Students growing students—Seeded by scaffolding deliberative practice

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ASOP (Assessment, Subjective, Objective, Plan) mind map as a progress note. The GMEB mind map re-organises the above-mentioned 15 categories into four GMEB categories and their distinct but easily associated subcategories. We make GMEB visually memorable by relating genes (G) to an individual's lower abdomen, mind (M) to head, environment (E) to factors external to the body and body (B) to the centre of the body. The GMEB also conveys the fact that all illnesses are caused from interactions between genes, mind, environment and body. The ASOP mind map is formed by branches of ASOP datasets with 'A' in the first rank and 'SOP' in the second. Problems and illnesses are marked under 'A' and are related to major relevant organs. For example, 'A' could be 'pneumonia' and is related to the lungs; then, 'S' records the patient's symptoms pertinent to pneumonia (if any), 'O' records objective data (i.e., physical examinations, imaging studies and laboratory examinations) pertinent to pneumonia and 'P' records related plans. 'A' and 'P' change whenever a substantial new 'GMEB' or 'S' or 'O' data become available. Thus, the human body becomes the cue and structure of clinical information collection, presentation and reasoning. Fifty-three medical students with 1 to 12 months experiences in editing computerised POMRs who learned and implemented this model were surveyed. Nearly all participants were satisfied with the model and agreed that it could help them collect data and supervise a patient's condition more systematically and efficiently than POMRs. Around 90% agreed that it could help reduce unnecessary treatments and examinations and avoid missing required treatments and that it should be integrated into current medical record systems. Altogether, 83% agreed that it could help avoid missing required examinations. Other proposed advantages include that it was interesting, memorable, readable, easily understood and helpful in clinical learning. Disadvantages include software issues, taking time to master and requiring a teacher's supervision.

3 | WHAT LESSONS WERE LEARNED?

The 'body mind map' medical record provides a visualised structure and cue for systematic data collection, presentation and reasoning. It synchronises what we see (human body), what we think (clinical reasoning) and what we edit (medical records). This model is welcomed by students and might improve clinical practice and learning.

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1 | WHAT PROBLEMS WERE ADDRESSED?

Health students generally commence their studies with science and clinical curricula and then find more reflective practice and ethical reasoning difficult to demonstrate. The ability to reason subjectively is critical, particularly with the increasing importance of person-centred health care and practitioner well-being. Pharmacy students struggle to articulate how their values underpin ethical reasoning or reflective practice, historically resulting in poorer performance in registration exams.

The authors support students to develop these skills across multiple courses in two pharmacy programmes (Bachelor and Master). Various strategies have had limited success. Student assertion of limited confidence or that they cannot 'think that way' contradicts values-driven student behaviour observed by staff. The challenge has been finding a way for students to personally uncover these values and build confidence and self-efficacy in ethical reasoning and complex decision making.

2 | WHAT WAS TRIED?

Deliberative Practice Network (DPN) (https://deliberativepractice.com) activities were scaffolded through a pharmacy programme to facilitate navigation through ethical dilemmas using a values-based framework, increase self-awareness of how values and evidence are inter-related in health professional decisions and improve student articulation of their own ethical decisions. The DPN has been used globally to make values-based elements of problem solving explicit to health students in a safe and collaborative learning environment. Students respond individually to online dilemmas and then explore group results to develop ethical reasoning, more confident decision making, articulation of potential outcomes and greater appreciation of the complex diversity of values inherent in practice.

Students were introduced to the DPN in a facilitated first-year workshop to promote confidence in values-based ethical reasoning and assessed via written reflection and a verbal case. The DPN was reintroduced two trimesters later, through student-driven assessment following experiential placements in community and hospital pharmacy, in aged care facilities and in both urban and rural settings. Student groups developed a scenario of an ethical dilemma for the platform, based on placement experiences. They then responded individually to all student-developed scenarios online. Assessment included a group presentation to their peers and academics, involving analysis and interpretation of their dilemma, and their insights into diversity in student responses.

3 | WHAT LESSONS WERE LEARNED?

The DPN values-based framework provided students with a process for tackling ethical dilemmas that increased student self-awareness and confidence. Student-driven assessment extended this to interpretation of their dilemma, proposed actions and the diverse views of others. It created a sense of community responsibility, with students more invested in their own responses due to reliance on peer input for analysis, and their attitudes shifted from self-centric to outwardly facing considerations. Students engaged well at both time-points and valued the DPN, so it will continue to be developed. A need for greater exposure to authentic scenarios earlier and continued scaffolding of these intofinal year capstone learning activities was highlighted by student expression of variable confidence in understanding of legal and ethical issues and limited ability to fully articulate the nuances of an ethical dilemma.

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Resident panel management to address continuity of care

1 | WHAT PROBLEMS WERE ADDRESSED

Routine primary care follow-up is essential for optimising patients' overall health and well-being. Unfortunately, the COVID-19 pandemic has led to delayed care across the country, including primary and preventive care. We aimed to proactively address this by increasing patient follow-up rates at the Cleveland Veterans Affairs Medical Center Primary Care clinic.

2 | WHAT WAS TRIED?

Using an electronic medical record (EMR) data collection tool, we identified patients who were lost to follow-up—defined as having no future appointments scheduled or pending—and labelled them as 'no future care' (NFC).[1] Resident panel sizes ranged from 197–217 patients, and the mean NFC rate per resident panel was 18.8%. We proposed reducing NFC rates using a resident-led panel management approach.