MedStudentLead

The Australian Medical Student Leadership Framework.

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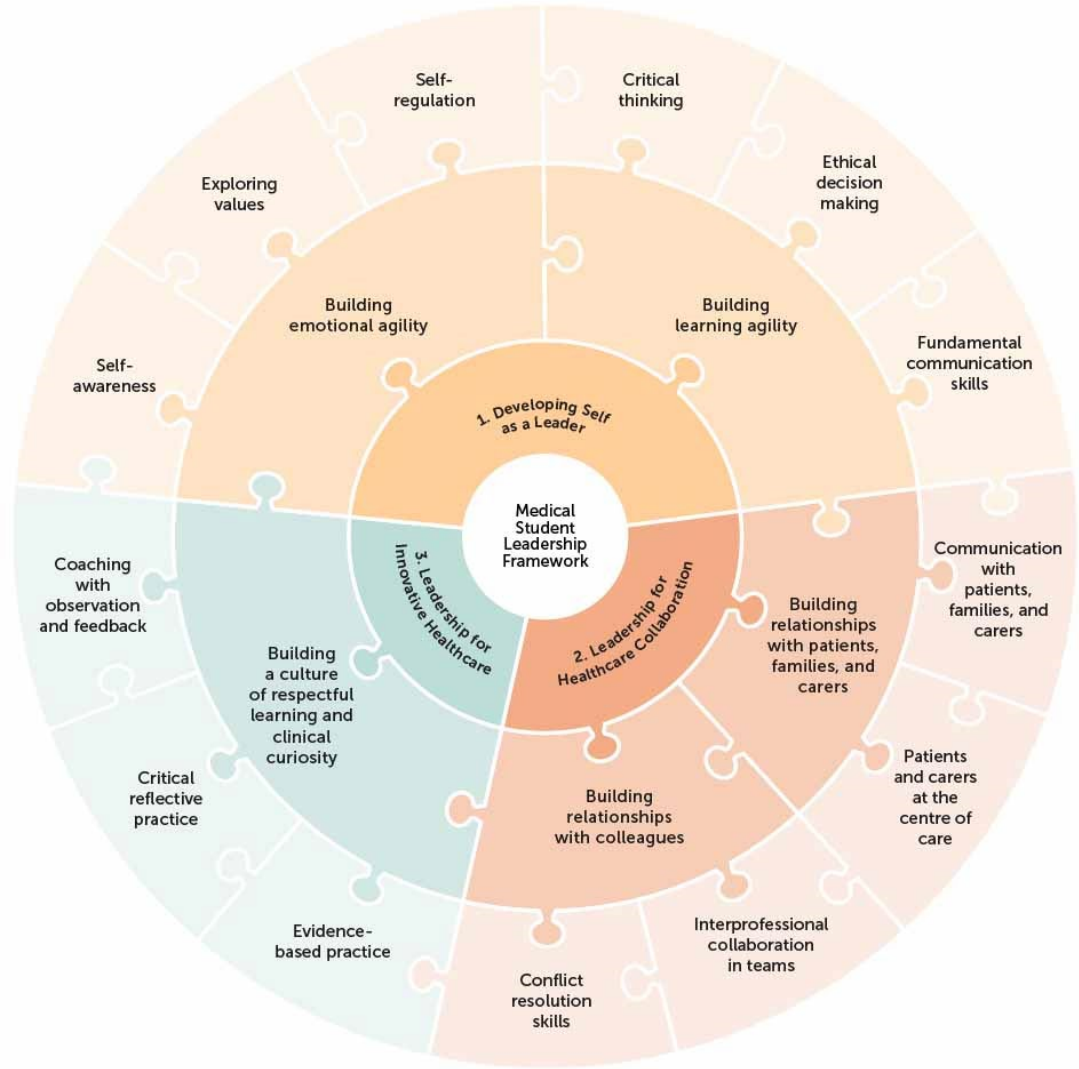

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Content

MEDICAL STUDENT LEADERSHIP EDUCATION (*MedStudentLead*) FRAMEWORK

How was the *MedStudentLead* Framework developed?

Australasian medical leadership study

The *MedStudentLead* Framework was developed from a multiphase PhD study examining stakeholder groups perspectives on medical leadership from different levels of the medical system. Stakeholders of this study included medical academics and Deans of medical schools, doctors, medical student association executives, and post-graduate training providers.[1,2] Questions asked were inter-connected to investigate best practice leadership training for the Australasian health system. To identify leadership competencies to be taught in medical education, a medical leadership competency matrix was developed from the book 'Leading and Managing Health Services: An Australian Perspective' and the Health LEADS Australia Framework.[3,4] A copy of this matrix was provided to all stakeholders via interview/focus group or survey.

The multiphase study started with an integrative review of medical leadership education, gaps in the literature, and a review of global medical leadership frameworks.[2] The first phase involved a review of leadership curricula and assessment in Australian and New Zealand medical schools.[1] The second phase involved a mixed-methods study of stakeholder perspectives on medical leadership and role-model training across the Australian medical education continuum. Each phase analysed and reported on (written up for publication), with results from each phase reflected on for contribution to the next study and phase. Phase three analysed the ratio data from the stakeholder completed medical leadership matrices, then added any barriers and recommendations from the previous three phases, resulting in the *MedStudentLead* Framework competencies.

Leadership competencies

Each competency received a percentage mark dependent on the number of stakeholders who agreed the skill was a necessary leadership competency to teach in medical school. Natural percentage groupings occurred between 100–85%, 63–53% and 45–8%. Therefore, a competency was deemed a High Priority skill and automatically added to the *MedStudentLead* Framework if 100–85% of participants agreed the skills was a necessary competency. Skills ranked between 63–53% were defined as a Medium Priority skill and considered for the *MedStudentLead* Framework. Any skill ranked between 45–8% were deemed a Low Priority skill and not added.

Some competencies were re-named to provide a greater understanding of the competency for both educator and students. For example, self-management was changed to self-regulation, and critical thinking and decision-making was shortened to critical thinking, as the framework already had an ethical decision-making competency. Inter-professional teamwork was also changed to collaboration with the healthcare team. Leadership skills based on the barriers and recommendations of studies one to three were also included [1,2] such as coaching with observation and feedback, and patients and carers at the centre of care. Communication was also split into two separate competencies of fundamental communication skills, and communication with patients, families, and carers.

Three key sections are identified for the *MedStudentLead* Framework. These sections are:

1. Developing Self as Leader;
2. Leadership for Healthcare Collaboration; and
3. Leadership for Innovative Healthcare.

These headings were preferred over the Health LEADS Australia Framework of Lead Self, Lead Others, and Drives Innovation. The *MedStudentLead* Framework sections and headings were created based on current transformative education literature of how to support building students mental models (their worldview of healthcare).[5,6] Validation of the *MedStudentLead* Framework has occurred by member checking with qualitative participants and feedback from medical education stakeholders.

Who is the *MedStudentLead* Framework for?

Academics and clinical staff

The *MedStudentLead* Framework was created for academics and clinical staff of medical schools to identify necessary leadership competencies for training medical students before they graduate as a registered medical doctor.

The *MedStudentLead* Framework also has an evaluation tool for academics to evaluate the current leadership teaching and assessment for their institution or medical program (see Section 4. Tools).

Medical students

Medical and other health professional students can use the *MedStudentLead* Framework to teach themselves about medical leadership. To build skills outside of the educational and professional settings, students can personally use the *MedStudentLead* Framework when observing choices, behaviours and interactions.

Using the Student Checklist, students can evaluate leadership competencies at their individual institution or medical program and, if required, advocate for specific leadership competencies to be taught in their medical program (see Section 4. Tools).

Policy makers

Accreditation bodies such as the Australian Medical Council can use the *MedStudentLead* Framework to update the Professionalism and Leadership domains of the Standards for Assessment and Accreditation for Primary Medical Programs.[7]

Specialist colleges

Specialist Colleges can review the *MedStudentLead* Framework for leadership skills training recommended for medical students. This would be helpful when reviewing their own leadership teaching.

Why is leadership in medical education important?

Medical leaders are required to nurture and shape the health service and organisational culture to ensure the delivery of safe and compassionate healthcare. This requires a focus on continuous quality improvement of staff, policies and processes, the work environment, the organisational values and resulting behaviours. Showing compassion for the unique work/life balances of staff is essential in the health service culture. Having trained leaders to provide quality feedback to staff allows individual staff to identify strengths and weaknesses, but to also confirm the trust and integrity of the health team, leader(s) and the organisation. Every individual and team member can contribute and be responsible, form group identity, and produce predictable and transparent communication when there are pre-formed clear organisational expectations.[8,9] Due to this continuous quality improvement service for the organisation, staff, and most importantly patients, this advocacy extends to communities. Medical leaders are vital in contributing to improving community health and well-being outcomes.

What is leadership?

The topic of leadership has been of interest to medical education for many years.[3,10,11]

The 'Transformational Leadership' style has been used in the development of this *MedStudentLead* Framework.[12-14] There has been much focus on this leadership style in the clinical setting for the last two decades as it is practical and people-oriented, ultimately benefitting healthcare at the bedside.[14-20] The four key aspects of the transformational leadership style are:

1) Idealised influence via role-modelling;
2) Inspirational motivation via enthusiasm and optimism;
3) Intellectual stimulation via an open and positive environment; and
4) Individual attention via empathetic guiding and supporting of staff.

In practice, a transformational leader uses a coaching and mentoring style to foster a positive environment while actively supporting staff, improving morale, organizational commitment and loyalty.

Assumptions underpinning the *MedStudentLead* Framework

Four main assumptions underpin the *MedStudentLead* Framework. These assumptions were observed in the literature and identified as themes in phases one to three.

1) Every medical student and healthcare worker drives innovation and leadership
2) Being a leader indicates acknowledged behaviours that transform and inspire followers to perform beyond expectation
3) Leadership training to occur longitudinally across career from medical student to senior clinician
4) Transformative leadership training requires both education and then practice opportunity in the clinical setting.

How to use the *MedStudentLead* Framework

The framework concentrates on three aspects of medical student leadership development. These are:

Section 1. Developing Self as Leader
1.1 Building emotional agility
1.2 Building learning agility

Section 2. Leadership for Healthcare Collaboration
2.1 Building relationships with patients, families, and carers
2.2 Building relationships with colleagues

Section 3. Leadership for Innovative Healthcare
3.1 Building a culture of respectful learning and clinical curiosity

Competency format

The competencies under the above sections have a working definition of the skill, as well as a description of how they are a leadership skill. All examples are health related with a sound understanding of the educational context in which the learning takes place. Each competency also has readings, example learning outcomes (Sections 1 and 2), and teaching and assessment examples.

Reading resources

Each competency has online reading resources (published reports and articles). References for these resources are in the reference list. They are also web linked to their individual online resource and provided with the below figure how to use them:

Online reading and resources for teachers

Online assessment resource for teachers

Online reading and resources for learners

Leadership teaching and assessment tables – novice and advanced learner

The Leadership Teaching and Assessment tables have options for both novice and advanced learners. The 2004 Dreyfus Five-Stage Model of Adult Skill Acquisition provides clear difference in skill level from novice, advanced beginner, competent, proficient, to expert learners.[21] The *MedStudentLead* Framework deems a novice learner equal to the Dreyfus novice stage of skill level (the learner closely follows the rules and waits for instruction before acting), whereas an advanced learner is equal to the Dreyfus competent stage of skill learning (the learner acts within guidelines but has enough skill to begin to question the reasoning behind the guidelines).

These five levels of learning were used due to the variety of medical professional entry degree/programs in Australasia, including undergraduate entry or graduate entry, or a mix of both. It is also due to guiding principle 1 – medical students should own innovation and leadership.

In the Teaching and Assessment table, a novice learner of leadership might refer to a student who holds a secondary school qualification or a university tertiary degree with limited leadership skills training. Whereas an advanced leadership learner might be close to graduation and is spending time in clinical settings where they can learn and practice leadership skills.

How to use these competencies as a medical educator

Below are options for how academics might use these competencies[1]:

1) Add example teaching and/or assessment to existing learning of a leadership topic;
2) Add a competency to strengthen teaching outcomes for the AMC Graduate Outcome Domain: Professionalism and Leadership[7];
3) Evaluate the medical school leadership teaching and assessment using the Academic Checklist from Section 4;
4) Create a standalone leadership subject for medical students, at a time when students can work in the clinical setting to practise these leadership skills.

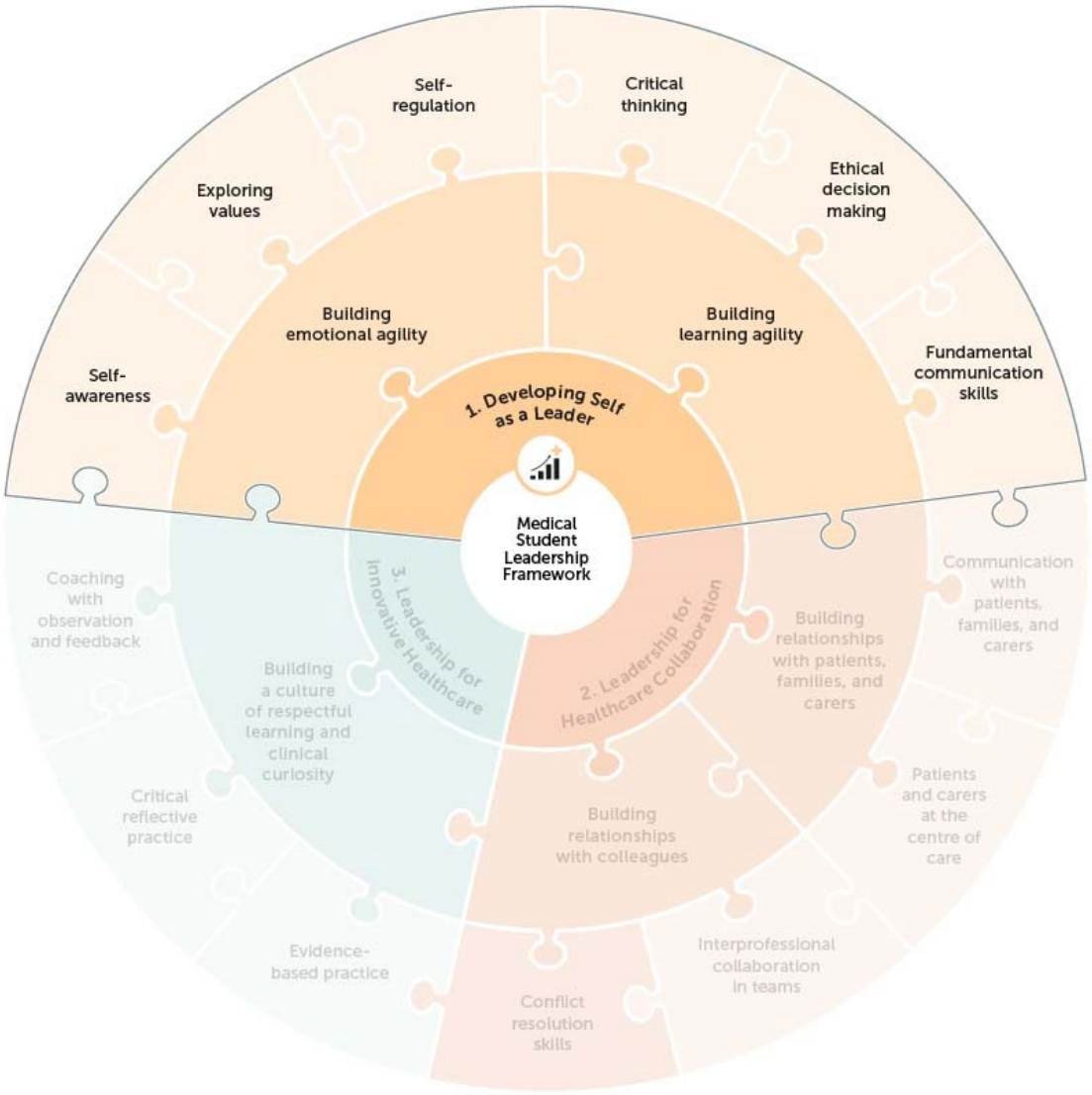
How to use these competencies as a medical student

Below are options for how students might use for these competencies[1]:

1) Read the competencies, review the readings, reflect on and practice the leadership skills.
2) Use the student checklist from Section 4 to review the leadership skills training at their own institution and advocate for leadership skills training if desired.

[1] The authors would appreciate any communication on the above (or other usage) to discuss best-practice, as well as future opportunities for evaluating the *MedStudentLead* Framework. Please contact Simone Ross by email: Simone.Ross@jcu.edu.au.

1. Developing Self as a Leader.



SECTION 1 –Developing Self as a Leader

1. Introduction

Having a strong sense of who we are as a person helps us to achieve personal and professional goals. These goals may include ones we want to achieve (driven by our own values and where we may wish to be in the future) and/or teamwork and organization goals.[22] Knowing one's own values and how to self-regulate emotions often builds stronger relationships with colleagues and leads to resiliency. Further, in relation to goals, individuals who display critical thinking and ethical decision-making often showcase high performance and dedication to goals. This occurs because others see a leader who respond logically to challenges rather than reacting emotionally. This motivates colleagues and inspires them to achieve the same success. Finally, learning effective and empathetic communication skills provides the ability to build rapport, trust and respect with others.[23] This is important for healthcare, but also for creating high performing teams.

The six Development of Self as Leader competencies are:

Section 1.1 Building emotional agility

- 1.1.1 Emotional intelligence and self-awareness
- 1.1.2 Exploring values
- 1.1.3 Self-Regulation

Section 1.2 Building learning agility

- 1.2.1 Critical thinking
- 1.2.2 Ethical decision-making
- 1.2.3 Fundamental communication skills

1.1 Building emotional agility

This section focusses on learning how emotions affect thoughts, actions and behaviours. When challenging emotions affect actions and behaviours, it can take over and stop one's own ability to complete tasks.[24] It can also affect the quality of care that patients receive.[25] However, identifying an emotion for what it is, linking it to the challenging thought and labelling the thoughts and emotions for what they are, broadens the choices available. Emotional agility is the ability to act on personal or professional values rather than raw emotion.[26] The ability to be able to manage thoughts and feelings is crucial for a healthcare provider.

Resilience has been extensively discussed in the psychological and sociological literature but is still yet to have one accepted definition. What is widely agreed is that resilience is the ability for flexible adaptability in the face of stress and challenge; with a set of positive attributes developed over a period of time in order to succeed.[27,28] The ethical and moral perspectives of resilience are particularly important for medical doctors and leadership in healthcare, and is important for medical students to learn core professional values during their training. Howe (2012) describes Doctors as having a close proximity to death and trauma, and when assisting patients this can represent a risk for personal moral injury or empathic distress.[28] Empathic stress is caused by taking in another's pain as our own and causes a strong need to withdraw to protect oneself from these feelings. Thus, developing coping strategies to increase resilience is important to reduce moral injury, empathic distress and burnout. As a leadership skill, the ability to be able to reframe a situation or stressor as a challenge to be conquered will start to build resiliency.

1) Emotional Agility. Harvard Business Review Magazine.[26]
2) Towards an Understanding of Resilience and its Relevance to Medical Training.[28]

1.1.1 Self-awareness

Emotional intelligence is commonly known as 'the ability to perceive and manage the emotions of oneself and others, to discriminate among them, and to use this information to guide one's thinking and action'.[29] Whereas self-awareness is a defined by Goleman (1998) as *"The ability to know one's own emotions, strengths, weaknesses, values and goals and to recognize their impact on others in influencing decisions"*.[30] Self-awareness includes knowing own strengths and weaknesses and behaving with humility.

Self-awareness helps to build one's own awareness of practice and behaviour, plus the ability to reflect on these outcomes for future behaviour. Over-time, individuals can understand, use, and manage emotions effectively with benefit to themselves and others.[31] For example, a medical student struggling with study and exam pressure can develop effective and appropriate coping strategies for stress management.

Within leadership of healthcare, high emotional intelligence correlates with positive doctor-patient relationships via building trust and respectful relationships, as well as teamwork and communication skills with both patients and colleagues. [32,33] Emotional intelligence and self-awareness also aids in coping with the pressure of the medical environment.

Readings

1) The importance of self-awareness: musings of a medical student.[34]

1) Emotional intelligence in medicine: a systematic review through the context of the ACGME competencies.[33]
2) Toward creating physician-healers: Fostering medical students' self-awareness, personal growth, and well-being.[31]
3) Preventing errors in clinical practice: A call for self-awareness.[35]
4) Your best life: managing negative thoughts – the choice is yours.[36]

Teaching and assessment

Example Learning Outcomes: Identify when own emotions, thoughts, and decisions are ruled by a known self-weakness; Develop strengths by cultivating decision-making rules; Learn from errors and develop a set of self-questioning reflective questions.

Teaching	Novice Learner	Lecture and small group learnings on life-long commitment to self-awareness, wellness, behaviour and attitudes to have a long medical profession Self-care workshops to include teaching on mindfulness, resilience, stress management, emotional intelligence, and self-care. Practical meditation exercises
	Advanced Learner	Small group learning about developing a growth mindset, stress management, and building resilience whilst in the community (on placement) Practical meditation exercises
Assessment	Novice Learner	Written essay on self-care learning linked to own student behaviours. A list of self-questioning reflective questions developed Written essay on learnings from the self-care workshops. What works for them and what does not. Include how they actively look after their health and are attempting to improve their resilience
	Advanced Learner	Community (placement) based learning assessment with feedback provided by supervisors

1.1.2 Exploring values

Exploring and understanding one's personal values helps to build a bridge to both the medical profession's values and health service values. Personal values are determined by personal morals and values systems shaped by lived experiences. These include culture, history, spiritual, social, and language naming conventions; to name just a few.[37] Professional and organisational values are added over-time to one's existing personal values framework.

Values shape behaviour, motivation, and emotions. For example, when individual values are perceived as being undervalued within the workplace, distress can occur. From a health professional perspective, the perception of a personal value being undervalued could be from a colleague or patient. Knowing one's own values and those of colleagues and the health service is necessary to be able to manage one's likely reactions and work effectively within a health team.[38] As a leadership skill, this is particularly important in a constantly changing health environment, where there is no room for self-doubt of one's skills. [38,39] Instead, choosing to identify one's own leadership values and rise to the challenge of leadership (via being open to change) is more important.

Readings

1) "Personal mission statement": An analysis of medical students' and general practitioners' reflections on personal beliefs, values and goals in life.[40]
2) Clinical leadership: values, beliefs and vision.[38]

Teaching and assessment

Example Learning Outcomes: Identify and describe core personal beliefs; review and compare health service beliefs (professional and organizational); design a personal mission statement on being a doctor based on own and health service values.

Teaching	Novice Learner	Lecture or small group learning on students exploring their own values, then linking types of decision-making based on their values
	Advanced Learner	Discussion of values and link to medical student own sense of professional value in preparation for placement. Discuss scope of practice and link behaviours back to values such as integrity, compassion, and humility Graduates provide presentations on their learning of values throughout their course and what this meant for them as a junior doctor
Assessment	Novice Learner	Assignment on exploring the values of a medical figure admired. Then exploring own values and how they may (or not) link with a medical career
	Advanced Learner	Assignment discussing community (placement) based learning. A written critical reflection of a health professional admired during placement. Student to provide the scenario and a breakdown of the persons values to their identity as a health professional

1.1.3 Self-regulation

Learning about self-regulation helps to understand how to control and manage one's emotions, personal capabilities, impulses, and behaviour. Self-regulation links to personal values and goals, but more importantly, to taking responsibility for one's own actions and adjusting to change. Further, self-regulated learning is linked to lifelong learning for medical professionals.

To be a self-regulated learner means one is 'metacognitively, motivationally, and behaviourally proactive in the learning process'. [41] According to Cho, Marjadi, Langdendyk, and Hu, "*the four processes of self-*

regulated learning are goalsetting, self-monitoring, feedback and control, whist the four areas an individual can regulate in are cognition, motivation, behaviour and context". [42] Personal context of self-regulation in medical students includes academic achievement and clinical skills. The proactive and self-regulated learning processes to achieve academically in the medical school environment positively correlates to doctors' proactive life-long learning strategies to maintaining and building competencies and skills in the clinical environment.[42,43]

Leaders who are effective are better at recognising how to control and manage their emotions, impulses and behaviours for the good of a health team, patient/s and the organisation. In terms of self-regulation, effective leaders are often motivated and display a positive and goal-oriented mindset, influencing resilience and improving colleagues own self-regulation.[44]

Readings

1) A reflective analysis of medical education research on self-regulation in learning and practice.[45]
2) Fostering self-regulated learning in higher education: Making self-regulation visible.[46]

Teaching and assessment

Example Learning Outcomes: Describe own self-regulation processes. Create goals for controlling own emotions, impulses and behaviour; Design a set of self-reflective questions to be accountable to self-regulation; Practice exercising control (focussing on the task at hand); Monitor progress of goals.

Teaching	Novice Learner	Group work discussion of strategies for learning Self-regulated learning added to course learning outcomes and assessments Guided self-reflection activities linked to current learning – to promote self-reflection
	Advanced Learner	Peer teaching opportunities for learners to be responsible for ownership of others learning Guided self-reflection activities linked to learning in the community – to promote meaning to their studies and future medical career
Assessment	Novice Learner	Written assessment - Development of a personal set of reflective questions regarding own study goals. Questions to be submitted and answered within a teaching semester – can include attendance, essay writing preparation, submission and completion of assessments, etc.
	Advanced Learner	Community (placement) based learning assessment with feedback provided by supervisors Assignment on future career goals and task planning for career

1.2 Building learning agility

This section focusses on learning how to adapt to a changing environment by using practices to help to continually develop and grow. Within health, learning agility helps Doctors to stay flexible, grow from mistakes, and rise to a diverse array of health challenges. A derailer to learning agility is being defensive when being challenged or giving feedback.[47] In leadership, learning agility links well with emotional agility as it helps individuals to think, act and make decisions logically.[47,48]

Learning About Learning Agility. White Paper. Center for Creative Leadership.[48]

1.2.1 Critical thinking

Using critical thinking allows one to make corrections in thinking, and therefore behaviour change, rather than wait for unintended outcomes. Critical thinking emphasises problem solving skills and shows a progression of logical thought.[49,50]

Critical thinking in the clinical context is defined by Huang, Newman, and Schwartzsteing as "the application of higher cognitive skills (e.g. conceptualization, analysis, evaluation) to information (gathered from medical history, records, physical exam, or diagnostic investigation) in a way that leads to action that is precise, consistent, logical, and appropriate".[51,52] Within medical education, discussion topics can provide problem-based scenarios that are aligned with students' knowledge and current learnings. Topics can include cultural, social, scientific, clinical and political factors of patient and community health, linked strongly with health equity and social justice.[49]

Critical thinking is essential for leadership as the traits and behaviours of effective leaders include problem solving and decision-making. When innovative change is required, a leader needs to be able to think critically so as to not fall back on previous and/or redundant solutions.[50]

Readings

Critical Thinking in Health Professions Education: Summary and Consensus Statement of the Millennium Conference 2011.[51]

Teaching Critical Thinking and Problem-Solving Skills to Healthcare Professionals.[49]

Developing Critical Thinking in Leaders.[50]

Teaching and assessment

Example Learning Outcomes: 1) Define open-mindedness; 2) Describe purpose of the topic, 3) Discuss and practice how to view items from a different perspective by paying attention to detail while identifying patterns, 4) Identify implications and consequences.

Teaching	Novice Learner	Summarise research articles and write detailed problem statements to be discussed in small group learning Remove challenging emotions from problem solving by identifying every large problem has key scenarios which can be broken down to smaller parts (problem elements) Small groups develop *problem solving trees* for a clinical case. The branch is a problem element which requires several leaves of possible solutions (options). Strategies chosen are then presented to the rest of class
	Advanced Learner	Student attendance at the weekly hospital based clinical reasoning tutorials, clinico-pathological case discussions, or grand round presentations to actively learn clinical decision-making frameworks Small group clinical decision-making problem solving of a clinical case, developed using a clinical decision-making framework. Students to identify patient/s diagnosis options and further studies
Assessment	Novice Learner	Multi-station assessment tasks– Clinical cases provided based on a health condition recently learned. Marking based on shown critical thinking skills rather than health condition content knowledge
	Advanced Learner	Community (placement) based learning assessment - Presentation of clinical case and potential diagnosis to supervisor. Verbal and written feedback provided by supervisor Multi-station assessment tasks - Clinical cases provided with simulated patient based on a health condition recently learned. Presentation of clinical case, potential diagnosis and further studies to assessor

1.2.2 Ethical decision-making

Ethical decision-making is based around the four ethical principles of beneficence, nonmaleficence, autonomy, and justice. It is an active process of evaluating and re-evaluating relevant factors for each patient. These include but are not limited to: sociocultural, legal, ethical, economical, and political factors.[53]

The WA Country Health Service defined 'ethics' as the "...ways on which we do, and should, treat each other. This extends from the 'bedside to the boardroom' and everywhere in between, and includes individuals as well as groups".[54] Due to the sheer volume of decision making, leaders can be vulnerable to making poor ethical decisions, and thus can be 'toppled by ethical scandals'.[55] Medical leadership requires being responsible for the moral dilemmas of self, colleagues, patients and the health system. Leaders need to know, understand and use ethical decision-making as this will create openness, trust and guidance for colleagues, patients, and health service stakeholders. Ethical decision-making should guide the behaviour within the service and promote quality and safety for all.[55,56] The below teaching and assessment recommendations can be added to the current existing teaching and learning on ethics in medical education.

Readings

Promoting Legal and Ethical Awareness: A primer for health professionals and patients. Chapter 2 – Ethical Foundations: The systems approach to health care professional ethical decision-making.[53]

Ethical Decision Making for Clinical or Patient Care Issues Guideline.[54]

Teaching and assessment

Example Learning Outcomes: Identify ethical implications; describe facts from unknown information and assumptions; analyse and develop a course of action; select course of action based on appropriate ethical guidelines and legal directives, make a choice and evaluate the process.

Teaching	Novice Learner	A lecture series on the introduction to the four ethical principles and ethical decision-making Small group learning – discussion of short theoretical cases based on ethical decision-making and the four ethical principles
	Advanced Learner	Small group discussion post community-based learning – identify common ethical dilemmas seen while on placement. The list can include items such as patient health questions without doctor present. Students do see a lot on placement, so it is best to allow them to identify the dilemmas
Assessment	Novice Learner	Written assessment – Reflective piece, linking self-care to the four principles of medical ethics
	Advanced Learner	Written assessment post community-based learning – Reflective piece, using the group list of common ethical dilemmas seen on placement (as above), each student to develop a personal action plan of these dilemmas for future use. Dilemmas to be introduced and explained prior to writing the action plan

1.2.3 Fundamental communication skills

For general fundamental communication to be effective, it must be clear, concise, correct, complete and compassionate (non-judgmental). Haji Iskan et al., define the elements of communication as *"the person giving the information, the information and feedback by the receiver, and the repetition of these*

processes".[57] Once a communicated message is transferred, knowledge development occurs through the practices of active listening, providing encouraging cues, and asking questions or providing feedback relevant to the communicated message.

Body language is important in effective communication. When determining others' emotions and attitudes, we mostly pay attention to others non-verbal communication of bodily action or gesture, facial expression, tone and pitch of voice rather than how they verbally express this emotion or attitude.[58] Often body language can display a message not meant to be transmitted. It is important to recognize these observations should be seen as clues, rather than facts, and be read in context of the situation.[59]

As a leadership skill, effective communication enhances social, emotional and mental health, while building stronger relationships with others and in a health team. Effective communication produces trust which is essential to interpersonal relationships and team performance and outcomes.

Readings

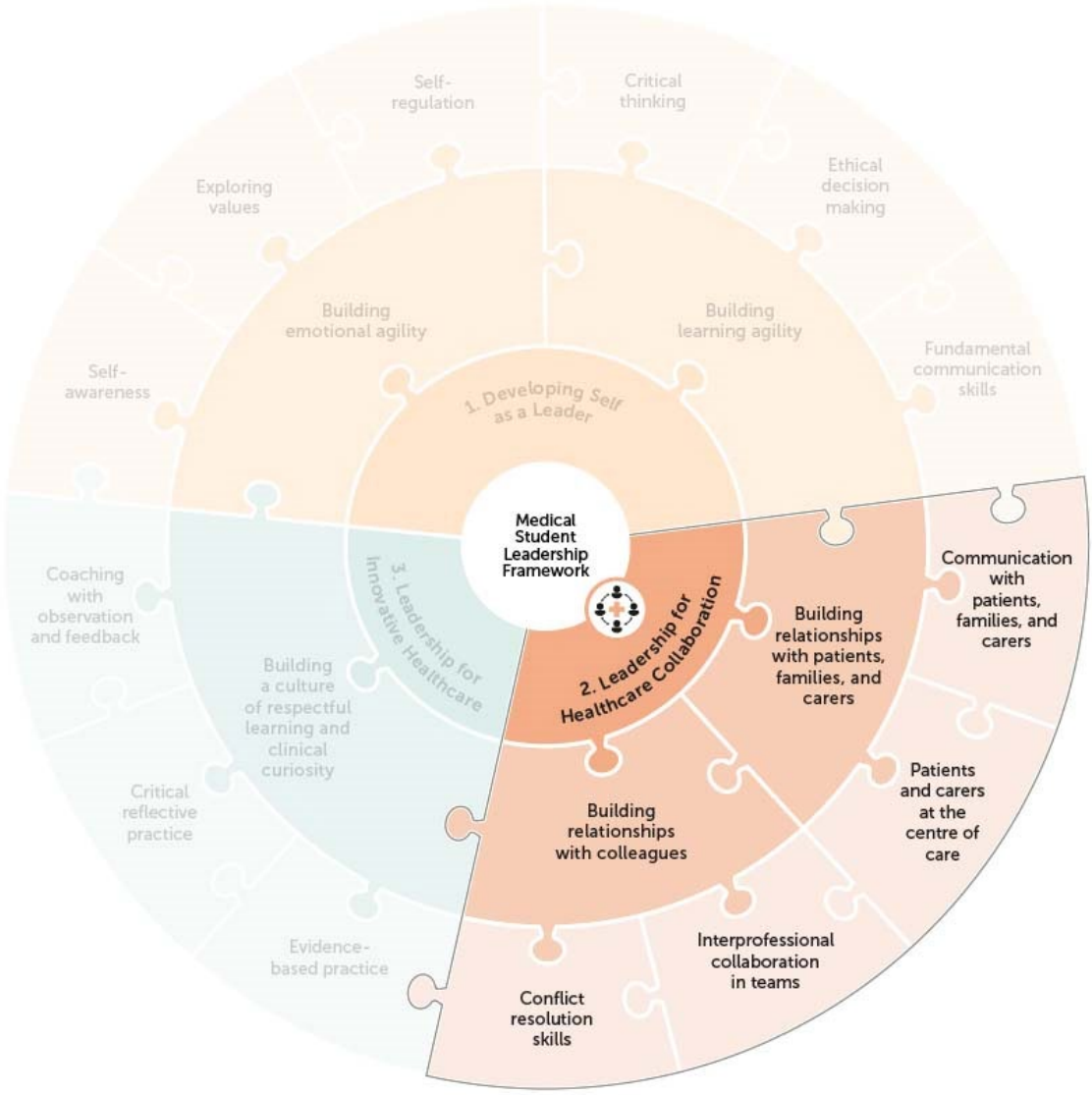
Undergraduate student's attitudes to communication skills learning differ depending on year of study and gender.[60]

Teaching and assessment

Example Learning Outcomes: 1) Describe and practice how to communicate clearly, concisely, sensitively, and with non-judgement; 2) Discuss how to give full attention to response (active listening); 3) Describe and practice channels of non-verbal communication, including encouraging cues (e.g., nodding, smiling); 4) Practice asking sensitive and non-judgement questions.

Teaching	Novice Learner	A lecture series on both verbal and non-verbal communication Small group learning – practice of fundamental communication skills with theoretical cases. Students to 'play' doctor and patient. Facilitator to focus particularly on communicating non-judgmentally, body language, and questioning
	Advanced Learner	Deliberately left blank
Assessment	Novice Learner	Practical assessment with a volunteer/simulated patient – communication skills, not focusing on history taking Practical assessment of testing communication skills during a simulated job interview
	Advanced Learner	Deliberately left blank

2. Leadership for Healthcare Collaboration.



SECTION 2 – Leadership for Healthcare Collaboration

2. Introduction

This section moves beyond developing self as a leader (Section 1) to building leadership for healthcare collaboration.

One's communication, teamwork and collaboration skills can affect patient outcomes. If collaboration is not effective with patients, carers, and families, it can reduce trust and confidence in the healthcare received and the healthcare service. Collaboration provides benefits to a healthcare team such as reduction of work duplication, interprofessional healthcare roles become valued, and job satisfaction is increased. Whereas, ineffective collaboration can effect patient care and delivery, workload increases, and unfulfilled colleagues.[61]

The Canadian National Interprofessional Competency Framework [62] defines the elements of 'collaboration' to include: respect, trust, shared decision-making and partnerships.[62] Whereas, for 'interprofessional collaboration', Gordon et al., advises interprofessional collaboration can produce for team members: an understanding of scope of practice and integration of role clarification, team functioning with goal priority, effective communication, and conflict resolution skills.[63] The outcome being an interprofessional health team with combined knowledge and skill for holistic patient care.

The below leadership competencies in how to build relationships are separated by patients, families and carers, then colleagues. This has been deliberate due to the unique needs of each.

The four Leadership for Healthcare Collaboration competencies are:

Section 2.1 Building relationships with patients, families, and carers

- 2.1.1 Communication with patients, families, and carers
- 2.1.2 Patients and carers at the centre of care

Section 2.2 Building relationships with colleagues

- 2.2.1 Interpersonal collaboration in teams
- 2.2.2 Conflict resolution skills

2.1 Building relationships with patients, families, and carers

This section focusses on how to build relationships with patients, families, and carers. Section 2.1.1. focuses on why communicating effectively with patients is essential, identifies strategies for communicating with patients, carers, and colleagues, and then introduces the 5Cs of Consultation model for how to consult with a supervisor about a patient. This section further concentrates on communication in healthcare service and goes beyond every day effective fundamental communication skills (Section 1.2.3) found under Developing Self as Leaders (Section 1).

Section 2.1.2 then focusses on why it is important patients and carers are at the centre of care, and how to foster and develop a partnership with patients, their carers, and families for health outcomes that values their knowledge and decision-making.

2.1.1 Communication with patients, families, and carers

Communication is a fundamental clinical skill all healthcare providers need. When communicating effectively with patients, the patient adjusts better psychologically, and healthcare providers have greater job satisfaction and less work stress.[64] According to Maguire and Pitceathly, there are four patient outcomes for doctors who communicate effectively with their patients.[64]

1) Patient problems are identified more accurately
2) Patients are more satisfied with their care and better understand their problems, investigations, and treatment options
3) Patients are more likely to adhere to treatment and follow advice on behaviour change
4) Patients distress and their vulnerability to anxiety and depression are lessened.

Effective communication as a healthcare professional requires fundamental clinical communication skills, the ability to adapt these skills, and the appropriate communication tools and skills needed for effective information transfer. Building a rapport with patients requires a consideration of the timing, environment, age of the patient, their culture, and the patient's health outcomes etc. Being aware of any inter-family politics can also be important for the best outcome of a patient; in particular, knowing the patient's needs and the roles and responsibilities they accept for their family or carer.[65]

Communication as a leadership skill with patients, families, and carers requires a willingness to listen and provide support, and an ability to work with patients to form clear expectations and feedback. The 5Cs of Consultation model is a communication model that can be utilised when consulting with a supervisor about a patient. These 5C's are: Contact, Communicate, Core Questions, Collaborate, and Close the Loop.[66]

Readings

1) Key communication skills and how to acquire them.[64]
2) Communication skills: A guide to practice in healthcare professionals.[65]

1) The 5C's of Consultation: Training Medical Students to Communication Effectively in the Emergency Department.

Teaching and assessment

Example Student Learning Outcomes: Aim to have a positive therapeutic relationship. Speak to the person (consider age, profession etc.); speak with clarity and avoid jargon; use positive body language and tone; actively listen and reflect; clarify with open questions.

Teaching	Novice Learner	Lecture series. Topics can include: Patient history taking (simple case), families and carers, how to access an interpreter, cultural competence
		Small group practice with theoretical cases. Topics can include carers, family challenges, the need for an interpreter, and cultural health beliefs. Students to 'play' doctor, patient, carer. Facilitator to focus particularly on communicating non-judgmentally, body language, and cultural competence
	Advanced Learner	Lecture series. Topics can include: Patient history taking (complex case), motivational interviewing, families and carers, how to access an interpreter, cultural competence

Assessment	Novice Learner	Practical assessment with a volunteer/simulated patient – consent, patient history taking skills of simple case, and verbal and non-verbal communication skills
	Advanced Learner	Practical assessment with a volunteer/simulated patient and supervisor – Patient: consent, patient history taking skills of complex case, and Supervisor: Information transfer about patient to a supervisor Community (placement) based learning assessment – Reflective activity around observation of clinician communication on placement with patients, families and carers Multi-station assessment tasks - Clinical cases provided with a volunteer/simulated patient and supervisor: 1) consent, motivational brief clinical intervention for behaviour change, including micro-counselling skills. 2) Patient history taking skills of a complex case, with information transfer of complex clinical case to a supervisor

2.1.2 Patients and carers at the centre of care

Patient-centred care (PCC) has many definitions, but is generally seen as '*understanding and respecting patients' values, preferences and expressed needs*'.[67] PCC is an essential practice for meaningful engagement with patients, families and carers. It becomes a partnership to define health needs and develop strategies for implementation. For example, patients manage their chronic illness at home, they have a wealth of knowledge on how this works for them. A doctor who asks questions and genuinely listens to a patient's health story receives valuable knowledge.

The aim of working in partnership with patients is to empower patients to be part of shared decision-making. Thus, provides patient/doctor trust. Assisting patients and their carers or families with personalised health information through printed and online channels can improve their health literacy and their ability to make informed decisions.[68] Other personalised health information includes: self-management education, self-help groups and peer support, and joint checking of records and care processes.[68]

Importantly, fostering collaborative relationships with patients restores their positive feelings of self-worth and satisfaction in healthcare and the different healthcare teams.[67] To define PCC with leadership values, these are: compassion, empathy, respect, and kindness. Behaviour tools include being non-judgmental, having coaching and question prompts for patients, and being responsive.[68,69]

Readings

1) Patient-Centered Care: The Road Ahead.[67]
2) Patient-Centred Care: Improving Quality and Safety Through Partnerships with Patients and Consumers.[68]

Teaching and assessment

Outcomes: Describe patient-centred consultations – active partners; Practice collecting patient feedback – customers in the care setting; Describe and practice advocating for change with patients; Describe the importance and impact of involving patients in the decision-making for change.

Teaching	Novice Learner	Lecture series. Topics can include: Social accountability in the health profession, health equity, viewing the patient as a person, sharing power and responsibility, defining quality of care Small group learning – theoretical cases defining aspects of patient centredness within the cases
	Advanced Learner	Lecture series. Topics can include: Health promotion, health advocacy, costs of healthcare to patients, how to involve patients in the decision-making, system and service-related patient-centred care (e.g., transparent patient-centred care policies, procedures, staff training and education, and accountability)
Assessment	Novice Learner	Written assessment – Essay defining patient-centred care. Link to student's own experience as a patient, with communication skills, behaviours and values described to obtain patient-centred care.
	Advanced Learner	Community (placement) based learning assessment – Reflective activity around observation of patient-centred care clinically Community (placement) based learning assessment – Review of patient consultations with written feedback provided by supervisors

2.2 Building relationships with colleagues

This section focusses on how to build relationships with healthcare colleagues. These colleagues may be but are not limited to hospital-based healthcare teams, referred specialist provider/s, or community organisation/s. Section 2.2.1 focuses on interprofessional collaboration; discussing the collaborative and coordinated approach to shared decision-making and effective teamwork. Being able to collaborate well in a healthcare team while respecting the roles of the other healthcare professions is essential to both patient safety and work satisfaction.

Section 2.2.2 focusses on being able to resolve conflict within the health team; it defines common sources of conflict in healthcare and how to establish a safe environment to express diverse opinions.

2.2.1 Interprofessional collaboration in teams

The Canadian National Competency Framework defined interprofessional collaboration as a "partnership between a team of health providers and a patient in a participatory collaborative and coordinated approach to shared decision-making around health and social issues".[62] This means interprofessional collaboration occurs with patients, carers, the community, and the other appropriate health professions during the design and implementation of healthcare and health services.

Interprofessional collaboration includes being able to communicate across professions and respecting the roles and expertise of other healthcare professionals. Knowledge of one's professional role and responsibilities is required, as well as the knowledge of other professional roles and their functionality within the health team, and to advocate for clear delineation of roles if they not known.[62]

For a leadership skill, it is important to know how to assist in producing group identity. This requires an understanding of the dynamics and group processes of collaboratively functioning teams (effective teamwork), as well as the application of collaborative decision-making and continuous quality improvement work processes and outcomes. Other practices involve communicating effectively with the health team and informing patients about the roles of the different professions within the team.[61,62,70]

Reading

CIHC – The National Interprofessional Competency Framework.[62]

Teaching and assessment

Outcomes: Understand one's professional role and responsibilities; Practice with other professions to understand and respect their role and expertise with the health team; Describe and practice team processes and guidelines to address conflict.

Teaching	Novice Learner	A lecture series – Understanding and respecting the role of all front-line health workers (e.g., supervisors, nursing, allied health, kitchen, cleaners, orderlies, and security). Collaboration and effective inter-professional teamwork Preparation for first community-based placement – Teamwork professionalism and how to get off to a good start and make the most of the practical learning experience
	Advanced Learner	Written assessment – Essay defining front-line health workers roles, responsibilities, and scope of practice including one's role as a medical student. Link to collaboration and effective teamwork
Assessment	Novice Learner	Presentation by graduates and patients on the effect of inter-professional collaboration on patient safety, health, and work satisfaction
	Advanced Learner	Community (placement) based learning assessment – Review of teamwork while on placement with written feedback provided by supervisors

2.2.2 Conflict resolution skills

Conflict can be negative or positive. Conflict can provoke negative emotional reaction, dysfunctional patterns of interaction, breakdown in problem solving, and entrenched position taking. Embracing the positive side of conflict involves the ability to change processes, personal change of attitudes and behaviour, social changes, and allows discussions of needs, wants and preferences.[71,72]

Common sources of conflict in healthcare include role ambiguity and differences in goals or values. For example, role ambiguity includes role accountability misunderstandings, as well as perceptions of role overloads.[73] Whereas for goals or values, this includes professional identity approaches to care, or dissimilar philosophies towards care, and/or personal religious or spiritual beliefs.[74] Identifying the triggers to conflict of common situations that are likely to lead to disagreements in healthcare, such as, treatment approaches, informed consent, diagnosis, and/or discharge, allows for early setting of guidelines for addressing these types of disagreements – thus establishing a safe environment to express diverse opinions.[62] It is also important for all team members to focus on the common goal of patient health outcomes, and have a shared vision on how to achieve it.[61]

So as not to detract from patient-centred care (see Section 2.1.2), effective conflict resolution strategies are required. These conflict resolution leadership skills include: concentrating on contribution to the conflict rather than blame, understand the issues and managing the processes not the person, as well as effective communication including assertiveness and problem-solving skills to define strategies, options and solutions (see Section 1.2.1 and 1.2.2).[72]

Readings

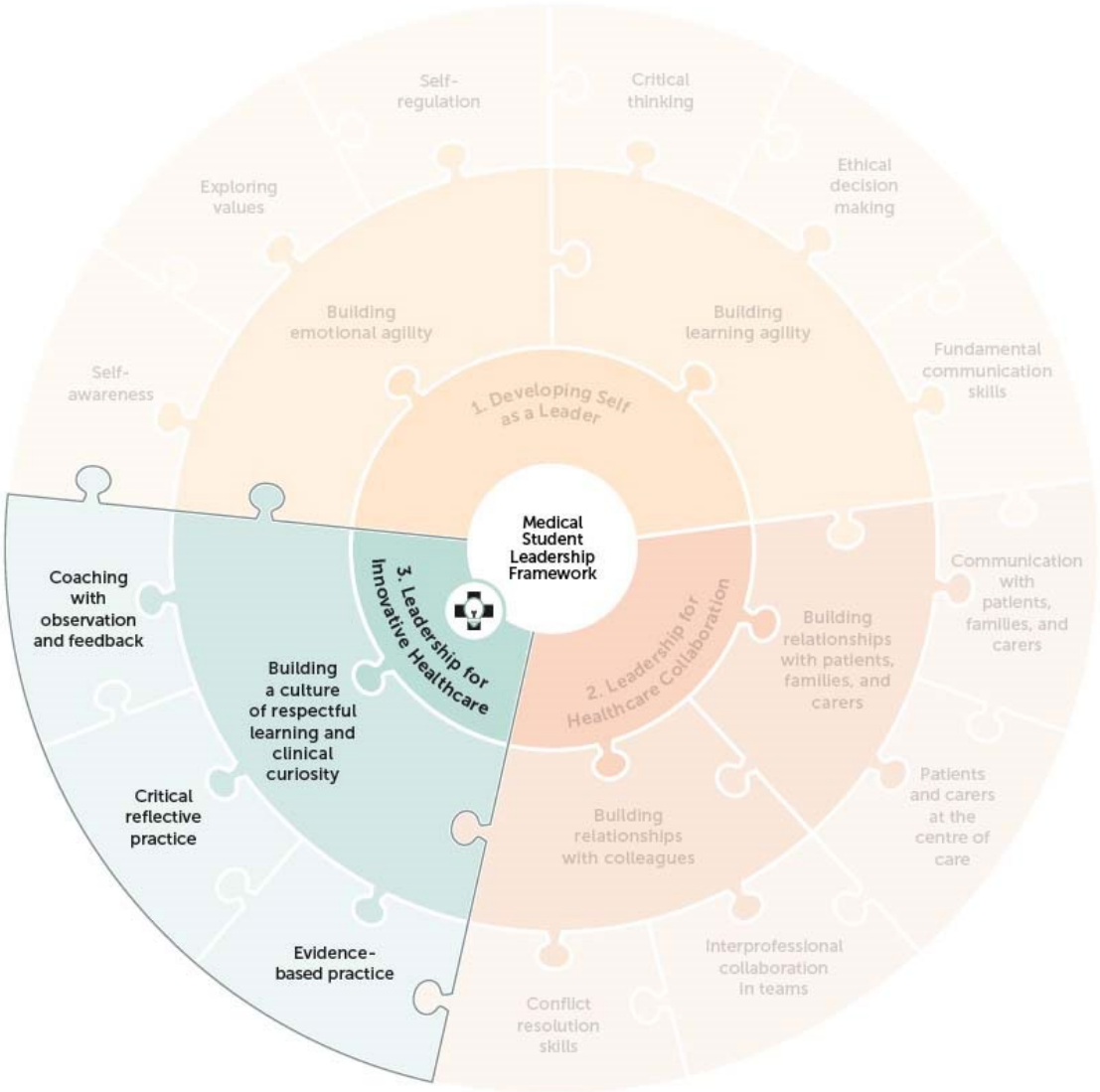
1) CIHC - A National Interprofessional Competency Framework.[62]
2) Understanding Healthcare Professionals' Self-efficacy to Resolve Interprofessional Conflict.[75]

Teaching and assessment

Outcomes: Introduce the difference between conflict and dispute, then discuss common sources of conflict in healthcare; Problem solve common healthcare conflict scenarios; practice required communication techniques; discuss strategies and options to solve the conflict.

Teaching	Novice Learner	Lecture series – Introduction to negatives and positives of conflict, common sources of conflict in healthcare, required communication techniques, problem solving techniques Small group learning – theoretical cases defining conflict, conflict resolution communication skills, and problem-solving techniques within the cases
	Advanced Learner	Lecture series – Topics can include: Procedures, policies, and education opportunities in a health service for effective conflict resolution. How and when to involve others in the decision-making. How to manage conflicts caused by power and personal values compared to those that are process driven Small group learning – complex theoretical cases defining conflict, conflict resolution processes, problem solving techniques, how to identify the type of conflict and within the cases, what to do next
Assessment	Novice Learner	Written assessment – Complete a workbook. Respond to the case defined in the workbook. Define objective of meeting, contribution/s of conflict, create an assertive message, define open questions, explore resolution, and create plan
	Advanced Learner	Written assessment post community-based learning – Reflective piece, to interview supervisor to discuss process of conflict resolution and regularly seen conflict. Discuss reasons as to why this occurs, and the policies and practices for conflict resolution. Questions to include outcomes for colleagues, patients, and the health service practices Community (placement) based learning assessment – Reflective activity around observation of interprofessional roles. Details to include each profession's role and the learning received from each profession. If conflict occurred, what was the probable cause and how it was resolved. If it was not resolved, the action the student believes would have resolved the conflict Multi-station assessment tasks - and/or work-based assessment to role-play a common conflict in healthcare, resulting in resolving conflict. Define objective of meeting, contribution/s of conflict, create an assertive message, define open questions, explore resolution, and create plan

3. Leadership for Innovative Healthcare.



SECTION 3 – Leadership for Innovative Healthcare

3. Introduction

This section moves beyond developing self as a leader (Section 1) and building leadership for healthcare collaboration skills (Section 2) to linking leadership skills together to promote innovative healthcare.

Building a culture of respectful learning and clinical curiosity makes it easier for colleagues and the health team to voice concerns in a constructive way. For example, a service outcome to be explored using evidence-based practice. Or individual and health team assumptions can be explored along with social inequalities and systemic gaps to tailor and form fit an innovative solution using critical reflective practice.

Role-models and coaches have distinct roles. A role-model influences and teaches by example (e.g., observe a specialist in surgery) but may not provide feedback to learners. Whereas a coach has a more formalised relationship with trainees, and regularly provide respectful feedback on the trainee's performance; thus, educating learners about their practice and providing opportunities for the trainee to develop a cycle of reflective learning.

The three Leadership for Innovative Healthcare competencies are:

Section 3.1 Building a culture of respectful learning and clinical curiosity

- 3.1.1 Evidence-based practice
- 3.1.2 Critical reflective practice
- 3.1.3 Coaching with observation and feedback

3.1 Building a culture of respectful learning and clinical curiosity

The below leadership competencies were designed to provide respectful learning and clinical curiosity; together which allow the building of a culture within healthcare where ideas, customs and behaviours produce respectful learning, and clinical curiosity can only improve staff morale and patient outcomes.

3.1.1 Evidence-based practice

Evidence-based practice (EBP) requires clinical curiosity and inquiry. EBP takes analysis and reading time; however, in the short-term it leads to higher quality care and improved patient outcomes. Longer-term, after new EBP's are published and/or verbally disseminated, they can reduce health system costs and efficiencies through reduced duplication of efforts. Evidence-based practice has five steps.[76]:

1) Ask clinical questions and search for the best evidence in research databases using the PICOT format. Patient population of interest (P), Intervention or area of interest (I), Comparison intervention or group (C), Outcome (O), and Time (T).
2) Critically appraise the evidence for relevancy, validity, reliability, and applicability to the research question to identify if they support an EBP decision or change.
3) Integrate the evidence with clinical expertise, the health system and patient preferences and values. Decisions of a new EBP require the above evidence, but are often influenced by institutional, clinical, and patient variables that may help or hinder the implementation of an EBP
4) Monitor and evaluate any new EBP's implemented, the outcomes of the practice decisions, or changes based on evidence. This helps to spot any flaws and monitor the effect of health care quality and outcomes.
5) Disseminate EBP practice and results.

Organisational culture, leadership, communication and champions have all been named as organisational contextual features that influence the implementation of evidence-based practices across healthcare setting.[77] Organisations require an openness to trialling new innovations and a learning culture showing strong positive staff attitudes and behaviours towards new initiatives. Leaders within the organisation are often seen as providers of new knowledge, and using transformational leadership they cultivate a culture of learning and ensure new processes are integrated and changes are sustained by expressing enthusiasm, and being present, supportive and attentive.[77]

Readings

1) Evidence-Based Practice: Step-by-Step: The Seven Steps of Evidence-Based Practice.[76]
2) Organizational contextual features that influence the implementation of evidence-based practices across healthcare settings: a systematic integrative review.[77]

Teaching and assessment

Teaching	Novice Learner	Lecture series: Topics can include evidence-based practice overview, clinical curiosity and inequity. Plus, why evidence-based practice is necessary, and the short and long-term outcomes Librarians and/or researchers teach how to critically appraise research articles for how
	Advanced Learner	Lecture series: Librarians and/or researchers teach the PICOT format to search for the best evidence in appropriate research databases Small group practice with a set of clinical questions. As a team students develop their search terms using PICOT, then appraise the evidence, and link evidence to provided theoretical patient preferences and values. The overall aim is to develop implementation strategies
Assessment	Novice Learner	Written assessment: Review a research article for relevancy, validity, reliability, and applicability to its given research question/s
	Advanced Learner	Deliberately left blank

3.1.2 Critical reflective practice

Critical reflexivity is a dynamic process of discovery, analysis and research of our personal assumptions that frame the decisions we make on others within an environment or system. Critical reflexivity is often used to improve professional and personal practice.[78,79]

Critical reflective practice [80,81] is embedded in reflective thinking and critical reflexivity. In the healthcare system, it defines how to understand one's own and the health teams' assumptions, the patients' needs and health teams' knowledge, social inequalities and systemic gaps, to tailor and form fit a solution, and to collaboratively advocate for and with the patient and team. It also requires evidence-based practice (see Section 3.1.1). Each of the five processes below do not have a pre-defined order and have been adapted to medicine from management [78], sociology [79], and health education [80,81] theories:

1) Understand the patient's needs within the health care system – for patient-centred care and future collaboration (see Section 2.1.2).
2) Appreciate, accept, and respect the knowledge of the healthcare team (and their role) by having collaborative discussions within the team – to gain insight and remove power (see Section 2.2.3).
3) Identify inequities and the underlying gaps in the system leading to inequitable access to service - to define workarounds to achieve patient health goals, or enact system change when possible (see Section 2.1.2).
4) Tailor theoretical and research-based knowledge - to fit the circumstances in the reality of the system (see Section 3.1.1).
5) Respectfully advocate as collaborators with the patient and healthcare team, and invite others to collaborate - rather than be directive in the outcome and hold the power.

As a leadership skill, critically reflective practice allows for one's own personal development. It is a process in which to identify strengths, weaknesses, challenges, assumptions, and to develop strategies to overcome them. This includes opportunities and learnings around goals, ambitions, values and performance. Critically reflective practice provides the opportunity for innovative healthcare, role-modelling (showcases) clinical curiosity, collaboration, patient-centred care and advocacy with colleagues.

Readings

1) Critically reflective practices and its sources: A qualitative exploration.[81]
2) Beyond communication training: The MaRIS model for developing medical students' human capabilities and personal resilience.[82]

Teaching and assessment

Teaching	Novice Learner	Lecture series. Topics can include and compare: Reflective practice, critical reflexivity, critically reflective practice, creative thinking, collaboration and advocacy
	Advanced Learner	Small group practice with theoretical cases: 1) Theoretical topics can include critically reflective practice, creative thinking, collaboration and advocacy. 2) Teach common health system challenges, health inequities, health teams and their roles. Students to 'play' doctor, patient, and health team. Facilitator to focus on and unpack assumptions, assist to identify inequities, and assist with collaborative decision-making (process and language)
Assessment	Novice Learner	Written assessment – Essay comparing difference between reflective practice, critical reflexivity, and critically reflective practice
	Advanced Learner	Practical group assessment with the clinical skills team (playing the health care team) and a volunteer/simulated patient – health needs of patient, correct identification of inequities, collaborative behaviour (process and language) with health team, and defined outcome

3.1.3 Coaching with observation and feedback

Effective feedback is necessary in the learning process as it aids learning and reinforces good practice, as well as provides an understanding to trainees of observed performance with information on how to achieve the desired outcome. Trainees experience support and increased confidence professionally and personally. The respectful discussion-based guidance they receive also ensures safe and efficient health care practices, the development of strategic thinking practices, and an increase in self-regulation [83] (see Section 1.1.3).

Formal feedback should be planned with formal feedback sheets (written); however, informal feedback can occur during clinical practice as long as both the role-model/mentor understand this will occur and both are prepared (verbal). Being a coach requires training, commitment, and the ability to respectfully question and challenge a trainee. A good example is The Pendleton Model of Feedback.[83,84] This model starts with the learner and asks what went well, then moves to the feedback provider and back to the learner on what could be approved; until a mutually agreed set of goals is formed.

Being able to respectfully promote discussion and reflection during active learning (via effective coaching and feedback) is an essential leadership skill. It allows colleagues to be able to reflect on immediate moments of specific incidents, which is essential to their learning and behaviour change. [85] Further, due to the guidance they provide, a coach can experience self-reflection and self-renewal of knowledge. Coaches can also receive workplace satisfaction and re-affirmation of their commitment to the field and profession.

Readings

1) How to give and receive feedback effectively.[86]
2) What do we know about coaching in medical education? A literature review.[87]

1) Feedback in the clinical setting.[83]

Teaching and assessment

Teaching	Novice Learner	Deliberately left blank
	Advanced Learner	Lecture series – The difference between coaching and mentoring, the setting of learner-centric goals with the aim to improve performance, provide individualised real-time formal or informal feedback, facilitate development of learner insights and behaviours Small group learning – practice of learner goal setting for performance, providing both formal and informal feedback, developing learner reflective strategies for improvement
Assessment	Novice Learner	Deliberately left blank
	Advanced Learner	Community based learning assessment – Review of coaching a junior student for development of medical technical skills or clinical skills. Review to be face-to-face or via video recording. Written feedback provided by supervisors

SECTION 4 – Toolkit

4. Introduction

Any tools created for use with this Framework can be found on the *MedStudentLead* website (www.medstudentlead.com.au).

4.1 Academic curriculum evaluation of *MedStudentLead* competencies

This evaluation is for use for primary medical programs. An Excel spreadsheet version is in the toolkit at the above website.

1. Developing Self as a Leader		Year level(s) taught	What content is taught?	How is the content taught?	Where is the content taught?	Level of teaching*[21] (novice, advanced beginner, competent)	Is it assessed? If yes add assessment type and percentage	Assessment content
Example		First year	Introduction to history taking/communication	Workshop with volunteer/ simulated patient	Campus room, or clinic	Novice – introduction to first year students	10% scenario-based assessment	Patient history taking with case & volunteer / simulated patient
1.1 Building Emotional Agility	1.1.1 Self-Awareness							
	1.1.2 Exploring Values							
	1.1.3 Self-Regulation							
1.2 Building Learning Agility	1.2.1 Critical Thinking							
	1.2.2 Ethical Decision-Making							
	1.2.3 Fundamental Communication Skills							

*Levels of teaching defined by the Dreyfus Five-Stage Model of Skills Acquisition (novice, advanced beginner, competent, proficient, expert).

2. Leadership for Healthcare Collaboration		Year level(s) taught	What content is taught?	How is the content taught?	Where is the content taught?	Level of teaching*[21] (novice, advanced beginner, competent)	Is it assessed? If yes add assessment type and percentage	Assessment content
Example		First year	Introduction to history taking/communication	Workshop with volunteer/ simulated patient	Campus room, or clinic	Novice – introduction to first year students	10% scenario-based assessment	Patient history taking with case & volunteer / simulated patient
2.1 Building Relationships with Patients, Families, and Carers	2.1.1 Communication with Patients, Families and Carers							
	2.1.2 Patients and Carers as the Centre of Care							
2.2 Building Relationships with Colleagues	2.2.1 Interprofessional Collaboration in Team							
	2.2.2 Conflict Resolution Skills							
	2.2.3 Coaching with Formal and Informal Observation and Effective Feedback							

*Levels of teaching defined by the Dreyfus Five-Stage Model of Skills Acquisition (novice, advanced beginner, competent, proficient, expert).

3. Leadership for Innovative Healthcare		Year level(s) taught	What content is taught?	How is the content taught?	Where is the content taught?	Level of teaching*[21] (novice, advanced beginner, competent)	Is it assessed? If yes add assessment type and percentage	Assessment content
Example		First year	Introduction to history taking/communication	Workshop with volunteer/ simulated patient	Campus room, or clinic	Novice – introduction to first year students	10% scenario-based assessment	Patient history taking with case & volunteer / simulated patient
3.1 Building a Culture of Respectful Learning and Clinical Curiosity	3.1.1 Evidence-Based Practice							
	3.1.2 Critical Reflective Practice							
	3.1.3 Coaching with Observation and Feedback							

*Levels of teaching defined by the Dreyfus Five-Stage Model of Skills Acquisition (novice, advanced beginner, competent, proficient, expert).

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