ORIGINAL RESEARCH

Simulation training for healthcare leaders supporting returning doctors

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ABSTRACT

Background
Many healthcare professionals experience challenges when returning to practice after absence, potentially affecting their health and wellbeing outcomes as they might relapse and need to take another leave of absence. These challenges may also affect patients by impeding the quality of care provided by the professional. Research suggests that managerial support can ameliorate some challenges that professionals encounter when returning to work.

Objectives
This pilot study evaluates a simulation training intervention offered to multidisciplinary supervisors of returning doctors in order to improve doctors' reintegration into the workplace

Methods
Participants (n = 38) were healthcare leaders who completed a 1-day training course consisting of didactic and experiential components.

Results
Thematic analysis identified that participants noticed changes in their social skills, management abilities, values in their managerial roles and implementation of structure in the workplace.

Conclusions
Simulation training might improve managerial competency when supervising doctors return to work. Future studies should address inconsistencies in feedback form completion and limitations of self-reporting questionnaires. Additional assessments of returning doctors' outcomes following intervention delivery could also be beneficial, as these were not evaluated in the present study.
A larger study is currently being conducted to evaluate impact and increase understanding of how simulation training can improve managers supporting doctors returning to practice.

Introduction

Healthcare professionals may take a leave from work for various professional or personal reasons, with approximately 10% of trainee doctors being out of practice at any one time in the United Kingdom [1]. Leave as a result of illness can cost over £100 billion per year, with long-term absences costing

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employers £11 billion annually [2]. Upon return to work, doctors may encounter several challenges, including a lack of confidence in clinical ability [3] and difficulties adjusting to new workplace organizational systems [4]. Not only does this impact the health outcomes of the professional by potentially resulting in a relapse of illness or the need for another leave of absence [2], the failure to organize a well-planned and timely return to work may also negatively affect patient outcomes [5].

Some doctors cite poor communication from managers and changes to job structures as obstacles to a smooth transition back to work, whilst personalized support and clearly outlined rehabilitation plans from managers were found to be protective factors [4]. One study reported that doctors perceive a lack of support from their colleagues after completing their leave, highlighting the importance of proper managerial support for doctors upon their return to the workplace [6].

Simulation courses have been offered as a training modality to support professionals returning to work, as well as to develop the clinical practice and professional development of healthcare staff [7–9]. However, there is currently a paucity of evidence-based simulation interventions aiming to improve managerial support for returning trainee doctors. This paper evaluates the benefits of a training intervention for supervisors of doctors returning to work after a leave of absence.

Methods

Training course

Four 1-day courses were offered to healthcare leaders. The courses aimed to enhance participants' communication and advanced listening skills, develop participants' empathetic and value-based leadership styles and allow participants to acquire essential coaching techniques to improve the outcomes of supervisees and patients. Training activities and subsequent learning outcomes were created based on reports from the Academy of Medical Royal Colleges [10] and Health Education England [1], outlining guidance for supported return to practice.

The course consisted of didactic and experiential simulation components (see Table 1.). The didactic modules focused on coaching techniques (including the GROW Model), appropriate verbal and non-verbal (also known as physical) communication, the circle of care and how to give critical feedback following the Advocacy Inquiry Model [12]. Experiential components included a listening exercise, coaching exercise and two simulated scenarios regarding a medical trainee who has experienced difficulties when returning to work. Following engagement in the scenarios, participants were debriefed following the Diamond Model [13].

Procedure

Training sessions took place at the St Helier Hospital Education Centre in South London with a multidisciplinary team comprised of psychologists, doctors and nurses, all with expertise in simulation training. The 1-day sessions were completed within 7 hours between April and October 2019. Whilst the timetable has been slightly revised since the pilot delivery, the training session activities and learning outcomes remained consistent across the 4 sessions. The training was offered to postgraduate educational supervisors, senior clinicians, workforce representatives, trainer faculty and other healthcare professionals involved in postgraduate medical training across South London, and not exclusive from the medical professions. Participants (n = 44) were college tutors (n = 5), educational supervisors (n = 14), clinical supervisors (n = 2), nurses (n = 6), doctors (n = 2), and other allied health professionals not otherwise specified (n = 15).

Two facilitators led the training interventions, which were offered to four groups of healthcare leaders. The courses began at 9.30 with an introduction, with the remainder of the morning consisting of didactic modules. Participants were given a brief 15-minute break, followed by more didactic components, then a lunch break. In the afternoon, participants engaged in the experiential exercises and scenarios. Each scenario lasted 10 minutes and every participant actively engaged in at least one scenario, with participants rotating between being actors or observers. Each participant entered the scenario with the position in which they were currently employed, i.e. a nurse would enter the scenario as a nurse, a doctor would enter the scenario as a doctor. Following, observers provided feedback on the interaction, and all participants were debriefed following the Diamond Model [13]. A summary of the key learning outcomes was presented, then a self-care closing exercise was run. Participants were asked to evaluate the course via open question forms post-training to assess knowledge self-confidence in one's clinical role for their supervisees.

Preliminary findings

Thematic analysis

Thematic analysis [14] was used to determine what participants learned from the course and how it could be applied to their practice. This included collating and reviewing the data, coding the key elements, then identifying the recognized themes. Analysis was conducted by the lead author, then reviewed and finalized with other researchers to mitigate bias. Analysis demonstrated that participants improved in the following four areas: social skills, management abilities, personal values in management roles and implementing structure.

Interacting constructively. Many participants reported perceived improvements in their interpersonal abilities and listening skills, particularly with regard to communicating clearly, directly and effectively with their staff. Participants also mentioned intentions to better engage and spend time with their staff and colleagues in an attempt to be more supportive. Reports were made regarding the intention to use more probing questions when interacting with their supervisees in order to gain a better appreciation of the supervisee's situation and to encourage employee-led solutions to instil confidence and resilience. Additionally, managers felt more able to provide feedback without expressing judgement.

Table 1 : Training session activities and learning outcomes

Learning outcomes	**1. Development of communication skills, with a focus on advanced listening skills. 2. Development of leadership skills, with insights to techniques that comprise authentic, value-based and empathetic leadership styles. 3. Development of coaching skills, providing an introduction to key skills and techniques.**	
Module type	Activity	Description
Didactic	Introduction to coaching	Participants are taught the basic principles of coaching and mentoring.
	GROW Model[11]	Coaching model consisting of four elements: Goal: what do you want? Reality: what is happening? Options: what could you do? Will: what will you do now?
	Communication	Participants learn about verbal and non-verbal communication; emphasis on what is said, how it is said and how accompanying body language and behaviour influences the interaction.
	Circle of care	A framework highlighting the importance of thinking about, practising and demonstrating compassion towards oneself and others.
	Constructive feedback	Advocacy Inquiry Model: a framework for providing constructive feedback. Advocacy: *When you (describe behaviour), I felt (describe feelings/ affect)* Inquiry: *Were you aware/why do you think this was happening?* BOOST feedback: providing balanced, observed, objective, specific and timely feedback to a coachee.
Experiential simulation	Listening exercise	In pairs, the participants practice speaking about important matters. One participant speaks for two minutes and the other listens. The listener is allowed to ask two questions: 'what do you want to talk about today?' and 'is there anything more?' In a debrief, both parties are asked how they felt during the exercise. The speaker is asked to make note of the non-verbal behaviours they noticed in the listener, and the listener is asked what they noticed about themselves.
	Coaching exercise	In groups of 3, participants simulate a coaching scenario. One coach is asked to direct the conversation with the GROW Model in mind. The coachee is asked to discuss a problem that needs to be solved. An observer is asked to provide feedback about the coaching process.
	Scenario 1	In a coaching circle, one participant simulates the role of a supervisor who is approached by a medical trainee with a complaint about Rebecca – a trainee returning after a 3-year leave of absence due to illness. The trainee expresses frustration with Rebecca. Observers are asked to comment on the simulated interaction. All participants are debriefed.
	Scenario 2	In a coaching circle, a supervisor is asked to approach Rebecca with constructive feedback to address complaints from other trainees. Observers are asked to comment on the simulated interaction. All participants are debriefed.

> Respondent 5; R5: '[I will] try to listen more, make use of gestures as a means of showing interest, and restrict myself from interrupting while being spoken to.'
> R9: '[I learned] to be direct without making the person feel undermined.'

Managing supervisees more effectively. Participants reported feeling more confident in their management abilities and felt more competent managing their employees' complex and difficult situations, compared to previously feeling less able to approach their employees in times of need. Providing participants with didactic tools and experiential practice appeared to be beneficial and well received.

> R26: '[The training was] useful with regard to facilitating a meeting with a trainee in difficulty and having the confidence to do this.'

Changing values. Participants revealed changes in values in their roles as supervisors. Specifically, many mentioned the intention to be more empathetic, patient, trusting and respectful towards their supervisees upon their return to work. This demonstrates a shift in the supervisors' values as a result of participating in the training sessions, which might foster the development of a better professional rapport and improve the work environment to optimize supervisees' return to work.

R26: '[I will prioritize] trust and feelings of safety of trainees.'
R22: '[I learned] how to demonstrate empathy when necessary.'

Implementing tools. Participants mentioned that they intend to implement more structure in the workplace by utilizing the models and techniques which were taught in the intervention, which were previously unbeknown to the supervisors. This illustrates the utility of the didactic modules in teaching supervisors about key coaching skills.

R24: '[I will] implement the GROW model', and '[I learned] the value of using a model to structure conversations.'

Whilst all feedback was positive, some participants identified elements of the course to be improved. Suggestions included more small group work, more background information on coaching, reducing work stress and identifying supervisees' current challenges, and providing more resources which could be distributed to supervisees in order to support their return to work.

Discussion

Preliminary findings demonstrate the potential benefits of a training intervention for supervisors of returning doctors. Thematic analysis found that participants perceived improvements in their interpersonal skills, improved management abilities, changes in values and implementation of structure in their practice. The identification of these themes demonstrates that the learning outcomes of the course were effectively met.

These findings are consistent with previous research suggesting that simulation training significantly improves self-efficacy in professional and social skills [9], as simulation training may provide the opportunity to practice and develop skills in a psychologically safe environment. Research has also established the efficacy of simulation training in improving communication and collaboration between professionals [8], further supporting the present findings. This study highlights the potential of experiential learning to improve the practice of healthcare professionals in relation to supporting colleagues, in addition to providing clinical care to patients. This provides an example of the pedagogy and methods of simulation training being applied to working relationships in the context of peer and pastoral support.

It is important to acknowledge the inconsistencies in feedback-form completion, with several of the pre- and post-course questionnaires being partially or fully incomplete – only 11 participants completed pre-training questionnaires, though 36 completed the post-course questionnaires. However, current research using qualitative and quantitative methodologies is being conducted to provide a better understanding of the participants' improvements from pre- to post-course assessment.

Another limitation is that this training intervention was only provided to training supervisors and healthcare leaders, failing to assess the trainees' outcomes following course delivery. Future research could benefit from investigating the impact of this training on supervisees.

Previous evidence clearly illustrates the pivotal association between proper organizational function and doctors' performance [15], which has important ramifications for patient outcomes. As this course has the potential to improve the provision of managerial support to returning doctors, therefore improving workplace operation, the present training intervention has consequential implications for the healthcare sector.

Declarations

Authors' contributions

Kat Novogrudsky and Hannah Ianelli led on drafting the manuscript, while all authors contributed to the overall project, including the final manuscript.

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Availability of data and materials

Research data are not shared.

Ethics approval and consent to participate

Ethical approval for the study was provided by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee at King's College London on behalf of the Health Research Authority. Ref. no. PNM/1314/173. The cited information in Table 1 are not from an actual patient. Any resemblance to a real person, living or deceased, will be coincidental.

Competing interests

No competing interests.

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