total of 90,500 interactions by users. The most popular months for OSCE station use are May (17,000) and June (20,000).

**Conclusion:** Participation in formative ‘mock’ OSCEs is an often utilised method of OSCE preparation by students. There is some evidence that participation in peer-led mock OSCEs improves student confidence. Our statistics show the web-based OSCE platform was heavily utilised by students, especially during assessment periods.

# **The Innovation Suite – Workshop, 11.00-12.30**

**Title**: “Being Human”

Poetic reflective practice – Using performance poetry to enhance reflective practice and develop consultation skills

**Author:** Emmanuel Oladipo, *Lecturer in Clinical Communication,* *Emmanuel.oladipo@manchester**.ac.uk, University of Manchester*

Abstract:

In this interactive workshop I will share the process I have developed as a tool to enhance my personal and professional reflective practice using poetry. The aim is that by the end of this session we will all have the foundations of a piece that can be developed further.

The workshop will start by exploring what spoken word poetry is, comparing reading a poem with seeing it performed.

Individually and then as a group we will pull apart the experience, focussing on what the experience has done to you and made you feel (who where you in the experience) as opposed to just what happened to you. The idea here is to process the visceral experience, what was happening in your body, what were you thinking, what emotions came to surface.

Then next part of the workshop will explore what it would mean to bring this experience or an aspect of it to life. If I wanted someone to have a small taste of that experience, what would they need to know.

We will then start building our poems stage by stage, sharing with each other as we go. In this process, the sharing (aloud) is just as important as the writing as it’s important to understand what the words sound like, and how that adds to the depth of the poem.

The workshop will end reflecting on the process as a whole and how this can be done individually.

# **The Rutherford Room – Workshop, 11.00-12.30**

**Title:** Deaf Awareness - Breaking down the Barriers: A collaborative workshop delivered in BSL

**Authors**: Dr Christopher Huntley1, Dr Isobel Jenkins1, Mr Ian Cockburn2, Mr Mark Hart2

1 University of Liverpool School of Medicine, 2 Merseyside Society for Deaf People (MSDP)

The General Medical Council expects graduates to adjust their communication approach to the needs of the patient, including using interpreters when English is not the patient’s first language. The UK Council on Deafness estimates there are 12 million people in the UK who are Deaf or suffer moderate or greater hearing loss and there are over 87,000 people using British Sign Language (BSL) as their preferred language. Therefore, it is important that medical students understand the communication barriers encountered by those who are Deaf or have hearing loss and explore and practise using strategies to meet their needs. At the University of Liverpool, we run Deaf Awareness workshops for our Year 4 student doctors in partnership with the Deaf community from Merseyside Society for Deaf People (MSDP). These 3-hour workshops, which receive excellent feedback, are delivered in BSL by experienced trainers from MSDP supported by interpreters and academic staff. As well as information on Deaf culture and on the experience of Deaf people and people with hearing loss when contacting healthcare, the session includes activities to help students reflect on the experiences shared and on the language we use and to practice role-plays with Deaf Simulated Patients with and without the support of interpreters. The aim of this interactive demonstration, run jointly with BSL speakers, is to showcase a sample of the activities from the workshop, to highlight the insights gained from collaborative delivery and prompt discussion of the advantages and challenges of organising and delivering this learning to students.

# **Round Table Discussions 13.30-14.30**

# **The Dalton Room: Thrive or Survive - Supporting Students in Clinical Communication Skills**

Recent discussions between clinical communication skills trainers across the UK suggests an increase in the numbers of students seeking help or being referred for additional help with communication skills. Why is this? what help is being provided, who is providing it and how effective is it?

Come and join our round table discussion and join our community of practice group who are passionate in supporting students become compassionate patient-centred clinicians and thrive in the current climate.

The purpose of this roundtable event is to share information. This is a wonderful opportunity to meet colleagues, listen, share and discuss experiences, thoughts, current practice and future directions around supporting ‘struggling’ students in clinical communication skills training.

**Moderator**: Mandy Williams, Senior Tutor in Clinical Communication Skills at Cambridge University Hospitals Trust.

**Contributors:** Juliet Brown, Jessica Buchan, Chris Huntley, Sarah Shepherd, Yvonne Wedekind, Connie Wiskin

# **The Innovation Suite:** De-mystifying empathy to develop authenticity in practice

**Introduction:** Despite being heralded as the cornerstone of clinical communication, empathy remains somewhat of an abstract construct to students who are encouraged to learn to feel and demonstrate empathy early on at medical school. The literature highlights the complexity of defining empathy within the clinical setting, offering many definitions including an array of alternative terms such as compassion, compassionate curiosity, compassionate solidarity, and rational compassion. Perhaps a more operationalised definition of ‘empathy’ that includes the discrete behaviours/skills that are taught and assessed would enable a more constructively aligned curriculum.

**Round Table Discussion Points:** Communication skills educators face numerous barriers when teaching what empathy is and what it looks like in practice. Common dilemmas include the student’s uncomfortableness with their own emotional landscape therefore lacking capacity to modulate emotions of others, resistance to the remoulding of existing skills/values, the ‘performative emphasis’ of empathy which encourages the use of stock phrases to tick boxes during assessment, the ‘wow’ effect of positive role-models, lack of self-awareness and empathy being viewed as a ‘liability’.

Teaching tools that could be discussed when seeking solutions to the dilemmas of teaching empathy are; to adopt a more standardised definition, the use of the model- empathy as a garden (Laughley et al.2021), a more comprehensive model (Bayne et al. 2013) and adopting the wider use of empathy maps (Cairns et al. 2020).

The objective of any effective teacher is to facilitate students to build skills incrementally leading to ‘authentic empathy’ being rewarded both in assessment and practice.

**References**

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# **The Rutherford Room:** *How can we create the conditions for safe and generative discussions about bias in educational and clinical settings?*

**Co-Facilitators:** C. Buckwell, J. Evans, A. Kubacki, R. Anwar, K, Lobb-Rossini, A. Spatz, A. Ilves, L. Yalley-Ogunro. St George’s, University of London, Section of Clinical Communication

Given ongoing revelations about bias in society, St George’s University London continues to prioritise inclusivity as part of its strategic vision (Worrell, 2022). Cognitive and neurobiological explanations of bias as a characteristic of humankind are not new, and its’ influence in interpersonal encounters and beyond are well researched. However, no one is immune to the zeitgeist, and energy and momentum for change at the level of the individual and system pervade our sociocultural landscape.

As corollary discussions emerge amongst medical students and faculty there is growing urgency to establish skilful responses to experiences of bias and demonstrate proactive measures to mitigate its impact in teaching and assessment. Yet there are few examples of evidence-based practical interventions, and guidance for the integration of bias training into healthcare education is insipient.

Our clinical communication team are currently developing a proactive approach to mitigate the impact of implicit bias in communication teaching. We recognise these aims resonate with the work of other UK medical schools and believe there is value in creating a collaborative inquiry about how to establish good practice in this area. We invite you to join us for 3 30-minute rotating round table discussions relevant to three related areas of enquiry.

Potential Questions for Round Table Discussions.

* To what extent are **teachers** obliged to examine their own complex histories and how they influence interpersonal encounters in the present?
* To what extent are **healthcare students** obliged to examine their own complex histories and how they influence interpersonal encounters in the present?
* How can we create **the conditions for safe training** about bias with students in educational and clinical settings?
* Do teachers need **a set of guidelines** for challenging real or perceived bias in classroom settings? What would those guidelines include?
* What are the **skills** required to promote inclusive, respectful and equitable classroom environments?
* What are the **adjustments** required to promote inclusive, respectful and equitable classroom environments?

Worrel, F. C (2022) Who will teach the Teachers? Examining bias in the educator workforce. Learning and Instruction. Access online 19/122022 doi.org/10.1016/J.learninstruc.101518

# **The Dalton Room 14.45 – 16.15**

# **Oral presentations – Broadening the Curriculum**

1. **Title: Literature Review: Delivering Resilience Workshops to Medical Students
Dr. Rachael Grant, Keele University**

**Background**: Medical schools must prepare students to deliver healthcare in an increasingly challenging and dynamic work environment. Coping with the demands of the job requires retention and application of up-to-date knowledge and skills, and the ability to react to varied and unpredictable demands. The recent COVID-19 pandemic has resulted in an unprecedented number of healthcare workers suffering from burnout, an emerging public health crisis. Although no doctor is immune to burnout, doctors with higher levels of resilience are shown to have lower levels of burnout.

**Methods**: A scoping literature search was conducted taught as part of a wider Master’s level project to discover what is known about encouraging resilience, and whether resilience skills can be successfully taught. Keele University’s Ex Libris Primo Search Tool was utilised.

**Results**: 108 studies were identified. 6 studies met criteria studying imparting resilience skills workshops to medical students. Far more literature pertained to teaching qualified doctors, nurses and allied health professionals. These preventative workshops looked at the ability to provide psychologically derived training in anticipation of experiencing risk factors for the development of occupational stress and anxiety. A range of training was identified in the literature, the majority of which were delivered in North America. Only one paper was identified from the United Kingdom. Workshops were universally well received from students. The literature demonstrated training was feasible to deliver and had positive impacts on markers of wellbeing. It is worth considering implementing this amongst undergraduate medical training in the United Kingdom and studying its effectiveness.

1. **Title: Clinical communication: improving medical student confidence in communicating with members of the deaf community.** S Scholfield1, D James1, A Wild1, and S Mak2. 1Clinical Teaching Fellow: School of Medical Sciences, Faculty of Biology, Medicine, and Health, University of Manchester 2Anatomy Demonstrator: School of Medical Sciences, Faculty of Biology, Medicine, and Health University of Manchester

**Background:** Effective clinical communication is an integral characteristic of modern medicine, and this acts as the fulcrum of the patient-doctor relationship. Higher levels of trust are correlated with improved outcomes, and thus communication teaching has become a core part of medical education in the U.K1.

Many deaf persons have unique methods of communication. Individuals may use sign (BSL: British Sign Language) as their first language or rely on techniques such as lip/speech reading2. However, exposure to these practices and deaf awareness is often limited in the medical curriculum3, potentially constraining a clinician’s understanding of how to consult appropriately. This is reflected in the healthcare inequalities experienced by deaf persons, including barriers to access4, misunderstanding medical information5, and dissatisfaction with healthcare services6. Unfortunately, COVID-19 and facemask use will likely compound these issues7. As such, there is a pressing need to address insufficient deaf awareness amongst U.K. health professionals. This should be reflected across all current-and-future patient facing staff, including medical students.

**Aim:** We aim to improve the confidence of medical students in communicating with deaf persons, principally through improving deaf awareness and exposure to the deaf community.

**Methods:** Members of the deaf community will be invited to the University of Manchester to share their healthcare experiences to approximately 60-120 medical students. This will occur within dedicated teaching sessions over 90 minutes. Student confidence will be assessed using internally ratified questionnaires, pre-and-post teaching, and statistical analysis will occur following data acquisition.

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1. **Title: Integrated Community Placement (ICP) Pilot: Improving the Early Clinical Experience. Authors: Atalabi O., Sharp S.**

This presentation showcases the integrated community placement (ICP), a half-day session which provides year 2 medical students with the opportunity to observe and carry out supervised hands-on tasks such as communication with clients and staff in diverse community settings.

This is addressing an expressed and apparent learning need to support the students in a smooth transition from preclinical to clinical practice in the NHS and ensure their personal and professional development as medical graduates.

**Aim of presentation:**

* To highlight how innovative practices such as collaboration with community services improve the experiential learning of students (2).
* To show how providing the students with diverse learning experience helps them develop communication skills in preparation for clinical practice.

**The presentation will highlight the following in relation to enhancing communication skills:**

* An overview of ICP, relevance of ICP, impact of ICP
* Lessons learned to improve the placement, the students’ learning experience and our role as educators.

**References** Yardley,S et al (2012 b) ‘Experiential learning: Transforming theory into practice. *Medical Teacher* 34:2, 161-164

1. **Evidencing impact of social accountability activities on Undergraduate Medical Students focusing on serving communities and health inequalities.**Authors: Joanne Thompson, Michelle Marshall.

**Objectives**: Our university situated in South Yorkshire has some of the highest indices of deprivation in the UK, often located adjacent to areas of affluence.  Our students are similarly diverse, generally from well-resourced backgrounds including international students, although a significant minority enter from widening participation contexts.

The literature evidences that undergraduates tend to consider social accountability as a concept for the qualified doctor. In addition, those exposed to service-learning activities are more likely to subsequently work in underserved areas. Ultimately, exposure to community learning activities can begin to have an earlier influence on future doctors. Our community based placement in year 3, underpin and reinforce the learning of the social determinants of health, inequity and communication skills.

**Methods**: In 2015 a 4 week full-time Social Accountability placement with community and voluntary sector organisations was introduced, with 2000 students in 150+ organisations over 8 years. The prime purpose was serving local communities, who determined the scope of work undertaken by their students. Core activities included service evaluation, research, resource development, and practical support. Evaluation has been undertaken comprising feedback from students, community organisations and transformative learning documented in students’ presentations and reflective journals.

**Results**: Preliminary analysis evidences significant impact on learners’ understanding of social determinants of health and includes key skills relevant to future clinical practice: the value of experiential learning, understanding the work of community organisations, holistic care and individually tailored support, improved communication and team working skills, and impact on future clinical practice. Partnership working with community organisations placing students working on aspects determined by the organisation is resulting in mutually beneficial outcomes. Many students remain engaged with community organisations after placements.

1. **Using Longitudinal Simulated Patient Scenarios. Authors:** Harvey Wells1\*, Elizabeth Wright1 & Adriano Buontempo2 1 Queen Mary, University of London – London campus, 2 Queen Mary, University of London – Malta campus. \*Correspondence: h.wells@qmul.ac.uk

**Abstract:** The use of simulated patient scenarios for teaching clinical communication is well established in UK medical schools. However, scenarios tend to be one-off clinical encounters where the student has a specific task to complete (such as take a history or explain a patient’s condition). Students therefore do not get the opportunity to learn, from the relative safety of a classroom, how build a relationship with their (simulated) patients in a way that is so vital to providing continuity of care.

Four patient scenarios with unfolding narratives were developed to support the teaching of clinical communication for Year 3 students. The scenarios were written to support the students learning of the clinical communication topics taught during the second teaching block in the year (Empathy, Diversity, Explanation, and Shared Decision-Making) and provide opportunities for students to develop skills relating to a broader range of communication areas, such as relationship building and reviewing treatment.

Students, tutors and simulated patients shared their feedback about the use of longitudinal scenarios on an anonymous electronic form at the end of the week’s teaching.

This session will discuss the feedback from the different stakeholders and share what was learned by designing and delivering these longitudinal scenarios. It will also highlight the implications of these type of scenarios on the teaching of Clinical Communication more generally.

1. **Title**: **The use of mentimeter to facilitate patient interview in a large group lecture.** **Author**: Dr Jessica Buchan, University of Bristol.

During the pandemic, with the accelerated use of technology and mixed delivery sessions, we noticed higher than usual interaction with large group lectures online. With the return to face-to-face teaching, we wanted to avoid a consequent return to single student-lecturer interaction during lectures. We were keen to facilitate engagement of a wider group of students, particularly those who may struggle to ask or answer questions in a large lecture, for example those who are neurodiverse, or those for whom English is not their first language. Technology is often used for voting/to promote interaction, but in this novel intervention we facilitated audience participation in a clinical consultation during a large lecture: In a communication skills based lecture for medical students, with a volunteer patient and clinician demonstration of a consultation, rather than asking students to ‘shout out’ questions, we used Mentimeter as a tool to seek questions from the audience. The clinician facilitator was then able to screen, theme, and use student directed questions for the patient interview. There was high engagement with this use of technology in a lecture, allowing many more students to participate than usual. Formal evaluation is needed to explore whether this technology does indeed help those who are neurodiverse in their learning of undergraduate medicine.

The oral presentation will share some of the learning from this teaching session and explore next steps.

# **The Rutherford Room – Workshop 14.45 – 16.15**

**Title:** Exploration of practical skills to respond to bias in clinical communication training.

**Co-Presenters:** Buckwell, Cherry and Anwar, Rakin. St George’s, University of London, Section of Clinical Communication

**Description**

Teachers are responsible for creating safe and equitable learning environments (Brandilynn 2022), yet there is frustration where the current surge of research around bias in education is not matched with practical evidence-based strategies to manage such phenomena in the classroom (Gonzalez et al 2021, Boysen 2012).

In specific, clinical communication training hinges on a climate of safety; given the nature of implicit bias -positive or negative- we can assume it’s multidirectional influence in interpersonal encounters. Teachers may exhibit their own bias during interactions with students (Worrel, 2022), they may perceive bias amongst students, manifest in actors during role play or they may be confronted with complaints of bias.

The communication team at St Georges, University London has taken a proactive approach to manage bias in communication training and assessment. A multilevel intervention is in development where tutors, actors, students and examiners will be trained in how to manage bias in educational and clinical settings.

This workshop will share elements of our intervention to facilitate understanding about the nature of implicit bias, knowledge about how bias may manifest during interpersonal encounters and awareness of skills and strategies that may mitigate its impact. Recent examples of bias in teaching and assessment will be used to generate a collaborative inquiry about emerging ideas and practices. We will discuss the concept of ‘cultural humility’ and the ongoing work required by us all to allay our own unconscious biases. We anticipate a lively discussion where the telling of personal experiences will be warmly welcomed.

* Boysen, G. (2011) Teachers’ Responses to Bias in the Classroom: How Response Type and Situational Factors Affect Student Perceptions Journal of Applied Social Psychology,2012,42, 2, pp. 506–534. Wiley Periodicals.
* Brandilynn J. Villarreal, Kimberly Vincent-Layton, Edelmira Reynoso, KaylaBegay & Kimberly N. White (2022): Do students perceive faculty as responsible for equitablelearning environments? Results from a mixed-methods study, Higher Education Research &Development, DOI: 10.1080/07294360.2022.2120856
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# **The Innovation Suite – Creative Arts 14.45 – 16.15**

***Creative arts performances or exhibitions to showcase innovations and alternative ways to approach learning***

1. **Title: “Compulsory Creativity” and clinical encounters.** Dr Juliet Brown, Dr Gayani Herath, Dr Jessica Buchan, Prof Trevor Thompson, Catherine Lamont.

Will be curated and presented by Dr Juliet Brown

Bristol Medical School has a long and rich history of “compulsory creativity” exploring the arts in medicine as well as the art of medicine (1). The COGConnect framework for teaching and learning Effective Consulting (2, 3) centres five core values for all students and graduates in clinical encounters, including **Creativity**. Additionally, one of the phases of COGConnect is Integrating, in which we are challenged to answer the question “Have I integrated this consultation effectively?” both by updating the clinical record, noting and acting on learning needs, and dealing with feelings evoked by the consultation. Creative work is one avenue for effective Integration.

Students at Bristol have dedicated tutorials in the Art of Medicine. They produce group art work for a “Foundations of Medicine” conference at the end of their first teaching block and individual creative submissions exploring the humanity (and humanities) within clinical encounters as part of their Effective Consulting Course. Creative work is an innovative way for students to go beyond logical reflection to the often unexplored aspects of medicine. For many students this facilitates the development of creativity as a tool box for self-exploration, patient understanding and self-compassion and for some they go on to share their work more widely (4, 5)

This Creative Exhibition will showcase some of the best student work from the last 5 years, and demonstrate the depth of reflection and understanding this type of creative endeavour can provide. A curated selection of work can be viewed in advance here <https://outofourheads.net/>

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* COGConnect Website [www.cogconnect.info](http://www.cogconnect.info/)
* <https://www.bristol.ac.uk/news/2021/december/the-art-of-medicine.html>
* <https://www.bristol.ac.uk/news/2022/december/graduates-debut-album-homage-to-patients.html>
1. **Title**: **“Being human” Using the creative arts to facilitate self-understanding and to encourage empathy** **Author:** Emmanuel Oladipo *Lecturer in Clinical Communication,* *Emmanuel.oladipo@manchester.ac.uk* *University of Manchester*

**Background:** Before being medical educators or practitioners, we are human. And learning to sit with this fragile reality is vital to promoting good wellbeing and a holistic reflective practice that will ultimately lead to a better patient experience. Only by “being human” well can we begin to heal the fracture between self and the professional identities we have.

In this performing arts piece, I will show how spoken-word poetry can be used to creatively explore and depict the human experience. These pieces are the product of a journey of learning how to make sense of intimate thoughts and feelings. They are in a way a study of the self and one’s own humanity, an exploration of “who I am” and not just the “what I do” which is often the focus of reflective practice. In this piece I propose to share my journey from junior doctor to full time academic, interweaving between spoken word pieces and a short documentary film, before facilitating a discussion about what the pieces illustrate and add to the understanding of mental health, illness and the human experience.

Along the way, I aim to demonstrate how poetry can be used by healthcare professionals and students to enrich their reflective practice, with a focus on self understanding and recognition of feelings.

# **Friday 24 March 2023, Day 2**

# **Integration of teaching Clinical Communication and Clinical Reasoning**

# **The Dalton Room, 9.30-10.40**

# **Keynote Talk Dr Anna Hammond**

**‘Integration of clinical reasoning and communication skills: Evolution of a medical school curricula and reflections of a GP’**

Anna is Deputy Director MB BS Programme and Academic Lead for Clinical Skills & Reasoning at the Hull York Medical School (HYMS). She is a practising GP in York.

She is a co-founder of the UK CReME (Clinical Reasoning in Medical Education Group) and co-author of the Consensus Statement on the content of clinical reasoning curricula in undergraduate medical education.

Anna will discuss the evolution of the HYMS curriculum (including the explicit teaching of clinical reasoning, and integration of the communication and clinical reasoning curricula) and reflect on the impact of her own practice as a GP.

# **The Dalton Room, 11.00-12.30**

# **Oral Presentations: Integration of teaching Clinical Communication and Clinical Reasoning**

1. **Gamification in Clinical Reasoning – Dr Ryan Peers (GP & Deputy Lead for Clinical Debrief)**

In an increasingly interactive world educational institutes are turning to new modalities to deliver content. Gamification is the use of education games in a non-traditional gaming situation, utilised to deliver curriculum content to students. Whilst these games are not widely considered to be mainstream education material their potential has been well documented, and we have incorporated their use into our small group teaching as part of clinical reasoning.

In our 7 years of small group teaching we have developed games in workshops and delivered them to students in clinical debrief sessions. The aim of these games is to develop students clinical reasoning skills. Feedback is reviewed and games modified to ensure their continued effective use and ensure they continue to have sound underlying pedagogical footings. Year on year we have received positive feedback from students who have benefitted from gamification.

In this talk we will look at theory of gamification and we will discuss our successes and failures over the last 7 years. We review the games we have developed and how we have modified their structure based on students needs at that time. We now have many high quality medical educational games with excellent student feedback, and we hope to share our experience with other academics interested in the area hopefully inspiring them to create their own educational games.

1. **What do doctors recall being taught about communicating diagnostic uncertainty? Insights from an online vignette study Authors:** Caitríona Cox, Thea Hatfield, Zoë Fritz **Affiliation:** The Healthcare Improvement Studies (THIS) Institute, University of Cambridge

**Background/aims**: Although diagnostic uncertainty is common, little is known about how and why it is communicated to patients in clinical practice. Some evidence suggests variation in how it is communicated, and that doctors do not feel adequately trained in such communication.

**Methods**: As part of a larger study, four written vignettes of clinical scenarios involving diagnostic uncertainty were developed. Doctors were recruited from 5 English hospitals until data saturation was reached (n=36). Participants read vignettes in a randomised order, and after each told an interviewer what they would tell a ‘typical patient’. A semi-structured interview explored, amongst other topics, any prior training participants remembered receiving in communicating diagnostic uncertainty, and whether more teaching is needed. Interview transcripts were coded and analysed thematically.

**Results**: Most had not received formal teaching on communicating diagnostic uncertainty in medical school. Participants reflected that medical school teaching emphasised certainty, in contrast to the murky realities of clinical practice. Whilst ‘on-the-job’ learning (observing seniors and personal trial and error) was considered important, most felt that more specific teaching on communicating diagnostic uncertainty would be helpful. Suggestions for how to deliver such teaching included using simulated patients and receiving structured feedback on real interactions with patients.

**Conclusions**: Few participants recalled receiving formal teaching on how to communicate diagnostic uncertainty, but many supported the idea. Future research should examine current medical school curricula to better understand what is currently taught. Exploration of the impacts of communicating diagnostic uncertainty to patients is also required to help develop best-practice guidelines.

1. **Title: Development of virtual reality simulation scenarios for undergraduate interprofessional education, using clinical reasoning as a framework for learning.**

## **Authors:** Dr Lisa Collins, University of Manchester, Professor Minal Singh, University of Manchester, Emma Omerod, University of Manchester, Clare Clarke, University of Manchester

## **Brief Outline:** In an increasingly complex health and social care environment, interprofessional learning and working is essential to the delivery of safe and effective patient centred care. However, the complexity of timetabling and competing professional outcomes limit its integration into undergraduate curricula. Clinical reasoning, the process by which health and social care professionals identify problems and make decisions regarding the healthcare needs of the patient, is common to all programmes and requires effective communication skills. We developed 3 virtual simulation scenarios working collaboratively across nine health and social care programmes, as a trigger for interprofessional learning, using clinical reasoning as a framework.

We will share our experience of the process of developing scenarios in virtual reality to trigger interprofessional education, including the development of competencies and learning outcomes, utilising clinical reasoning as a framework for student learning.

1. **Title: Bridging the Theory-Practice Gap in Consultation Skills Teaching**. **Author**: Dr Ellen Lowry, Lecturer in Medical Education, Norwich Medical School, University of East Anglia.

The theory-practice gap is often described as the inability to relate the learning acquired from formal teaching settings with clinical practice. The literature suggests that a dis-integration between classroom based clinical communication teaching and clinical workplace teaching may be responsible for this gap in clinical communication (Rosenbaum, 2017). Learners confront two conflicting models, as classroom-based communication skills focus on the *process* (the how) whereas clinical placement focuses on the *content* (the what) (Kurtz et al., 2003). The *hidden curriculum* is an important factor in medical education, meaning the lessons that are learned by students but are not openly intended to be taught, such as the norms, values and beliefs of the educator (Mahood, 2011). Addressing the theory-practice gap is critical for a joined-up curriculum between classroom and clinical placement learning. Norwich Medical School Consultation Skills academics have joined-up with their clinical counterparts to enhance consistency in how consultation skills are being taught in practice. This presentation aims to briefly describe the core principles for teaching communication skills in a busy clinical setting in order to maximise learning opportunities for students. We will share best practice from the evidence base and examine the power of three specific teaching methods namely: role modelling, case presentations and focused student observations.

References

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* Kurtz, S., Silverman, J., Benson, J., & Draper, J. (2003). Marrying content and process in
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* Mahood, S. C. (2011). Medical education: beware the hidden curriculum. *Canadian family physician*, *57*(9), 983-985.
1. **A ‘fly on the wall’ approach to debriefing clinical encounters - bridging the classroom to practice gap. Authors:** Sarah Merrifield, Sarah Shepherd, Sarah Sharp. University of Manchester

**Introduction:** Making sense of clinical interactions in the early year is an integral part of professional identify formation. This session was created to allow year 1 & 2 students to gain additional experiential learning from a fly on the wall perspective of real-life GP consultations.

**Method:** In 2022/23 we piloted a 90 min workshop for 23 students’ year 1 and 2. Using the Virtual Primary Care [developed by the medical school’s council] platform participants watched a real-life GP consultation about mental health. They then answered a series of reflective questions underpinned by the clinical reasoning model. A discussion was then facilitated. Finally, students were asked to role play in small groups and practise asking sensitive questions [based in the context of the consultation watched].

**Results:** Participants completed a pre and post survey. Confidence increased across all areas; the biggest improvements in ‘*understanding how who the patient is will affect their management plan’* (23% increase) and ‘*confidence in talking to patients about their mental* health’ (18.5% increase). Themes of the free text comments included the importance and value of feeling able to share freely and learn from the insights of others and feeling equipped to develop an approach for talking about mental health.

**Discussion:** Feedback was positive and indicated that it was useful and relevant to students learning. The format of the session appeared to be well received with allocated time for consultation review, debrief and practice. The consultation chosen to observe can change within the session model to suit the teaching needs.

1. **Title**: Communication in acute medical units: A systematic literature review. **Authors**: Annabel Green, Mandy Williams, Debbie Critoph. Affiliations: The University of Cambridge

**Abstract**: Aims: To highlight an important, understudied area in clinical communication and guide further research.

**Outline**:Effective doctor-patient communication is the cornerstone of patient-centred care and is associated with improved treatment compliance, patient satisfaction and positive health outcomes. The acute medical unit (AMU) presents challenges to effective communication. During a placement on AMU, the lead author (A.G., a 4th year medical student) observed the patient experience of these communication challenges, which serve as the inspiration for this systematic review.

Acute medicine as a speciality has rapidly evolved over the past decade. Patients are admitted to AMU from the GP or ED, where they undergo rapid definitive assessment, investigation, and treatment. High patient turnover distinguishes AMU from other inpatient settings. The communication needs of the patient might be at their greatest, but the capacity of doctors to meet said needs may be at its most strained.

Communication broadly refers to information exchange and may be verbal (oral, written) or non-verbal. There is substantial literature evaluating communication in the community or outpatient settings. However, there is a relative paucity of papers investigating its importance for hospital inpatients.

This systematic review aims to characterise the communication challenges and opportunities on AMU, with an emphasis on the information exchange, explanation, and planning aspects of communication. We find that oral communication is insufficient to meet patient needs. Written resources may act as communication adjuncts although there are limitations. We make recommendations for further research and clinical practice.

# **The Innovation Suite – Workshop, 11.00-12.30**

**Title: Clinical Reasoning in medical education – developing the consensus statement. Author: Nicola Cooper**

Abstract:

Communication and consultation skills are at the heart of how clinicians gather data. Clinical reasoning encompasses the application of knowledge to collect and integrate information from various sources to arrive at a diagnosis and management plan for patients in a shared decision-making process. Due to its multifactorial nature and unconscious components it is both difficult to learn and teach. A lack of clinical reasoning ability is a primary cause of cognitive errors in patient care and threats to patient safety including unnecessary pain, treatments, or procedures for patients and increasing the costs of healthcare (<https://did-act.eu/>).

Few medical schools or postgraduate training programmes have a comprehensive clinical reasoning curriculum. The aim of this workshop is to bring the recent consensus statement on the content of clinical reasoning curricula in undergraduate medical education to life.

The workshop will be in two parts: the first part will introduce “the what” of teaching clinical reasoning; the second part will cover “the how”. “The what” was developed by consensus by members of the UK Clinical Reasoning in Medical Education group (CReME: [www.creme.org.uk](http://www.crème.org.uk)). “The how” was developed from a review of the literature on teaching clinical reasoning.

There will be time for discussion in small groups as to how we can put the ideas described into practice in our own context.

Dr Nicola Cooper is a Clinical Associate Professor in Medical Education, and interim course director of the PGCert/PGDip/MMedSci in Medical Education at the University of Nottingham. Nicola’s interests are in the science of learning and the science of instruction, clinical reasoning, and expertise development. She is co-editor of the second edition of the ABC of Clinical Reasoning and chair of CReME.

Consensus statement on the content of clinical reasoning curricula in undergraduate medical education: <https://www.tandfonline.com/doi/full/10.1080/0142159X.2020.1842343>

# **The Rutherford Room – Workshop, 11.00-12.30**

**Title**: Immersive learning in Stopford A&E: making the transition to clinical years

**Author names and affiliation links:**

Dr Sarah Collins, Senior Lecturer in Clinical Communication, Edinburgh Medical School, University of Edinburgh, Dr Joe Froggatt, Haematology Registrar, North West, Dr Ben Simpson, Anaesthetics and Intensive Care Trainee, North West, Dr Louise Smith, Lecturer in Clinical Skills, Division of Medical Education, University of Manchester

***Background*:** The ‘Consultation Skills Learning Centre’ at Manchester Medical School is purpose-designed to promote authentic, immersive learning. In 2015, two elective medical students (Joe Froggatt and Ben Simpson) collaborated in designing and delivering a new session, ‘Stopford A&E’, preparing all Year 2 students for transition to clinical years.

***Aims*:**

* Share best practice and challenges relating to immersive, integrated consultation skills learning and teaching.
* Celebrate benefits of student involvement in curriculum design.
* Consider how diversity can be authentically represented in consultation skills sessions.
* Reflect on ways to incorporate practices and concepts across medical schools.
* Critique the effectiveness of integrated, immersive teaching and learning.

***Outline of content:***

1. **Introductory activities** (30 min)
2. Participant introductions
3. Definitions/understandings of “immersive learning”
4. Participants share innovations, experiences, challenges
5. Introduce ‘Stopford A&E’: background, design, delivery, evaluation
6. **Showcase-in-action** (30 min)
7. Allocate observation tasks– waiting room, doctor’s office, consultation scenarios, clinical reasoning, handover, teaching/learning in action.
8. *Guided tour, or re-enactment if not possible to visit a session*:

Showcase elements and learning processes in ‘Stopford A&E’

1. Final 5 minutes - participants individually reflect:
2. Authentic, immersive, innovative, holistic, diverse?
3. Evidence of student involvement in design and delivery?
4. **Reflection, discussion and action planning** (30 min)
5. Best practice points for immersive learning.
6. Ways to promote student involvement.
7. How immersive designs can promote diversity.
8. Challenges in implementing ‘Stopford A&E’ across medical schools.
9. Revisit definitions of “immersive learning”.

# **The Dalton Room, Oral Presentations, 13.30-15.00**

# **Challenging Communication**

1. **Title:** Today’s Doctors, Yesterday’s Medical Students: priorities for undergraduate communication **Authors and affiliations**: an anthology film involving approx. 30 junior doctors Presenters:

Dr Sarah Collins, Edinburgh Medical School, University of Edinburgh

Dr Harvey Wells, Centre for Medical Education, Queen Mary University of London

Dr Emmanuel Oladipo, School of Medical Sciences, University of Edinburgh

**Abstract :** In medical education, we design curricula based on evidence from literature, policy directives, and the expertise of senior clinicians and academics. We tend not to include (either as a matter of course or embedded principle) the views of those from whom we stand learn something new – recently qualified doctors.

Communication challenges encountered in the early years of being a doctor, are a prism through which to view and critique the effectiveness of undergraduate communication teaching and learning. What content stood out? What has been most useful? What would have been helpful, but wasn’t taught?

This oral presentation gathers the views and experiences of around 30 junior doctors in a short film, with time for questions and discussion. The film format promotes participation from these busy junior doctors who are the primary authors. The film conveys compelling directives for content and priorities in communication courses. Each doctor’s message contains three dimensions: 1) something they learned in their communication programme in medical school that continues to be useful and they’ll never forget; 2) something they wished they had learned/been taught; 3) one piece of wisdom for those who design undergraduate communication curricula.

Involving junior doctors in shaping the content and direction of undergraduate communication programmes is key. Given imperatives to train increasing numbers of doctors, and the widening demands of policy directives and service delivery in a highly pressured NHS, it becomes ever more important to ask: What can we teach that will get to the heart of what tomorrow’s doctors need?

1. **Title:** Is trauma informed pedagogy useful for improving inclusivity in medical education? **Author**: Amy Spatz, St George’s, University of London

Colleagues at Harvard University Medical School (Brown et al, 2021) propose a Trauma-Informed Medical Education (TIME) framework, based on recommendations from the United States Substance Abuse and Mental Health Services Administration (SAMHSA) for improving intersectional inclusivity in healthcare. The 6 domains of established Trauma-Informed Care (TIC) approaches for working with patients include safety; trust and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historic, and gender issues. The same principles are centred in a TIME approach. This may improve awareness around othering or oppressive behaviour, including micro aggressions and stereotyping related to bullying, sexism, homophobia, racism or ableism, whether in the classroom or in clinical environments.

When modelled in teaching sessions, TIME could benefit students in an embodied fashion, experientially demonstrating TIC skills for use with future patients, and encouraging student awareness in an open and empathic fashion while reducing common causes of bias. However, developing knowledge and a language of TIME may be challenging in the face of current difficulties in the UK healthcare system and culture. Historically, clinical communication has been a pioneering platform for transformation of existing norms. Following a description of the effects of trauma and how TIME could help, in this round-table discussion we will explore some of the following questions together.

Would a TIME approach offer any advantages over a person-centred approach?

What disadvantages might there be to teaching using TIME?

How might clinical communication teams innovate in this area?

1. **Title**: Tackling Uncomfortable Consultations: Preparing Students for Challenging Interactions. **Authors**: Rachael Grant Alison Irvine Janet Lefroy

**Introduction**: How can we best prepare our medical students in the classroom for the real-life challenges when something within the consultation feels uncomfortable and there are conflicting agendas, or when the right course of action is not clear?

**What we did**: At Keele Medical School, we have devised a consultation skills scenario in which a patient withdraws their consent for a procedure and wishes to take their own discharge because of their racist beliefs. This sits within a 3-hour session for Year 4 students and alongside our wider efforts to tackle microaggressions and provide active bystander training, and where the local hospital trust’s policy is zero tolerance towards racism. A second case addresses communication skills and professional duties when there is a case of suspected child abuse at a GP surgery. This session gives students opportunities to address their concerns and try reacting in a safe, simulated environment and to have supportive feedback discussions, demonstrating the types of challenging scenario encountered both in primary and secondary care settings.

**Evaluation**: We will share individual tutors’ experiences and student evaluations. In summary, students found collecting background details difficult from both cases. They also found communicating a need to involve seniors to support and guide decision making challenging within the consultations. We found students appreciated facilitated discussions about identifying and supporting colleagues in need, and managing their own emotions when interactions are difficult. They did particularly well at identifying the issues within these cases and remaining professional, despite the additional challenges.

1. **Title: Communication skills training to support students in responding to discriminatory language** Author**:** Dr Lucy Morris  FAcadMEd , Lead for Communication Skills, Cardiff University School of Medicine, Ellen Nelson-Rowe, Final year medical student, Cardiff University

Following on from the November 2022 UKCCC meeting, we recognise that medical schools have differing approaches to delivering training to support students confronted by inappropriate language. Clearly, this is an area which should be handled with sensitivity as there is scope to impact student and staff wellbeing with discussion or role play involving unacceptable concepts and language.

This presentation explores the challenges faced when introducing elements of racist and sexist language into a communication skills tutorial. Prior to delivering the teaching, opinions were sought from students, tutors, actors, staff members responsible for Equality and Diversity Training and practicing health care professionals. There were different opinions on how the training should be delivered and indeed whether it should be part of communication skills at all. After collating opinions, the session was developed with actors primed to use phrases that would very likely be considered offensive. Following the teaching, students were invited to give feedback.

Significant attention was given to the student experience but, on reflection, more time could have been spent supporting tutors and actors as they found the tutorial very challenging, albeit worthwhile. We will discuss our experiences from the perspective of the students, actors and tutors.  We believe there is scope to improve this teaching and the debriefing provision.

1. **Title:** Interpersonal mindfulness increased empathy more efficiently than intrapersonal mindfulness in a randomised controlled comparison study in UK medical students. **Author**: Amy Spatz, Lecturer in Clinical Communication, St George's, University of London

Improving empathic communication in healthcare professionals is preferable due to numerous benefits, such as increased patient concordance. However, medical students' average empathy levels remain stable throughout their education in the UK and decrease in the US. Theoretically, mindfulness training improves students' capacity to remain present and empathic during stressful situations, and as such could be a useful addition to medical curricula.

*Intra*personal mindfulness is a non-judgemental, present-centred practice of awareness in which each thought, feeling, or sensation that arises is gently acknowledged without necessarily engaging or reacting. *Inter*personal mindfulness (IM) involves meditation, followed by engaging in mindful listening and speaking in dyads while adhering to guidelines for gaining relational insight. The effects of IM have not been previously investigated in medical students.

Seventy-eight students participating in a 5-week mindfulness SSC course in a UK medical school were assigned to intra or interpersonal mindfulness in a randomised controlled comparison study. Fifty-one students completed pre and post-intervention questionnaires. Group 1 were introduced to Mindfulness-Based-Stress-Reduction (MBSR), while group 2 experienced MBSR with added IM exercises. Both groups were taught by a trained mindfulness coach and experienced medical educator. Both groups achieved positive results despite significantly less reported home practice time for the IM group.

The results show that IM was an acceptable intervention which was more efficient than MBSR alone in this cohort. Improvements in empathy were positively associated with self-compassion, indicating a potential benefit to fostering this trait in trainees. Lessons learned from this research will be discussed during a short presentation.

# **The Innovation Suite – Workshop , 13.30-15.00**

**Title: Faculty Development: Equipping teachers with the skills to assist students to develop their clinical reasoning and communication skills in patient consultations: an integrated approach**

**Authors:** Dr Anna Hammond Hull York Medical School (HYMS), Dr Mark Lillicrap University of Cambridge School of Clinical Medicine *(This is one of two workshops to be delivered by the UK Clinical Reasoning in Medical Education Group (UK CReME))*

This interactive and multimedia workshop will showcase an approach that integrates the teaching of communication and clinical reasoning skills, through observation and discussion.

* To consider the challenges teachers/tutors (experts) might face in helping medical students (novices) develop their clinical reasoning skills
* To develop awareness of the role of faculty development in helping teachers/tutors develop the skills required for both clinical reasoning and communication skills teaching in real life patient encounters.
* To encourage delegates to share best practice and reflect on faculty development in their own institutions.

Experienced clinicians spend most of their time doing swift/Type 1 pattern recognition drawing on an extensive bank of illness scripts from many years of clinical practice, when making clinical decisions. Novices spend a considerable time doing more effortful /Type 2 clinical reasoning, using more hypothetic deductive or algorithmic reasoning approaches. This mismatch can present a challenge for learners and teachers and creates a need for explicit shared approaches to support experiential learning.

The workshop will draw upon the presenters’ experiences of addressing some of these challenges, particularly making the clinical reasoning approach explicit and linking this with processes for teaching communication skills. Furthermore, this workshop will link communication and reasoning skills with the evidence based approaches published in the CReME consensus statement on the ‘what’ and the ‘how’ of teaching clinical reasoning.

**References**

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# **The Rutherford Room, Symposium, 13.30-15.00**

# **Reframing reflective practice symposium**

1. **Title:** How do medical educators experience reflective practice? **Author:** Dr Tom Fairfax, GP Tutor University of Sunderland, **Affiliations:** University of Cambridge, University of Sunderland

**Aims:** To set the scene and present data from interviews with medical educators at two partnered medical schools. Themes are presented as a walk through an art exhibition.

**Background:** Medical students and doctors are routinely asked to share evidence of their reflections for progression, appraisal, and revalidation. We have little understanding of what learners and educators make of being asked to evidence their reflective thinking. This study aims to improve our understanding through interviews with medical educators about their experiences of reflective practice.

**Methodology:** Medical educators were recruited from two partnered medical schools. Raw data was drawn from semi-structured, iterative one-to-one interviews held over Microsoft Teams. Video-corroborated, software generated transcriptions formed the primary interview datasets. Texts including GMC Outcomes for Graduates were also considered. The qualitative interpretation of data was undertaken using reflexive thematic analysis.

**Analysis:** Five themes were identified: Theme 1 describes latent reflection, the inherent reflective capacity of learners. Theme 2 outlines an artless imposition, how operationalisation potentially harms reflective practice. Theme 3 examines how reflective practice is broadly seen by practitioners as essentially professional. Theme 4 addresses remedial tensions that are inherent to the practice of interrogating reflective thought for remediation. Theme 5 presents a rational affinity, capturing the pragmatic adoption, assimilation and sense of professional ownership that prevails.

**Conclusion:** Whilst medical educators think that evidencing reflective practice is worthwhile, there are perceived risks of a negative experience especially with arbitrary targets, an unsupportive or unresponsive learning environment and from mandatory remedial reflection. The themes together indicate that learner autonomy through reflective practice is valuable and vulnerable. There are opportunities for enhancement in this area of medical education.

1. **Title:** UM, ER it’s not what you do it’s the way that you do it, **Author:** Dr Kate Stobbart, Associate Clinical Tutor, University of Sunderland

**Aims:** A reflection on reflecting with art.

**Outline:** Using 3 examples of art (a print, a film, and a poem) I will discuss how making art can facilitate reflection on clinical encounters. The talk will draw on my experience of making art - alongside my career in medicine.

I will touch on my AHRC funded practice-based PhD in Fine Art (Newcastle University, 2019) - when I approached all art making with empathy, adopted from clinical practice. This approach to making art led to recognition of the value of hesitation - that to hesitate is to be human.

Hesitations can allow nuance and meanings within discourse to become apparent, and hesitations can present us with opportunities to respond to others in ways that are different from usual. In addition, the perceived (and/or real) vulnerabilities in hesitation resist the current orthodoxy - that confident fluency is better. This potential within hesitation extends well beyond artistic practice into spoken and written communication, academia, and clinical practice.

1. **Title:** To be human, first. **Author:** Dr Emmanuel Oladipo, Lecturer in Clinical Communication, University of Manchester

**Aims:** Using poetic reflective practice to facilitate self-understanding and to encourage empathy.

**Outline:**

The writing of spoken word poetry provides an alternative means of reflection focussing on bringing to light and exploring one’s own feelings and in doing so providing a broader framework to understand, explore and communicate the experiences of others. This creative practice also gives space to an unconventional but complementary vocabulary for describing experiences of illness, adding a richness and depth to the traditional language used in healthcare settings. In this oral presentation I aim to demonstrate how poetry can be used by healthcare professionals and students to enrich their reflective practice, with a focus on self-understanding and recognition of emotions. Interweaving with examples of my poetry, the talk will explore why a different approach to reflection is necessary, how poetry can provide a more creative way to develop communication skills, and finally it can also provide a platform for growing and demonstrating empathy.

# **Roundtable Discussions 15.15 – 16.15**

# **The Dalton Room:** Students writing in EPRs – what’s the guidance needed?

**Caroline Sprake**

When we think of teaching communication skills we tend to consider the spoken word alongside non - verbal cues. What we don’t always think about is how much of our communication is by the written word. Texts to patients, written advice and communicating with colleagues in our various teams. A bigger move is the opening up of electronic patient record (EPR) to patients in General Practice. No longer are the free text thoughts a private record for the clinician alone. This round table discussion will be an opportunity to share ideas and challenges and contribute to a guide for students about what to do and not do when writing in the EPR.

We will also be looking at potential survey questions for students to gain insight into what they find most challenging when committing “pen to paper” or rather “tapping the keyboard and pressing save”!

# **The Innovation Suite:**

# **Posters**

1. **Title**: A scoping review of doctor-patient communication in inflammatory bowel disease **Author names and affiliations**: \*Hussain Buxa, Immanuel Sanib, Jacqueline F. Lavalleea a The University of Manchester, Oxford Road, Manchester, M13 9PL, United Kingdom. Email: hussain.bux@student.manchester.ac.uk, Email: jacqueline.lavallee@manchester.ac.uk b Leicester Medical School, George Davies Centre, Lancaster Road, Leicester, LE1 7HA, United Kingdom. Email: is197@student.le.ac.uk

The effectiveness of the doctor-patient communication in inflammatory bowel disease (IBD) is crucial to ensure patients’ needs are addressed sensitively. The literature on the evaluation of doctor-patient communication in IBD is limited.

**Objective**: To conduct a scoping review to understand the current methods of doctor-patient communication in IBD.

**Methods**: Two authors completed the literature search using four electronic databases from inception to 2021 in accordance with the PRISMA guidelines. The reference lists of the retrieved studies were also examined. Relevant data from eligible studies were extracted by a single author. A second author verified the accuracy of the extracted data and analysed for discrepancies. Each paper was then assessed using the Cochrane risk of bias tool for quality assessment.

**Results**: We found 572 articles and included seven studies involving 4369 participants. Evidence suggests that patients diagnosed with IBD require their information needs to be met directly by the doctor or through reliable internet sources. Involving patients in their care through shared decision making is vital.

**Conclusion**: The role of doctor-patient communication has evolved and aims to actively involve the patient at the forefront of services. This review highlights the importance of keeping patient education at the core of care for patients living with IBD.

**Practice Implications**: Patients living with IBD want to be actively involved in the decisions surrounding their care. There is a need to cultivate a culture of including patients living with IBD in service planning to drive reform in patient education and shared decision making.

1. **Title: – COGConnect as a teaching and learning tool in practice. Authors**: Dr Jessica Buchan, Dr Juliet Brown, Dr Gayani Herath, Prof Trevor Thompson

COGConnect (1,2) is a visual resource for teaching and learning 21st Century consultation skills: it centres five core values of Compassion, Curiosity, Creativity, Collaboration and Criticality, with each COG reflecting the phases of a clinical consultation. With its tag line of “Connection. Cognition. Care”, it reminds learners and teachers that consulting is a whole-person commitment of head, heart and hands. It can be used for teaching and learning, reflection and assessment within individual clinical encounters. However, it can also be utilised as a tool for educators to map clinical learning sessions in an undergraduate curriculum, facilitating the integrated delivery of teaching across Clinical Reasoning, Clinical Communication and Clinical Skills. This poster presents a diagrammatic representation of COGConnect and its exemplar teaching sessions at Bristol Medical School.

* + Thompson T, Grove L, Brown J, Buchan J, Kerry AL, Burge S. COGConnect: A new visual resource for teaching and learning effective consulting. Patient Educ Couns. 2021 Aug;104(8):2126-2132. doi: 10.1016/j.pec.2020.12.016. Epub 2021 Jan 6. PMID: 33422369.
	+ COGConnect Website [www.cogconnect.info](http://www.cogconnect.info/)
1. **Title: Using video data of a mental health counselling intervention as a clinical education innovation** Jamie Murdoch1, Tamar Waller2, Lauren Simkin2, Bernadette O’Neill2, Jon Wilson3, Brioney Gee3, Shuangyu Li2 1School of Lifecourse and Population Sciences, King’s College London 2GKT School of Medical Education, King’s College London 3Norfolk and Suffolk Foundation Trust

In this poster presentation we will report medical student’s (TW, LS) and supervisor’s (JM) perspectives of a clinical education innovation. Clinical communication education typically involves students and actors role-playing simulated clinical scenarios followed by reflexive feedback sessions. Opportunities to strengthen students’ communication skills may lie in teaching analysis of communication within ‘naturally-occurring’ clinical consultations.

This educational project involved undergraduate medical students drawing on conversation analysis (CA) to analyse video-recorded data of counselling interactions between mental health practitioners, educational practitioners and young people experiencing borderline personality disorder symptoms (BPD). The data were collected in 2018-19 as part of a feasibility study of a Brief Education Supported Treatment (BEST intervention) delivered in schools. BEST was designed for young people experiencing symptoms of BPD, involving six face-to-face sessions over eight weeks.

Two students had NHS ethical approval to analyse recordings of BEST intervention sessions over a 3-month period. Students needed to: a) purposively sample extracts of recordings relevant to evaluating the intervention; b) characterise communication patterns within their sample; and c) explore the interactional consequences for successful delivery of the intervention. TW and LS met with JM bi-weekly to discuss progress, learn about CA, present ideas and receive formative feedback. On completion of the project LS, TW and JM participated in a recorded discussion to share their perspectives of the project, focusing on their prior experience of interactional analysis, how the project had strengthened their knowledge and skills, and how they envisaged using the learning to improve their clinical communication in future practice.

1. **Title: Gambling: the hidden killer in your phone,** Rachel Lindley, University of Manchester. With thanks to Dr Jenny Blythe, Medical advisor to Gambling with Lives, NIHR ARC North Thames Doctoral Fellow, GP Health Equity Fellow-Newham Training Hub, Honorary Senior Clinical Lecturer - Barts & The London Medical School who has co-created the content but is, due to other commitments, unable to attend the conference).

Gambling is promoted as a fun, relaxing leisure activity. It can take many forms including a football sweepstake at work, playing bingo with your nan, to visiting the bookies to place bets on the horses. Over the last decade there has been an explosion of gambling via our smart phones which allows gambling 24/7 without anyone else being aware. Evidence is emerging of the harmful health effects of gambling, with people reducing spend on things which keep them healthy to allow spend on gambling, and by indirect effect on affected others around the person gambling. Stigma and shame make it extremely difficult for people to admit to health professionals and other that it has become harmful to them. If we don’t ask, we don’t know, and we can’t risk assess.

Currently 1 person a day dies by suicide linked to their gambling. It is a causative factor in mental health problems, chronic pain, housing insecurity, poverty, domestic abuse, other addictions for both the person who is gambling and affected others. NHS gambling services exist across the country and allow patients access to expert help to prevent harm and death.

I will share some key literature on the health effects of gambling; recommended screening questions and suggestions of how gambling harm assessment can be incorporated into undergraduate communication teaching.

If we don’t ask we don’t know.

1. **Title: Accessing learning opportunities on the ward – What can I do as a medical student?** *Dr Anna Politis (Clinical Education Fellow, Salford Care Organisation, Northern Care Alliance)*

**Background:** Integrating clinical placement into medical students’ curricula is mandated by the General Medical Council as an essential component in their learning (1). However, evidence suggests that medical students can struggle to access learning opportunities, often describing the feeling of being a ‘spare part’ (2). Medical students from the University of Manchester anecdotally reported a similar notion, feeling there are limited ways in which they could learn by being on the wards - especially when first introduced to the clinical environment.

**Aims:** This poster was therefore designed with the aim of inspiring our medical students to access learning opportunities on the wards that may not have been immediately obvious. It also aims to act as an aide for the multi-disciplinary team (MDT) to recognise where they can involve medical students in their practice.

**Methods:** Through consultation of medical, nursing and administrative staff, a list of learning opportunities was drawn up and incorporated into an infographic-style poster. Senior academic staff and Equality, Diversity and Inclusion representatives reviewed the work, and vocabulary was aligned to the Manchester MBChB curriculum. A QR code linking to online resources was added to further develop the design.

**Outcomes:** The poster has been approved for integration into the MBChB curriculum, starting with the ‘Early Clinical Exposure’ module in years 1 and 2, through to a ‘Getting the most out of your placement’ pilot project for year 5. It is to be circulated for display throughout teaching hospitals in the region for easy access by medical students and the MDT in clinical areas.

*References:*

* *General Medical Council (2022) Guidance on undergraduate clinical placements - GMC. Available at: https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/undergraduate-clinical-placements/guidance-on-undergraduate-clinical-placements (Accessed: March 20, 2023).*
* *Seabrook, M.A. (2004) “Clinical students' initial reports of the educational climate in a single medical school,” Medical Education, 38(6), pp. 659–669. Available at: https://doi.org/10.1111/j.1365-2929.2004.01823.x.*
1. **Title**: “Deep beneath the peel every fruit is unique…” Satsuma: a student-designed framework for patient-centred communication learning **Authors and affiliations links:** 306 Year 1 students (2022-2023 cohort), Edinburgh Medical School, University of Edinburgh, Dr Sarah Collins, Senior Lecturer in Clinical Communication, Edinburgh Medical School, University of Edinburgh

***Background*:**

We are a whole year – first year medical students – at the University of Edinburgh. In our learning we have been introduced to a variety of existing consultation frameworks and models. While these are helpful, it can be hard to grasp the concepts and language, and hard to remember in our busy timetables. We have therefore devised our bespoke framework: a common reference point we have shaped to accommodate challenges and skills in communicating with patients. Working together, we have shared communication ideas and aspirations, through lectures, small group sessions and a student project. Our framework uses the satsuma as image, metaphor and structure, to help us navigate areas and skills; and, importantly, our satsuma accommodates different ways of thinking and learning about communication, to meet our diverse learning styles and needs as a group of 306 individuals.

***Aims*:**

1. To describe our satsuma framework
2. To show how the satsuma framework builds on existing literature
3. To illustrate ways the satsuma framework can be applied in:
	1. learning and practising communication as medical students
	2. designing and delivering student-informed communication teaching.

***Outline of poster content:***

Our poster will present the satsuma framework, situate it in existing literature, and give illustrative examples of how it can be applied.

The poster will be accompanied by:

* a series of 1-minute podcast commentaries (headphones supplied) on how the satsuma framework helps us learn effectively
* a leaflet of practical tips, written by us as students, to take away and use in other medical schools.
1. **Humanising Teaching, inviting learner voices through Ice breakers.** Author: Sarah Shepherd, with and through ICCH members.

Inviting the voices of learners into the room as quickly as possible is key to ensuring their effective engagement in the session. This can be achieved through ‘ice breakers’ which are separate from the learning topic and do not require topic knowledge.

each other a little better and humanise the humans in the room.

Participation in an ice breaker enables learners to speak without worry about demonstrating knowledge or a skill, thereby gaining confidence to speak with less risk attached. Starting a session in this way can step you out of automatic pilot, enabling a quality of presence from everyone and enhancing meaningful connections.

This poster will present a teaching tips document covering using Ice Breakers in teaching to increase the quality of connection with learners.

Feedback on this teaching tips sheet would be welcomed, is it helpful / relevant / applicable, alongside clarity of the message.