Title: How Can Medical Education Be Improved for the Benefit of the Patient?

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Good Psychiatry has at its core a focus on interpersonal nuance, legal complexity, and ethical decision-making. As a clinician, educational fellow and simulation champion in Northern Ireland, with a background in law, I posited how Simulation-based education could be a powerful tool for enhancing medical education in ways that tangibly benefit patients in a multi-faceted way. This essay argues that simulation enhances not only clinical knowledge but also the relational, legal, and ethical dimensions of care that are central to psychiatry.

Backgorund: Health Inequality in the Western Trust, Northern Ireland

The Western Health and Social Care Trust, including the city of Derry and Strabane, represents one of the most socioeconomically deprived regions in the United Kingdom. Around 25% of Northern Ireland's most deprived areas are concentrated in this district. Life expectancy in these regions has shown a worrying decline with men in the most deprived areas of Derry living on average just 71.1 years, over six years below the district average, and even below global averages in countries like Libya or Syria. Women's life expectancy also lags, at 78.1 years compared to 81.1 in more affluent parts of the region. Drug-related deaths, alcohol misuse, chronic illness, and suicide rates remain disproportionately high in this area (*Northern Ireland Statistics and Research Agency, 2022*).

These alarming statistics underscore the urgent need for a workforce that is not only clinically competent, but deeply sensitive to the socioeconomic and psychological stressors experienced by patients. Medical education in this setting must prioritise patient-centred communication, post-conflict trauma-informed care, and systems thinking. Simulation, when situated within such a context, is uniquely placed to prepare clinicians for this kind of multifaceted, compassionate care and a Quality Improvement project I curated demonstrated that clinician learning was better retained at 6 weeks compared with traditional didactic teaching.

Simulation Background

Simulation aligns with Kolb's experiential learning model (*Kolb, 1984*), offering immediate feedback, structured debriefing, and iterative practice in a psychologically safe environment. Unlike traditional didactic methods, simulation immerses learners in emotionally and cognitively rich scenarios. In psychiatry, this includes navigating interpersonal dynamics, narrative reasoning, and legal frameworks often simultaneously. This immersive approach helps learners build empathy and communication skills while confronting unconscious biases.

Traditional lectures often fail to prepare students for the emotional complexity of psychiatric consultations. Simulation allows learners to engage with the tension of real clinical encounters, navigating silence, building rapport, and responding to distress, whilst experiencing the emotional atmosphere transmitted by the patient. In scenarios involving psychosis or suicidal ideation, the realism of actor portrayals encourages reflection and feedback, essential for developing therapeutic alliance, the cornerstone of effective psychiatric care.

Negative assumptions and lack of confidence around mental illness are relatively common among trainees, especially in contexts like Northern Ireland where cultural trauma and the legacy of The Troubles may influence presentations. Simulations involving standardised patients, adapted to the local sociocultural environment, help counter stigma by enabling practice in active listening, de-escalation, and sensitive interviewing. Studies show simulation improves attitudes toward mental illness and reduces stigma contributing to better patient care. (*Zare-Bidaki., et al 2022*)

Case Study: Western Trust Psychiatric Emergencies Simulation Day

In April 2025, the Western Health and Social Care Trust in Northern Ireland hosted a psychiatric emergencies simulation programme for the first time. The six high-fidelity scenarios included:

- An agitated, manic patient requiring rapid tranquilisation
- A patient with Emotionally Unstable Personality Disorder (EUPD) and Type 1 Diabetes Mellitus (T1DM) refusing insulin
- A patient who had swallowed a button battery
- A patient with psychotic depression who had crashed their car and required detention under the Mental Health (Northern Ireland) Order 1986

Each scenario required participants to consider not just clinical management but the legal and ethical dimensions of care. The simulations were broadcast in real time to other learners, and structured debriefs with targeted microteaching followed each session. The approach allowed all learners to observe each scenario unfold and participate in critical reflective discussion and shared learning.

The T1DM/EUPD case was particularly impactful. The learning objectives focused on capacity assessment and respecting a patient's right to refuse treatment. Participants experienced the emotional discomfort of permitting a decision they perceived as risky, prompting deep reflection on the limits of medical paternalism. This scenario highlighted the difference between clinical wisdom and legal permissibility, reinforcing the importance of applying mental capacity legislation with sensitivity and precision.

Another scenario, involving detention under the Mental Health (NI) Order 1986, allowed participants to rehearse the complex process of balancing autonomy with risk mitigation. Participants were required to assess for risk of harm, initiate legal paperwork, and communicate their reasoning to distressed relatives and a resistant patient. The incorporation of documentation exercises (Forms 5 and 7 under the Mental Health Order (NI)) created a realistic bridge between theoretical knowledge and procedural competence. This process was

also the focus of a separate Quality Improvement project comparing Didactic teaching with simulation. At 6 weeks using a Likert Scale, the learning was much better retained in the simulation cohort.

The button battery ingestion case tested communication and decision-making under pressure, particularly across medical, surgical and psychiatric domains. Rapid triage, escalation, and safeguarding discussions reinforced the need for coherent, interprofessional responses in unpredictable emergencies. The scenario helped participants appreciate how psychiatric distress can obscure medical emergencies and vice versa.

Finally, the scenario involving rapid tranquilisation challenged participants to act quickly and decisively while maintaining respect and preserving patient dignity. Feedback highlighted how this experience made abstract concepts such as the ‘least restrictive option’ or ‘therapeutic alliance’ feel tangible and immediate. Debriefing sessions allowed participants to explore moral injury, staff safety concerns, and communication strategies to support both patient and team well-being.

Feedback collected after the event showed an overwhelmingly positive response. Learners described a heightened sense of preparedness and a clearer understanding of the ethical grey zones they might encounter. Many commented on the importance of seeing dignity maintained in difficult situations, such as administering rapid tranquilisation, where physical safety measures had to be reconciled with the patient’s emotional and psychological needs.

This simulation programme was particularly meaningful given the context of local deprivation and high clinical demand. Practising ethically complex decisions under pressure prepared trainees to better serve the vulnerable populations they would encounter daily. The sessions modelled a standard of care that balanced empathy, legality, and clinical pragmatism, values that should sit at the heart of any medical education programme. We now plan to run this day on an ongoing basis twice a year.

Discussion

Simulation provides a powerful blend of visual and emotional learning that leads to better retention vis-à-vis traditional didactic teaching. High-fidelity simulations can portray nuanced psychiatric behaviours, for example, agitation, delusional beliefs and affective withdrawal, in a way that leaves lasting impressions. Emotional engagement deepens learning by provoking reactions that are later reflected upon during debriefs. This fosters self-awareness and emotional intelligence that can then be applied to improving patient-centred care.

Trainees learn to manage their own countertransference and empathize with patients in distressing situations (this is drawn out in debriefing rather than naming explicitly). For example, in scenarios involving rapid tranquilization or involuntary detention, participants practiced maintaining calm while upholding patient dignity. These exercises prepare them for real-life emergencies where ethical judgment and emotional regulation are vital.

The immersive nature of simulation also helps identify blind spots in learners’ ethical frameworks or clinical knowledge. Participants often discover unconscious biases or outdated assumptions. One resident doctor in our programme noted how they had never previously questioned their belief that refusing insulin was automatically grounds for intervention. The scenario helped them articulate and challenge this assumption and understand the complex balance of a patient’s competing human rights.

In addition, the emotional realism of simulations can reduce learner detachment. Traditional teaching and portfolio requirements can make ethical reflection feel formulaic, whereas simulations place learners into ethically fraught situations that mirror real-world complexity. This emotional investment creates fertile ground for meaningful, reflective practice. Simulation prepares doctors for ethically complex, high-stakes situations such as capacity assessments, forced sedation, or mental health detention. These scenarios are often too risky to practice in real life. Practicing them in a safe setting enhances clinical decision-making and confidence.

Studies show that simulation significantly boosts preparedness for psychiatric emergencies (*Ajaz et al., 2015*). Importantly, a recent systematic review and meta-analysis further supports this, showing that simulation-based learning significantly improves knowledge, skills, and confidence across a range of psychiatric scenarios, particularly when it includes structured feedback and reflective debriefing (*Piot et al., 2020*). Trainees report increased confidence across tasks like using mental health law and de-escalating crises. These gains translate into safer patient care, fewer errors, and improved respect for patient rights.

Practicing the management of a psychotic patient who had attempted to drive into a wall, based on a real scenario, encouraged participants to consider competing psychiatric needs and legal obligations. Participants struggled with the balance between ensuring safety and showing compassion, and the debrief allowed these tensions to be explored openly with the aid of skilled facilitators. Patient-centredness was not assumed but therefore earned through rigorous ethical reflection.

In the button battery ingestion scenario, participants learned to recognise acute medical illness in a psychiatrically unwell patient and the need for urgent coordination with medical and surgical teams. Such skills are vital in real-world settings where delay or miscommunication can result in irreparable harm. Repeated exposure to ethical challenges in simulation further builds moral resilience. This is increasingly important in the context of burnout and moral injury in healthcare and psychiatry. Simulation may therefore also serve a preventive function in staff wellbeing, enabling clinicians to better process and learn from morally difficult encounters.

Simulation fosters interprofessional learning, mirroring real clinical teams. Scenarios involving multiple professionals such as doctors, nurses and social workers further enhance understanding of roles and strengthen collaboration and indeed team morale. This leads to more coordinated care and better patient outcomes. Feedback and reflective debriefs are core to simulation. They encourage participants to analyse communication styles, decision-making, and emotional responses. The next step could be to include patient representatives in development and feedback, further enriching this process.

Moreover, co-production with patients and carers can improve and refine the design of simulation scenarios, ensuring they reflect lived realities. Engaging service users in co-design not only aligns scenarios more closely with genuine patient experience but also fosters dignity, respect, and partnership in care. For example, *Clarke et al.* (2022) described a multi-agency, mental health simulation programme intentionally co-produced with service users and carers; participants reported increased empathy, understanding, and responsiveness after the intervention, demonstrating tangible benefits in real-world contexts

Critically, simulation also encourages reflective peer learning. Watching peers navigate a challenging interaction such as a chaotic emergency encounter with an agitated patient, can help observers internalise both effective and ineffective communication strategies. Structured group debriefing, when managed well, reinforces this shared learning whilst also maintaining that any negative experiences are not exposed outside of the simulation.

Conclusion

Simulation-based education is a transformative strategy to improve psychiatric training for the benefit of patients. It builds clinical and ethical competence, enhances communication, and promotes interprofessional collaboration. Psychiatry is particularly well-suited to this approach, as it requires few technical resources, only time, expertise, and thoughtful design. Practising complex scenarios in a safe environment enables clinicians to navigate uncertainty, uphold autonomy, and develop confidence in ethically fraught situations.

My experience in the Western Trust, one of the most socioeconomically deprived regions in the UK, demonstrates the feasibility and impact of this approach. Participants emerged better equipped to manage psychiatric emergencies with empathy, legal clarity, and emotional resilience. Embedding simulation into postgraduate training is therefore not just a pedagogical enhancement, but a moral imperative. Medical education must ultimately serve the betterment of patient care; simulation helps bridge the gap between competence and compassion.

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