MED Showcase 2026 – Reflections and Project Summaries

Feedback and Reflections:

Supporting Disabled Doctors

What's the why?

Recent high profile reports from the BMA and GMC have highlighted UK-wide limitations in support for disabled doctors and those entitled to reasonable adjustments. Locally, senior leaders had recognised neurodiversity being raised regularly in formal meetings about doctors experiencing difficulties at work or in training. Many had not previously been linked with support services or offered adjustments. Our initial scoping work found increasing numbers of medical students declaring disabilities, indicating growing need, while examples of good practice for supporting physical disability were identified within NHS Grampian.

These findings suggested that support was often relatively reactive, beginning only after difficulties had escalated and relatively late in doctor's careers. The project aimed to identify system gaps, particularly at key transitions, and develop practical changes creating a fairer training environment.

What have you done?

We established links with local and national stakeholders, including staff with lived experience, disabled employee networks, clinical and educational supervisors, programme directors, occupational health, the Foundation Programme, NES trainee development and wellbeing services, and specialist local support services.

Given the scale of the issue, we focused on one high-risk transition: moving from undergraduate training into FY1. Through stakeholder discussions and focus groups, we mapped this process in detail. With support from the quality team, we created a visual process map identifying gaps, delays and unclear responsibilities. Focus-group findings also informed a journey map illustrating their human impact.

Learning from other health boards identified a 'gold standard' model using a named disability adviser to coordinate support, referral routes and continuity. We also identified a local service with relevant capacity and roles. Our findings were shared with stakeholders and senior MED leaders. We agreed a route for providing information to incoming graduates before arrival and directing those with additional needs to appropriate services from the start of training.

Focus groups with undergraduate-to-FY1 transitioners further explored how they wanted to receive this information and how barriers to engagement could be reduced, including concerns about how information would be used and shared.

We also co-designed a Supporting Disabled Doctors workshop with the disabled employee network. Delivered at a Train the Trainer event and adapted for Grand Rounds, it prompted challenging discussion, clarified minimum responsibilities, and provided supervisors with practical resources and referral options.

What is next?

We will evaluate the pre-arrival communication with key stakeholders and use the findings to guide further action. We also plan to embed the workshop within Train the Trainer activity and continue supporting wider cultural change.

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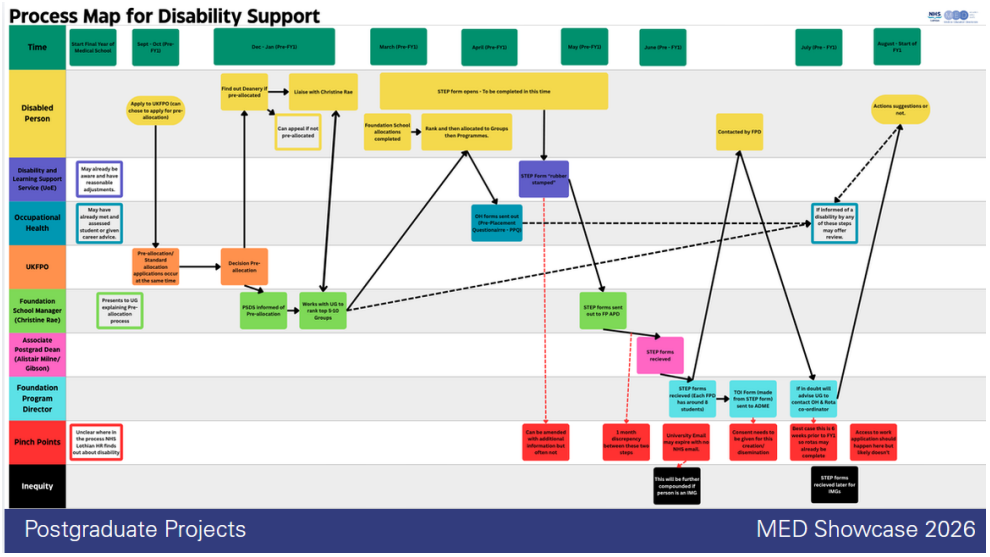


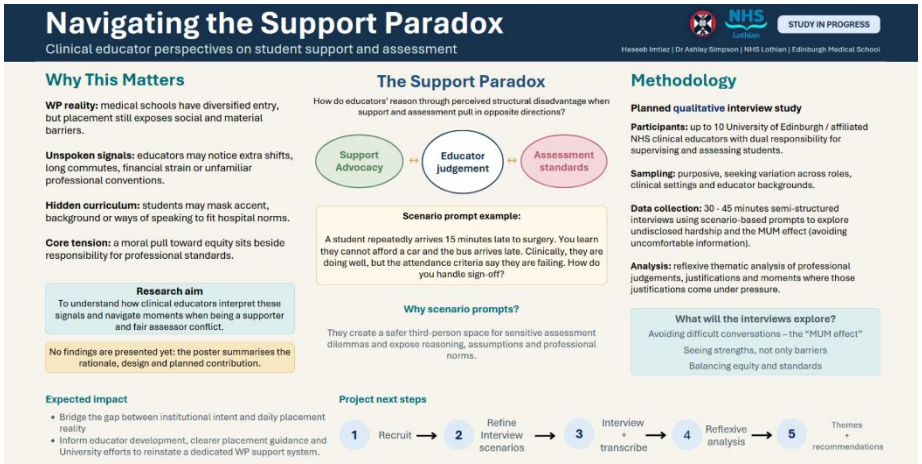
Perspectives on Student Support and Assessment - Haseeb Imtiaz

Background: Widening participation (WP) initiatives have made progress in diversifying the medical student population, but getting through the door is only the beginning. By definition, these students face longitudinal adversity for a variety of reasons. These barriers may be felt most keenly on clinical placement While WP status is kept confidential, educators may pick up on signals that reveal a student's background, such as working extra shifts to cover rent, commuting long distances, or hesitating over professional conventions they were never socialised into. Educators notice and interpret these signals even without formal knowledge but how they respond is less clear. They have simultaneous responsibility for supporting students and determining whether they meet minimum professional standards, the support paradox. Many navigate this tension while feeling under-prepared for these grey areas, worried that adjusting their approach for perceived disadvantage might introduce bias or overlook competency gaps. Furthermore, disclosure of personal circumstances raises questions about whether openness affects a student's professionalism marks.

Aim: This study examines which signals educators notice, how they interpret them, and how their own backgrounds shape the process in moments when being a supporter and a fair assessor do not sit comfortably together.

Methods: Up to 10 clinical educators affiliated with the University of Edinburgh will participate in semi-structured interviews. Recruitment will occur via email and educator networks. Sampling will be purposive, seeking variation in roles, clinical settings, and whether educators identify as coming from a WP background. Interviews will explore how educators recognise undisclosed hardship, handle the "MUM effect" (avoiding uncomfortable information), and manage assessment after a disclosure. Data will be analysed using reflexive thematic analysis.

Contribution: The study will bridge the gap between institutional intent and daily placement reality. Findings will inform educator development, help move away from deficit-focused thinking, and support the University's efforts to reinstate a dedicated WP support system.



Ready to Prescribe: From Student to Safe Prescriber

What's the why?

Previously, a peer led programme of year 4 prescribing teaching (Postgraduate and Undergraduate Learning in the South East (PULSE)) was delivered. Following the discontinuation of this programme, there has been a gap in practical prescribing education during the early clinical years. In addition, feedback from year 6 practical prescribing teaching consistently highlighted that practical prescribing teaching earlier in the clinical years would better support their preparation for both the prescribing safety assessment (PSA) exam and clinical practice as a foundation year (FY) doctor. Addressing this gap by introducing practical prescribing teaching into the early MBChB clinical years is therefore anticipated to improve prescribing competence, reduce risk and better prepare graduates for safe prescribing practice.

What have you done?

Following consultation with colleagues across NHS Lothian Medical Education Directorate (MED) and the University of Edinburgh (UoE), ACT funding supported the creation of an additional Lead Pharmacist Medical Education (LPME) post. This enabled the development of a year 4 prescribing workshop series aligned to the General Medical Council (GMC) outcomes for graduates. The 'Ready to Prescribe: From Student to Safe Prescriber' workshop series will focus on high risk medicines and practical prescribing skills. The workshops will be delivered by the LPME (undergraduate) during the cardiology block at the Royal Infirmary of Edinburgh. Students will attend four 90-minute small group workshops, with delivery scheduled to commence in August 2026. It is anticipated that 80 workshops will be delivered to approximately 339 students over the 2026 – 2027 academic year. This series of workshops aims to embed safe prescribing earlier in the clinical years to address prescribing risk and support students' transition to FY1 practice.

What is next?

The year 4 workshops will be delivered and evaluated for their impact on student confidence, prescribing competence, and preparedness for practice. Findings will inform future iterations and potential scaling of the programme. Additionally, year 6 prescribing workshops will be reviewed and updated to build on the knowledge and skills introduced in year 4 to ensure a spiral curriculum of learning and support progression towards independent prescribing practice.

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Collaborating towards better care: an interactive workshop to support international medical graduates.

What's the why?

Supporting the successful integration of international medical graduates (IMGs) and promoting inclusive, reflective practice is vital to enable IMGs to thrive within a new healthcare system. While multiple initiatives exist for supervisors and IMGs themselves, effective integration relies on a shared commitment from the multidisciplinary team (MDT). IMGs must often learn on the job and rely heavily on the support of colleagues. Every member of the MDT can contribute to creating an environment in which IMGs feel welcomed, supported and empowered, which can ultimately strengthen team cohesion and improve patient care.

What have you done?

We developed an interactive workshop that enables participants to recognise the common challenges and support needs experienced by IMGs integrating into a new healthcare system, including the important role of the MDT in this process. Through case-based discussions and principles of interprofessional education, participants identify practical strategies that can promote inclusivity and create supportive environments for IMGs.

What is next?

This workshop has been piloted locally, refined through feedback, and delivered at the ASME ASM 2026 conference in Birmingham. It is now being packaged as a resource that can be made available to departments across NHS Lothian.

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Recognise, Listen, Support, Act- Gender Based Violence Training

What's the why?

Gender Based Violence (GBV) is a significant issue that affects trainees, students and staff across healthcare and higher education. Supervisors and educators may be among the first people to receive a disclosure of GBV, yet many report feeling uncertain about how best to respond. We identified a need for practical, trauma-informed training that would help supervisors feel more confident in supporting disclosures while also increasing awareness of GBV within healthcare learning and working environments.

What have you done?

This project was completed by project team comprising of Amritha, Eleanor, Emma P, Jenny and Sara. Together, we developed and delivered a training worhsop for educational and clinical supervisors focused on recognising, responding to and signposting disclosures of GBV.

A key output was the creation of a disclosure training video, developed with Medical Photography and an undergraduate scholar. The video demonstrates an initial disclosure conversation and introduces a practical framework to guide supervisors during an initial discussion. This resource has attracted considerable interest due to its practical and accessible approach.

The training was piloted in April 2026, with valuable feedback from MED colleagues helping to refine the content. The project was subsequently presented at the NES Conference in collaboration with the University of Edinburgh, the NHS Lothian Equality, Diversity and Inclusion Conference, National Wellbeing Week, and the Sexual Harassment Network hosted by Scottish Government. Modified versions were created and developed for wider staff groups, extending learning beyond supervisors alone.

What is next?

Building on this work, we have partnered with PSDS and EmilyTest to develop a national online learning module on GBV for all incoming FY1 doctors in Scotland. The module will be piloted during shadowing week and aims to raise awareness and improve confidence in responding to GBV from the earliest stages of postgraduate training.

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One year of clinical debriefing: progress, partnerships, and practice

Project team: Dr Emma Claire Phillips, Dr Stephen Waite, Dr Jocelyne Velupillai, Dr Edward Mellanby, Dr Vicky Tallentire.

Acknowledgements: We thank Dr Charlotte Dewdney and Dr Katherine Ralston for their early work in this project.

What's the why?

Clinical debriefing (CD) is a structured reflective conversation following clinical events, intended to support learning, team performance, and patient safety. Evidence indicates that effective CD can improve staff experience, team working, processes and patient outcomes.

The CD project aims to deliver educational sessions to interdisciplinary staff in NHS Lothian to motivate participation in CD and provide them with skills in CD facilitation. It also aims to support departments in introducing and sustaining CD programmes. Our hope is to increase both the quality and quantity of CDs in NHS Lothian, leading to improvements for healthcare teams and our patients.

What have you done?

We have had a busy year delivering teaching and supporting CD activities in NHS Lothian. In addition, we have focused on scholarship activities, including a series of interviews with international experts to inform our practice and develop a collaborative network.

Below is a summary of our activities:

- Teaching
    - 5 workshops for resident doctors across different specialties
    - 3 one-day facilitators' courses for interdisciplinary teams
    - Online session delivered to all medical registrars across Scotland
- Implementation support
    - St John's Hospital Maternity unit: support with debriefing programme implementation
    - Victoria Hospital Kirkcaldy ICU: adaptation of Theatre Team Tool
    - Royal Infirmary of Edinburgh & Western General Hospital ICUs: use of Theatre Team Tool for routine mid-shift debriefings
- Scholarship

    - 4 published articles
    - 1 academic letter
    - 2 oral presentations at national conferences
    - 1 poster presentation at international conference
    - Featured discussion on Simulcast Journal Club podcast
- Collaboration
    - 9 interviews with international experts in clinical debriefing

What is next?

Looking ahead, we are excited to build on this year's progress by expanding our team, strengthening our educational offer, and embedding CD more firmly within NHS Lothian. Our focus will be on sustaining delivery, translating learning into practice, and developing structures that support long-term improvement and collaboration.

Key priorities for the coming year include:

- Welcoming new team members in the incoming Medical Education Fellow cohort.
- Continuing delivery of workshops and the facilitators course, alongside follow-up questionnaires with previous attendees to assess transfer of learning into clinical practice.
- Disseminating insights from expert interviews through presentations and peer-reviewed publications.
- Establishing a NHS Lothian CD Community of Practice.
- Introducing CD as a quality improvement project within the RIE Emergency Department.

We look forward to presenting our continued progress at next year's Showcase.

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Emotions and learning in medical emergencies: midway reflections and future directions

Dr Emma Claire Phillips

Supervisors: Dr Vicky Tallentire, Dr Jane Hislop, Professor David Hope

What's the why?

The Medical Education Directorate is supporting my pursuit of an MD in Medical Education at the University of Edinburgh. My research explores the emotions experienced by newly qualified doctors while managing medical emergencies, and how these shape learning. These experiences are often novel and occur during a critical period of professional identity formation. Understanding this relationship may inform initiatives that enhance preparedness and support early-career doctors.

What have you done?

I am currently midway through the MD programme and, having completed data collection, am now engaged in analysis. The study includes responses from 104 participants who completed a SenseMaker survey, generating narrative and quantitative data for a mixed-methods analysis. This presentation reflects on three key insights from my research journey so far and considers future directions.

Reflection 1: The importance of looking beyond medicine

Healthcare can be remarkably siloed, yet many concepts relevant to my research have been extensively explored elsewhere. My literature review examined emotions and learning in emergency contexts across professions including policing, fire and rescue services, pre-hospital care, and disaster medicine. Engaging with these wider bodies of work enriched my theoretical framework and challenged assumptions commonly embedded within medical education research.

Reflection 2: People genuinely want to help

A consistent lesson throughout this project has been the value of collaboration. Recruitment was only possible through the support of Medical Education Fellows and the simulation team, while the research design benefited from feedback from supervisors, colleagues, and participants. I also

received valuable guidance from international experts at the Rogano and SESAM conferences. This has reinforced how willing people are to share their time, expertise, and support when asked.

Reflection 3: Feeling lost is a normal part of the journey

The past year has included numerous challenges, setbacks, and unexpected obstacles. While uncertainty can be uncomfortable, I am gradually becoming more accepting of it as an inherent part of doctoral research. Developing a growth mindset has been essential, although putting this into practice is often easier said than done.

What is next?

Over the coming months, I will focus on analysis, further developing expertise in the methodologies underpinning this research. This will be followed by thesis preparation and publications. My priority is to generate credible, participant-centred findings that provide meaningful, practically relevant insights for medical education and clinical practice. I look forward to sharing the study findings at next year's Showcase.

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TALKS WERE THEN GIVEN ABOUT OUR UNDERGRADUATE PROJECTS, INCLUDING PROJECTS COMPLETED BY OUR FANTASTIC UG SCHOLARS.

INTRODUCTIONS GIVEN BY MED'S OWN ANT AND DEC (JOE AND JOCELYNE). DR SARA ROBINSON WELCOMES THE CROWD.

MED'S SCHOLARSHIP ACHIEVEMENTS ARE CELEBRATED!

THE BREAK ALLOWED FOR SOME NETWORKING OPPORTUNITIES

Q&AS ALLOWED SPACE FOR OPEN DISCUSSION ABOUT ALL THE PROJECTS PRESENTED.

PROF SIMON EDGAR THEN CLOSES THE SHOW.

AWESOME PROJECTS WORKING WITH POSTGRADUATES WERE THEN PRESENTED BY NUMEROUS TEAM MEMBERS.

MOST IMPORTANTLY, THE INAUGURAL GREAT MED BAKE OFF WAS WON BY HANNAH MARTIN. THE RUNNER-UP WAS JOE MCKAY.

BEHIND THE SCENES PHOTOS OF ALL THE HARD WORK (ESPECIALLY BY EMMA AND EL).

ALSO MEETING A MINIATURE MEF IN THE MAKING.

Designing simulation for competing demands: an innovation to make cognitive overload visible during high risk prescribing

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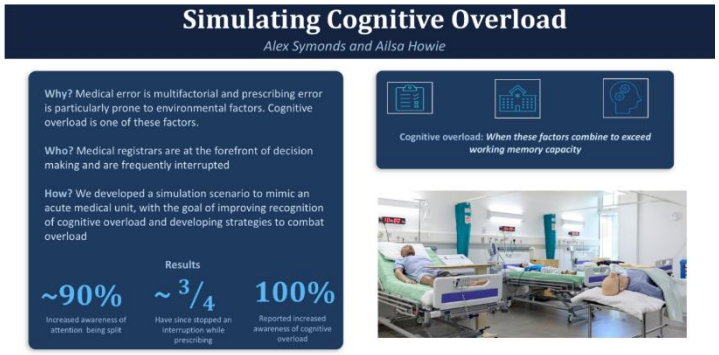
The acute medical unit (AMU) is a high-risk transition point between the community and secondary care where diagnostic, medication and monitoring errors lead to poorer patient outcomes. Within the AMU medical registrars are often the most senior decision maker and work in an environment under high cognitive load. Cognitive overload contributes to the likelihood of errors, particularly when prescribing.

Simulation allows challenging environments to be reproduced safely, enabling trainees to develop strategies for managing cognitively demanding tasks while under pressure. We developed a simulation scenario designed to reproduce competing demands encountered on the AMU; helping medical registrars to recognise cognitive overload, develop strategies to manage interruptions and complete tasks during high-risk clinical activities.

A simulation scenario was developed by two clinicians and the pharmacy team, using a simulated ward with simulated participants and a mannikin. Participants received a prescribing task and were simultaneously exposed to a structured sequence of medical and non-medical interruptions, replicating competing demands on the AMU. The scenario was designed to elicit the efficiency-thoroughness trade-off, cognitive offloading, and interruption management. An electrocardiogram (ECG) from a 'low-risk' patient tested inattentional blindness. Participants completed a post-scenario questionnaire immediately following the session and an impact questionnaire one month later.

Twenty-six medical registrars participated across 5 sessions. All participants made at least 1 prescribing error, with the majority making 5 or more. A minority (*n=7*) identified the ECG abnormality. While all participants immediately rated the scenario as useful and relevant, thematic analysis highlighted the specific utility of the debriefing. The impact questionnaire highlighted a distinction between awareness and behaviour change: 90% reported increased awareness of split attention, while 70% reported having actively stopped an interruption while prescribing. One participant described asking colleagues to hold questions until prescribing was complete; another recognised previously undetected errors: "I didn't think I had made any errors … but I had made a few".

This simulation scenario has been adapted into a workshop for medical registrars, broadening spread of learning, and has been further developed in a specialty specific scenario for psychiatry trainees. Future work will expand the scope and target addition groups of resident doctors.



New Year 4 Placements: A Multifocal, Mixed-Methods Evaluation

What's the why?

Year 4 clinical placements in Infectious Diseases (ID) and Clinical Neurosciences (incorporating Neurology, Neurosurgery, Stroke, and Neurorehabilitation) were created for the 25/26 academic year. New evening placements in the Lothian Unscheduled Care Service (LUCS) were also added to General Medicine placements.

Currently, undergraduate placements are evaluated by default via the ACT questionnaire, a standardized survey of students at the end of placements. The inability to tailor the survey to the placement, the time taken for results to reach placement organisers, and low participant numbers, can pose challenges to interpreting and acting on this feedback.

The aim of this project was to carry out an alternative evaluation of the new placements, and provide tailored, prompt, and actionable feedback to placement organisers. This would allow for iterative improvement and re-evaluation, with the overall aim of developing the placements' educational value.

What have you done?

Mixed-methods evaluations, incorporating surveys and focus groups of students, were designed. For LUCS and ID, the experience of staff involved in supervising students was explored, and the LUCS evaluation included a patient survey. Focus groups were designed around empathy-mapping, a technique for exploring experiences of participants in a particular setting.

Feedback was shared with placement organisers from January 2026 onwards. Placements were subsequently re-evaluated if further changes were made. Information on improvements made in response to feedback was shared with students to support their continued engagement in evaluation.

For LUCS, insights from surveys and focus groups led to the production of expectation setting documents for staff and students, clearer integration with the General Medicine placement, and the introduction of Saturday shifts. From the first to the second half of the year, students' mean overall rating of the LUCS placement increased from 6.8/10 to 7.8/10. The proportion agreeing that the placement met their learning needs also increased, from 58% (17/29) to 69% (9/13). All patients surveyed (n=8) supported students continuing to attend.

For ID, developments included the expansion of clinical learning opportunities, the introduction of targeted teaching, and an (ongoing) redesign of online learning materials. From the first to the second half of the year, students' mean rating of the ID placement increased from 6.6/10 to 7.4/10. The proportion who agreed their learning needs were met by the placement increased from 48% (20/42) to 80% (35/44).

For Neurosciences, there was consistent praise for the staff and the quality of teaching, but the breadth of available clinical opportunities was a challenge. The decision was made to explore a larger-scale restructuring of the placement for August 2026.

What is next?

The project demonstrated that collaboration between MED, clinical, and university teams, can lead to meaningful improvement in placements within an academic year. It also showed the importance of including multiple stakeholder groups in evaluation to prevent valuable insights being overlooked.

Relevant information documents, including the surveys, information on empathy mapping, and key lessons from the project, have been developed to support similar evaluations in the future.

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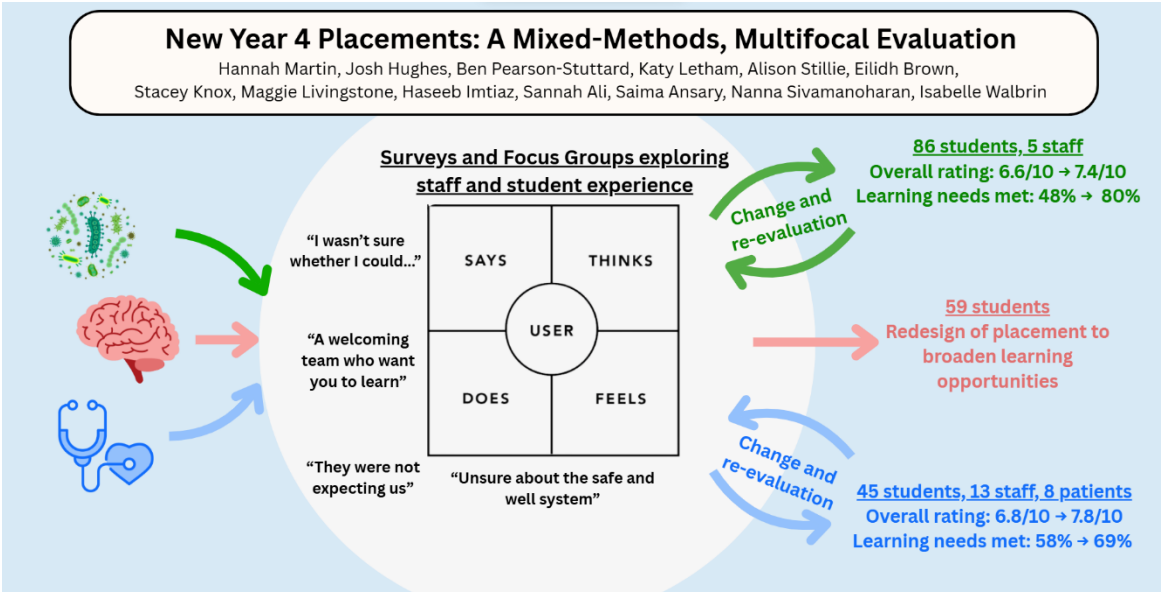

Racial Inclusivity in Medical Education: Clinical Educator Perspectives

By Ellen Mphande and Maggie Livingstone, Supervised by Dr Ashley Simpson

What's the why?

Black students continue to face challenges of navigating a healthcare system that is associated with adverse healthcare outcomes, biases, differential attainment, and often face compounding challenges due to intersectionality of different socio-demographic factors. Appropriate inclusion of Black populations in healthcare professions education is essential to supporting students and trainees, and developing a healthcare workforce equipped to provide equitable and culturally responsive care. However, educators may face challenges in teaching topics relating to race, ethnicity, and cultural diversity, particularly where curricula and teaching resources have historically centred White populations. Understanding clinical educators' experiences, preparedness, and support needs is critical to informing future curriculum development and educator training.

What have you done?

A scope of literature around racial inclusivity related to Black populations was conducted, and the search was narrowed to black students and trainees. From this, we identified a gap in understanding clinical educator perspectives, as they are the forefront to training current and future health professionals. Data was collected through 30-60 minute semi-structured interviews, initially piloted with one clinical before the 10 participants in this project. The interviews were voice recorded, transcribed and anonymised. The interview narratives have been analysed, prompting generation of the following initial themes (subject to change) :

1.Vviewing whiteness as the default. Whiteness is understood as universal or neutral, resulting in the omission or displacement of racial identity.

2. Legitimacy of race when it is clinically exceptional, such as when it is measurable and has clinical consequences.

3. Understanding racial inclusion through intersecting factors such as culture, religion, language, migration and IMG status which is important, but can displace attention from racism and leave institutional norms unexamined.

What is next?

The next steps are to complete our analysis and reflexivity, before beginning on writing our output. We hope that these findings will contribute to recommendations for strengthening educator support and enhancing inclusivity within healthcare professions education.

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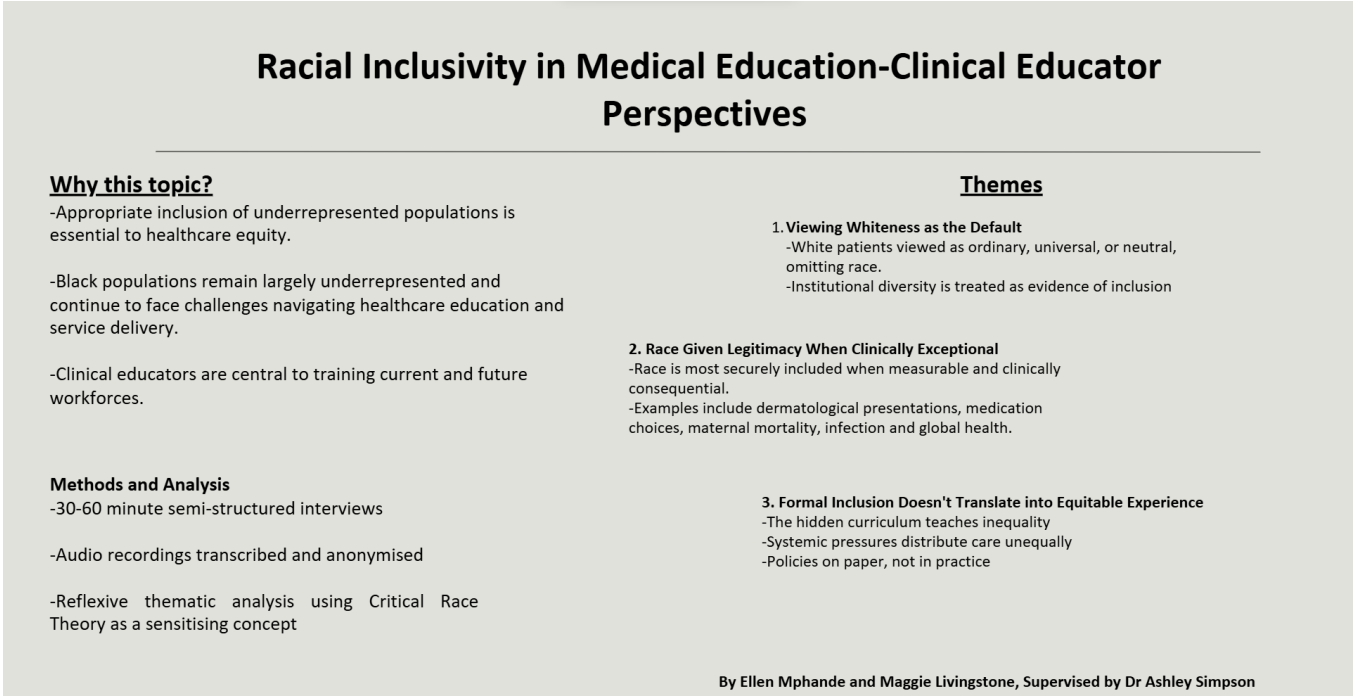

Gentamicin Prescribing Project

What's the why?

Gentamicin is a high-risk medicine, with potential to cause nephrotoxicity and irreversible ototoxicity. In Lothian, errors relating to gentamicin are increasing, despite existing education for FY doctors on how to prescribe it safely. Existing teaching focuses on the process of prescribing gentamicin, rather than increasing clinical knowledge. Simplifying the process of prescribing gentamicin will hopefully allow education sessions to deepen FY doctors' understanding to optimise gentamicin use in clinical practice.

The existing process for prescribing gentamicin is felt to be complex, time-consuming and cumbersome. Efforts to mitigate gentamicin risks (e.g. additional paper monitoring charts, individualised dosing calculator, time window for blood monitoring) may have inadvertently introduced further issues. A recent FY2 QI project found that 75.8% of staff (n=33; 48% doctors) felt the NHS Lothian gentamicin monitoring chart is not well-designed. Previous QI projects have not resulted in lasting improvement, as these tend to introduce additional steps rather than simplifying the process.

What have you done?

A particular "hot spot" for gentamicin errors is after the transfer of patients from ED to AMU at the RIE, therefore this was our starting point for **discovery**.

- Initial process mapping of prescribing, administration and monitoring processes – "work as imagined"
- Informal interviews with ED and AMU staff to gather local intelligence on perceived barriers and workarounds – "work as disclosed" process map.
- Learning from other patient services, Scottish health boards, and NHS Trusts in England to understand alternative models for prescribing and monitoring
- Observation of gentamicin prescribing processes in ED by Y6 MED Scholars
    - Four real-time observations have been entered into the last 10 patients tool. Challenge of being able to observe at the right time considered to make this too resource-intense for 10 patients
    - Waiting for bloods to be reported on Trak taking longest; clinical appropriateness of this is hard to determine
    - 21 retrospective observations entered into run chart
- Phase 2 of discovery is processes in AMU: handover/transfer of information & documentation from ED, process of reviewing which meds have already been given to patient (not restricted to gent as we know that duplicate dosing is problematic for other meds too), process for prescribing gentamicin in AMU
    - Creation of audit tool to review Trak handovers, which has been piloted by AMU FY1 and ANP

What is next?

- Once we have understood the problem, define it and generate ideas for testing with stakeholder input
- Support Antimicrobial Management Team with development of national and local educational resources on gentamicin

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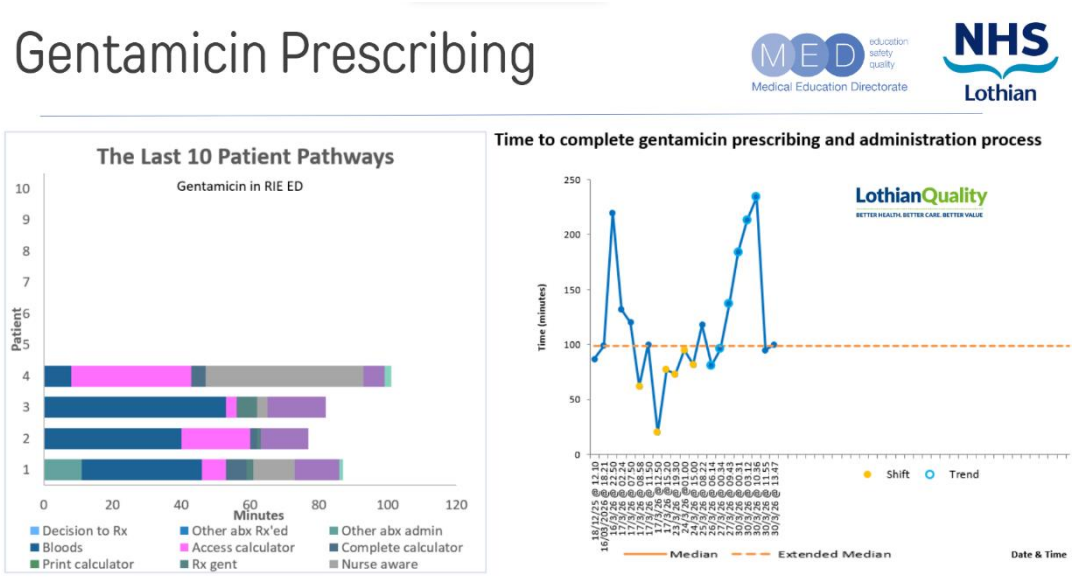


Improving the learning experience for Yr 3 HCP Med students at WGH.

What's the why?

UG RAG Data 2025 showed the need for improvement across many domains.

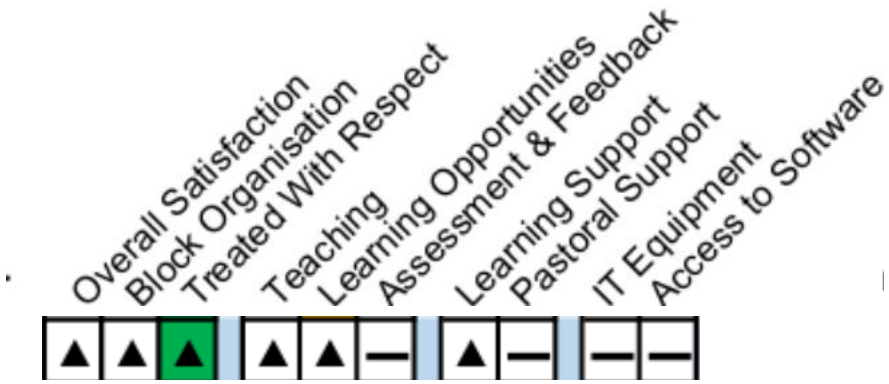
What have you done?

- Focus group with students to better understand the issues within the system.
- Linked the cohort with the clinical skills facilitator at WGH to provide bespoke clinical skills training.
- Worked with the MED sim team to see if Sim Converse could be a useful tool to enhance the students' learning.
- Focus group with the students halfway through the year to touch base and see if there have been any improvements and present sim converse to them to gauge interest.
- Developed an HCP Med cohort on the Sim Converse platform with 5 meaningful activities which were launched to the students.

What is next?

- Unfortunately, due to the time of the academic year in which Sim Converse was launched to the students there has been no engagement with the platform. Plan to look at this in the new academic year for the new cohort of year 3 students.

- 2026 UG RAG Data shows significant improvement across multiple domains with the addition of clinical teaching fellows in both MOE and Oncology making a positive impact as well as the clinical skills facilitator linking in with the students.



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MED SHOWCASE · 2026 PROJECT SUMMARY · WGH

YEAR 3 · HCP MED · WESTERN GENERAL HOSPITAL

Improving the *learning experience* for Year 3 HCP Med students.

A year-long effort to close gaps surfaced by UG RAG 2025

01 *Context & Rationale*

UG RAG 2025. Multiple areas flagged for improvement in the Year 3 experience.

Overall Satisfaction
Block Organisation
Treated With Respect
Teaching
Learning Opportunities
Assessment & Feedback
Learning Support
Pastoral Support
IT Equipment
Access to Software

02 *Actions Taken*

Initial student focus group to surface the key issues.

Cohort linked to the WGH Clinical Skills Facilitator for tailored teaching.

Collaboration with the MED simulation team to explore Sim Converse.

Mid-year focus group to assess progress and appetite for Sim Converse.

Bespoke HCP Med cohort launched on Sim Converse with 5 activities.

03 *Outcomes*

2026 UG RAG. Significant improvement across multiple domains.

Impact linked to new clinical teaching fellows in MOE and Oncology.

Strong engagement reported with the Clinical Skills Facilitator.

Overall Satisfaction
Block Organisation
Treated With Respect
Teaching
Learning Opportunities
Assessment & Feedback
Learning Support
Pastoral Support
IT Equipment
Access to Software

04 *Next Steps*

Late launch meant no current engagement with Sim Converse yet.

Review platform use and engagement with next year's Year 3 cohort.

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Evaluating the Feasibility and Impact of an Interprofessional Simulation Session in Primary Care Education

What's the why?

Primary care professionals often train within their own professional pathways yet delivering effective patient care relies on collaborative working within multidisciplinary teams. This can create challenges around communication, understanding of professional roles, and collaborative decision-making. Interprofessional simulation-based education (IPSE) combines principles of interprofessional education and simulation-based learning to provide opportunities for learners to practice collaborative working in a realistic but safe environment.

Previous literature exploring IPSE within primary care has highlighted potential benefits in areas such as teamwork, communication and role understanding. However, challenges remain around the implementation of the intervention including time constraints and the practicalities of delivering interprofessional learning within primary care environments.

This project explores whether a brief, low resource interprofessional simulation session can be feasibly delivered within primary care education settings. The aim is to evaluate the acceptability of this approach and explore its perceived educational impact on teamwork, communication, and role clarity among healthcare learners and professionals.

What have you done?

An interprofessional simulation session has been designed to be delivered across 3-5 practices across Lothian. The session brings together participants from different professional backgrounds, including medicine, nursing, pharmacy, and allied health professions.

The simulation uses low-fidelity patient representation, allowing participants to work through an evolving acute asthma scenario without requiring simulation equipment or facilities. Participants are encouraged to respond as a multidisciplinary primary care team, exploring how different professional roles contribute to recognising deterioration, gathering information, making decisions, and coordinating escalation.

The session consists of three components: a pre-brief to establish expectations, an interprofessional simulation scenario, and a structured facilitator-led debrief. The debrief focuses on reflection around teamwork, communication and professional roles.

The intervention will be evaluated using pre- and post-session Interprofessional Collaborative Competency Attainment Survey (ICCAS) questionnaires, alongside qualitative participant feedback exploring the usefulness, acceptability, and perceived educational value of the session. Feasibility will also be assessed through practical measures including recruitment, attendance, questionnaire completion, and the ability to deliver sessions across primary care settings.

What is next?

The next stage of the project is to deliver the simulation sessions and gather feedback from participants. Findings will help determine whether this type of brief, scalable interprofessional simulation is practical and valuable within primary care education.

These findings may help inform future development and evaluation of IPSE within primary care education. Future research could explore the longer-term impact of IPSE including whether repeated sessions influence collaborative working and the translation of interprofessional skills into clinical practice.

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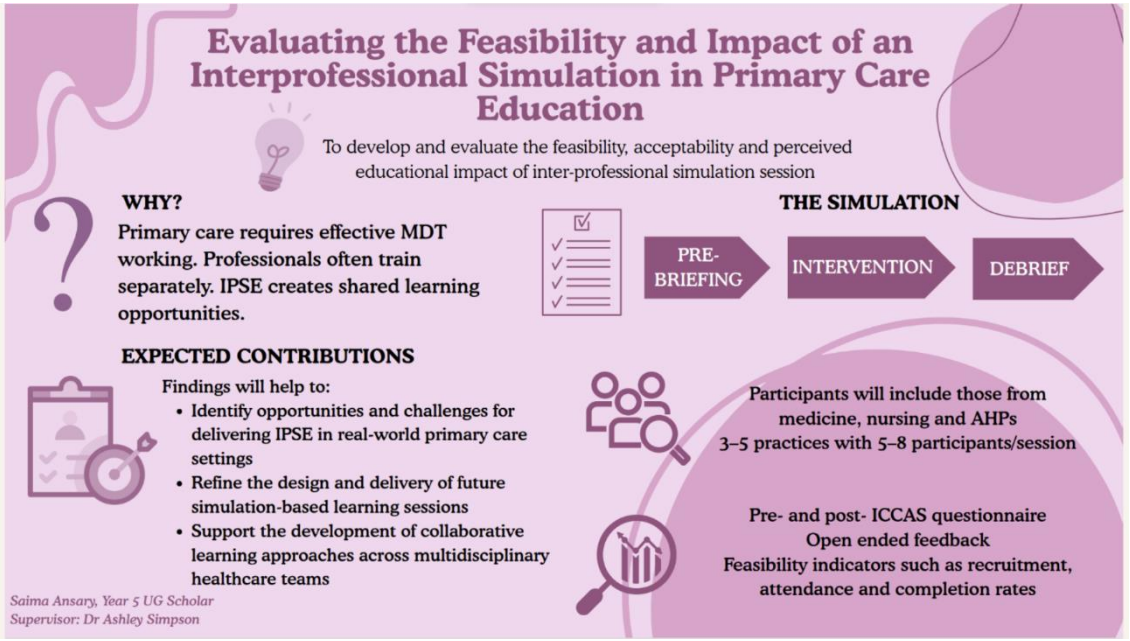


What makes work meaningful, and why should we care?

Stephen Waite, Michael Dodson, Cheryl Tudor, Simon Edgar, Victoria Tallentire

What's the why?

Resident doctors in the UK are under considerable strain. Burnout is widespread, attrition from training remains high, and dissatisfaction with working and training conditions is well documented. Most research and policy attention has focused on what is going wrong: measuring burnout, tracking attrition, and identifying deficits to be remedied.

Meaningful work offers a different lens. It is consistently associated with improved wellbeing, greater job satisfaction and reduced burnout. However, almost no research has examined what makes work meaningful for resident doctors in the UK, meaning that efforts to improve the training environment currently proceed without this evidence.

What have you done?

We undertook an empirical research project using SenseMaker, a narrative mixed-methods tool, surveying doctors-in-training across South East Scotland. Participants shared a story of a time their work felt meaningful, then interpreted their own account through a series of structured questions. In a 10-week period we received 124 responses spanning all stages of training.

The findings of this project are striking. While many participants shared familiar stories describing deriving meaning from helping patients, accounts were more nuanced than simple altruism. Many shared a moment where they personally made a difference, describing how their own effort and initiative directly contributed to positive outcomes. Other narratives referenced recognition from colleagues or gratitude from patients as being particularly meaningful. ‘Mattering’, both the perception of adding value and feeling valued as a result, seemed particularly important to our cohort.

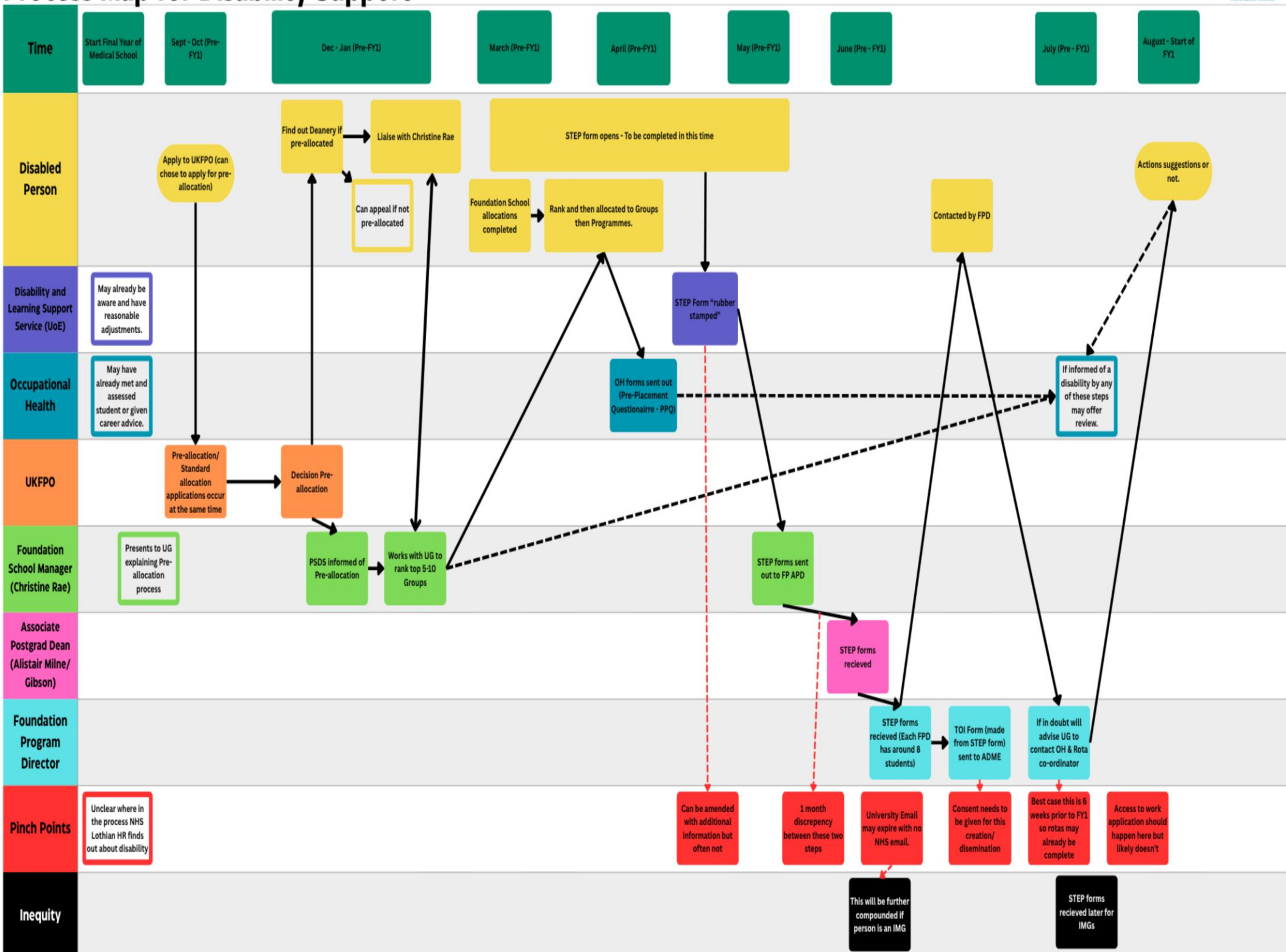
Learning also featured prominently, but less as skills acquisition than as professional becoming: being trusted with complexity and growing into competence. Many accounts were clearly developmental without participants framing them as such. Relationships, supervision and culture varied widely in their reported impact, and meaningful experiences occurred even where these conditions were suboptimal. Although remuneration was rated comparably important to meaningfulness, it appeared in almost none of the narratives.

What is next?

The findings of this project are being prepared for publication and will be shared via internal report. The next steps for this work are unclear; much remains to be learned on meaningfulness, including what disrupts meaning for resident doctors and whether meaningfulness can be deliberately fostered within training. In the meantime, practical steps will be undertaken to improve the local training environment, aiming to provide residents with visible ownership of their clinical work, individual recognition, and to underline the developmental value of everyday service. We would welcome discussion with colleagues about the implications of this work.

SENSEMAKER®

Process Map for Disability Support



Navigating the Support Paradox

Clinical educator perspectives on student support and assessment

STUDY IN PROGRESS

Haseeb Imtiaz | Dr Ashley Simpson | NHS Lothian | Edinburgh Medical School

Why This Matters

WP reality: medical schools have diversified entry, but placement still exposes social and material barriers.

Unspoken signals: educators may notice extra shifts, long commutes, financial strain or unfamiliar professional conventions.

Hidden curriculum: students may mask accent, background or ways of speaking to fit hospital norms.

Core tension: a moral pull toward equity sits beside responsibility for professional standards.

Research aim

To understand how clinical educators interpret these signals and navigate moments when being a supporter and fair assessor conflict.

No findings are presented yet: the poster summarises the rationale, design and planned contribution.

The Support Paradox

How do educators' reason through perceived structural disadvantage when support and assessment pull in opposite directions?

Scenario prompt example:

A student repeatedly arrives 15 minutes late to surgery. You learn they cannot afford a car and the bus arrives late. Clinically, they are doing well, but the attendance criteria say they are failing. How do you handle sign-off?

Why scenario prompts?

They create a safer third-person space for sensitive assessment dilemmas and expose reasoning, assumptions and professional norms.

Methodology

Planned qualitative interview study

Participants: up to 10 University of Edinburgh / affiliated NHS clinical educators with dual responsibility for supervising and assessing students.

Sampling: purposive, seeking variation across roles, clinical settings and educator backgrounds.

Data collection: 30 - 45 minutes semi-structured interviews using scenario-based prompts to explore undisclosed hardship and the MUM effect (avoiding uncomfortable information).

Analysis: reflexive thematic analysis of professional judgements, justifications and moments where those justifications come under pressure.

What will the interviews explore?

Avoiding difficult conversations – the "MUM effect"

Seeing strengths, not only barriers

Balancing equity and standards

Expected impact

- Bridge the gap between institutional intent and daily placement reality
- Inform educator development, clearer placement guidance and University efforts to reinstate a dedicated WP support system.

Project next steps

1 Recruit → 2 Refine Interview scenarios → 3 Interview + transcribe → 4 Reflexive analysis → 5 Themes + recommendations

Why?

- Loss of PULSE prescribing
- Year 6 feedback requested earlier practical prescribing teaching
- Improve prescribing competence, safety, and FY1 preparedness

What have we done?

- New MED pharmacist post (ACT funded)
- Developed the *Ready to Prescribe* Year 4 workshop series aligned to GMC Outcomes for Graduates
- Each student will attend four 90-minute workshops

Next steps

- Deliver and evaluate the workshops
- Update year 6 workshops to create a spiral curriculum

Supporting International Medical Graduates

Jenny Houston, Jocelyne Velupillai, Jan Engel-Morton, Goran Zangana

WHY

- Diversity is not enough - inclusion matters
- Inclusion is a shared responsibility
- Small actions make a big difference

WHAT

- Interactive workshop
- Case-based discussions
- IPE principles
- Co-produced practical strategies

NEXT

- Local pilot
- Delivered at ASME ASM 2026
- Reusable workshop package

NHS Lothian

MED education safety quality
Medical Education Directorate

THE UNIVERSITY of EDINBURGH
Edinburgh Medical School

Recognise, Listen, Support, Act

Gender Based Violence Training

The Scottish Government

NHS Education for Scotland

National Wellbeing Champions Network

National Wellbeing Week
22-28 June 2026

supporting compassionate leadership in health, social care, social work, local government and third sector

EmilyTest

Tackling Gender Based Violence in Educatior

"A structured, reflective team conversation following clinical events, intended to support learning, team performance, and patient safety."

Teaching

5 workshops for resident doctors
3 one-day facilitators' courses
Online session delivered to all medical registrars across Scotland

Scholarship

4 published articles
1 academic letter
2 oral presentations at national conferences
1 poster at international conference
Featured discussion on Simulcast

Implementation support

SJH Maternity unit
VHK ICU
RIE & WGH ICUs

Collaboration

9 interviews with international experts in clinical debriefing

One year of clinical debriefing: progress, partnerships, and practice

MED Showcase July 2026

Simulating Cognitive Overload

Alex Symonds and Ailsa Howie

Why? Medical error is multifactorial and prescribing error is particularly prone to environmental factors. Cognitive overload is one of these factors.

Who? Medical registrars are at the forefront of decision making and are frequently interrupted

How? We developed a simulation scenario to mimic an acute medical unit, with the goal of improving recognition of cognitive overload and developing strategies to combat overload

Cognitive overload: ***When these factors combine to exceed working memory capacity***

Results

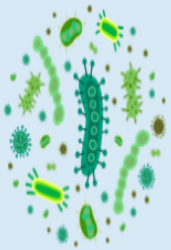
~90%
Increased awareness of attention being split

~ 3/4
Have since stopped an interruption while prescribing

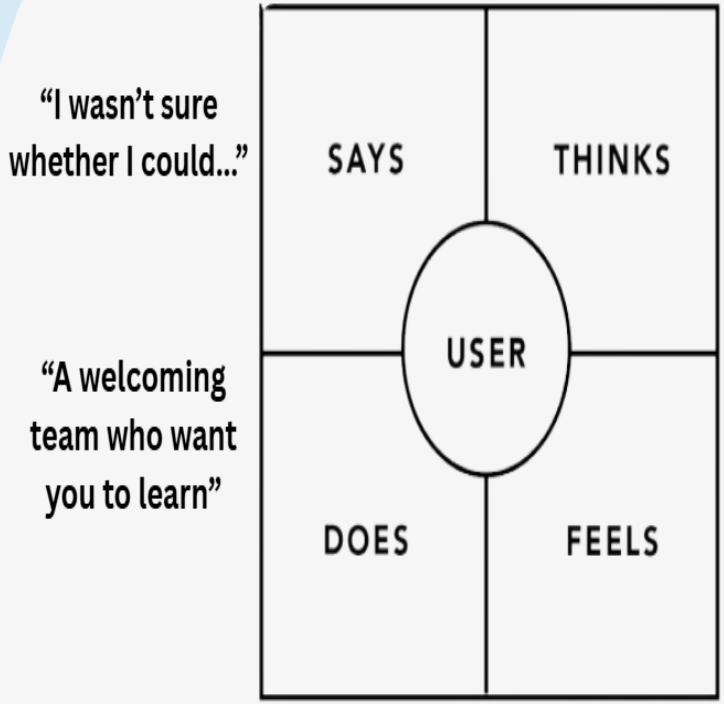
100%
Reported increased awareness of cognitive overload

New Year 4 Placements: A Mixed-Methods, Multifocal Evaluation

Hannah Martin, Josh Hughes, Ben Pearson-Stuttard, Katy Letham, Alison Stillie, Eilidh Brown,
Stacey Knox, Maggie Livingstone, Haseeb Imtiaz, Sannah Ali, Saima Ansary, Nanna Sivamanoharan, Isabelle Walbrin



Surveys and Focus Groups exploring staff and student experience



Change and re-evaluation

86 students, 5 staff
Overall rating: 6.6/10 → 7.4/10
Learning needs met: 48% → 80%

59 students
Redesign of placement to broaden learning opportunities

Change and re-evaluation

45 students, 13 staff, 8 patients
Overall rating: 6.8/10 → 7.8/10
Learning needs met: 58% → 69%

Racial Inclusivity in Medical Education-Clinical Educator Perspectives

Why this topic?

-Appropriate inclusion of underrepresented populations is essential to healthcare equity.

-Black populations remain largely underrepresented and continue to face challenges navigating healthcare education and service delivery.

-Clinical educators are central to training current and future workforces.

Themes

1. **Viewing Whiteness as the Default**
   -White patients viewed as ordinary, universal, or neutral, omitting race.
   -Institutional diversity is treated as evidence of inclusion

2. Race Given Legitimacy When Clinically Exceptional

-Race is most securely included when measurable and clinically consequential.
-Examples include dermatological presentations, medication choices, maternal mortality, infection and global health.

3. Formal Inclusion Doesn't Translate into Equitable Experience

-The hidden curriculum teaches inequality
-Systemic pressures distribute care unequally
-Policies on paper, not in practice

Methods and Analysis

-30-60 minute semi-structured interviews

-Audio recordings transcribed and anonymised

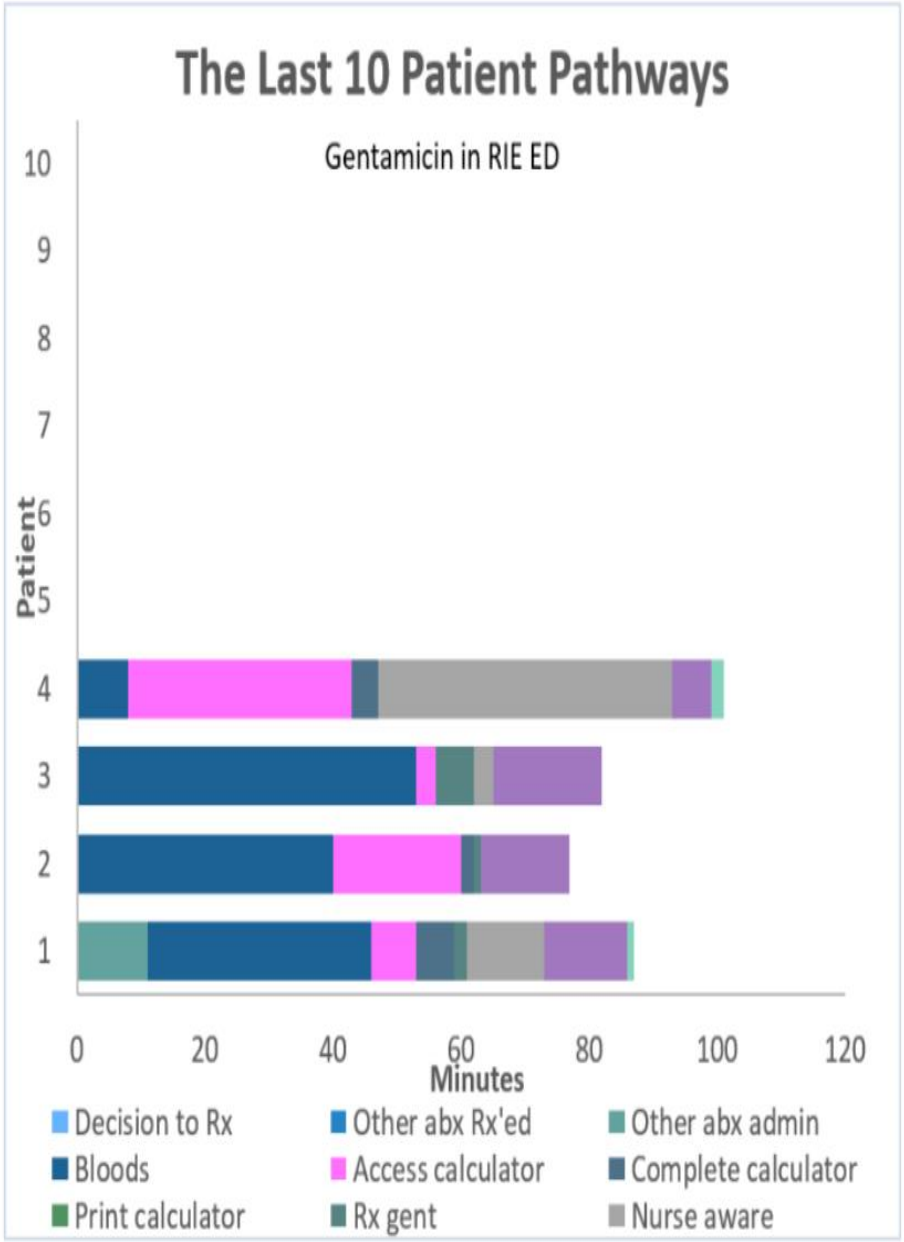
-Reflexive thematic analysis using Critical Race Theory as a sensitising concept

By Ellen Mphande and Maggie Livingstone, Supervised by Dr Ashley Simpson

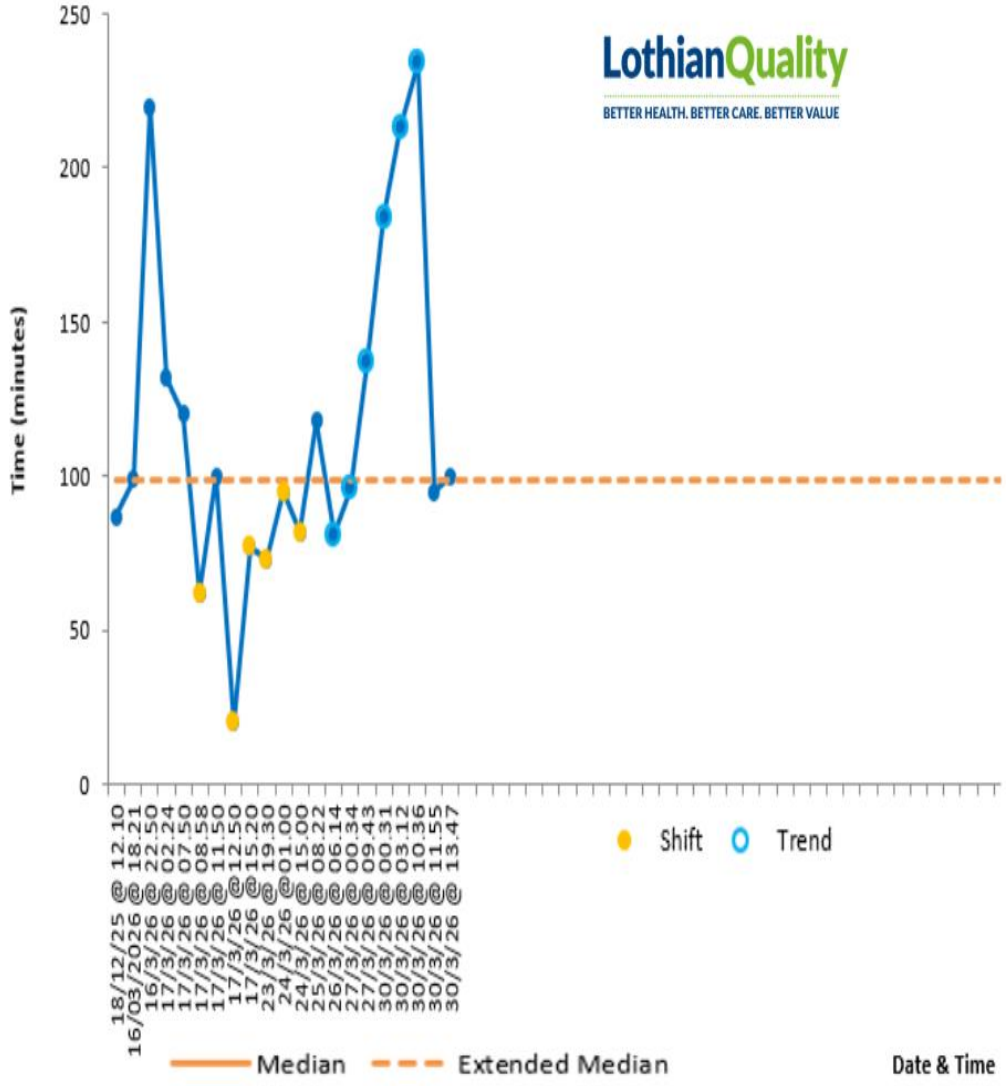
Gentamicin Prescribing

Medical Education Directorate

NHS Lothian



Time to complete gentamicin prescribing and administration process



YEAR 3 · HCP MED · WESTERN GENERAL HOSPITAL

Improving the *learning experience* for Year 3 HCP Med students.

A year-long effort to close gaps surfaced by UG RAG 2025

01 *Context & Rationale*

UG RAG 2025. Multiple areas flagged for improvement in the Year 3 experience.

02 *Actions Taken*

Initial student focus group to surface the key issues.

Cohort linked to the WGH Clinical Skills Facilitator for tailored teaching.

Collaboration with the MED simulation team to explore Sim Converse.

Mid-year focus group to assess progress and appetite for Sim Converse.

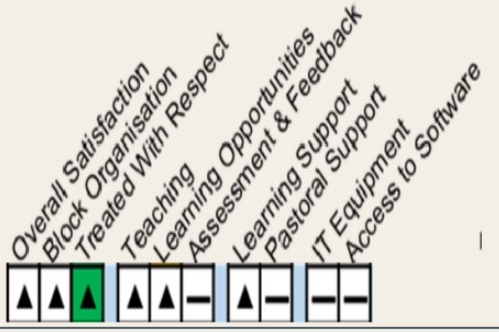
Bespoke HCP Med cohort launched on Sim Converse with 5 activities.

03 *Outcomes*

2026 UG RAG. Significant improvement across multiple domains.

Impact linked to new clinical teaching fellows in MOE and Oncology.

Strong engagement reported with the Clinical Skills Facilitator.



04 *Next Steps*

Late launch meant no current engagement with Sim Converse yet.

Review platform use and engagement with next year's Year 3 cohort.

CONTACT **Eilidh Brown** Eilidh.brown8@nhs.scot or **Alison Stillie** alison.stillie@nhs.scot

Evaluating the Feasibility and Impact of an Interprofessional Simulation in Primary Care Education

To develop and evaluate the feasibility, acceptability and perceived educational impact of inter-professional simulation session

WHY?

Primary care requires effective MDT working. Professionals often train separately. IPSE creates shared learning opportunities.

THE SIMULATION

PRE-BRIEFING → INTERVENTION → DEBRIEF

EXPECTED CONTRIBUTIONS

Findings will help to:

- Identify opportunities and challenges for delivering IPSE in real-world primary care settings
- Refine the design and delivery of future simulation-based learning sessions
- Support the development of collaborative learning approaches across multidisciplinary healthcare teams

Participants will include those from medicine, nursing and AHPs
3–5 practices with 5–8 participants/session

Pre- and post- ICCAS questionnaire
Open ended feedback
Feasibility indicators such as recruitment, attendance and completion rates

Saima Ansary, Year 5 UG Scholar
Supervisor: Dr Ashley Simpson