

## Action Plan for Norwich Medical School, University of East Anglia

### Requirements

Report Ref	Due Date	Description	Action taken by medical school to date	Further action planned by the medical school	Timeline for action (month/ year)	School lead
N/A	N/A	N/A	N/A	N/A	N/A	N/A

### Recommendations

Report Ref	Due Date	Description	Action taken by medical school to date	Further action planned by the medical school	Timeline for action (month/ year)	School lead
	Next scheduled report to the GMC	We encourage the school to continue with their plans to reintroduce patient and public involvement.	(Since November 2015) a) On February 29 2016, we held an Experts by Experience event, where senior members of the MB BS team came together for dialogue with 20 lay people and five students. Key aspects of the course were explained: admissions process, the different modules, professionalism, the clinical exposure in primary and secondary care, consultation skills and the inter professional education. As well as question and answer sessions after each of the four presentations, there were group	a) Two lay people have been recruited to Professionalism Committee, with the support of the staff Student Liaison Committee (SSLC).  b) Each module will recruit lay people, with lived experience of the relevant health issue, to participate in face to face meetings of the module team (> once per year). Many of these module representatives will be drawn from the group that attended the Experts by	<b>September 2015-Mar 2016:</b> "Working with disabled people" module runs for first time <b>29 February 2016:</b> First Experts by Experience day held <b>June 2016:</b> CDD group considers report of day and agrees next steps <b>June 2016:</b> Training event held for service users contributing to UEA Faculty of Medicine and Health Sciences <b>September 2016:</b> Thank you	Professor Tom Shakespeare, FMH Service User Lead

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			<p>discussions between staff, students and lay colleagues. The discussions focussed on four questions relating to the presentations (Appendices A and B).</p> <p>Everyone felt this day went extremely well. Understanding grew between lay people and MED staff. Valuable contacts were made. All comments and suggestions were recorded, and a report is in preparation for submission to the Curriculum Design and Delivery committee (CDD). The activity will be repeated in two or three years' time.</p> <p>b) A Studies Allied to Medicine (SAM) optional module "Working with disabled people" was held for second year students, in ten sessions between 24.09.15 and 03.03.16 Each week, several lay people with particular lived experience came to talk to the students and answer questions. These included: learning disability, mental health, physical disability, hard of hearing, deafness, sight loss, parent of autistic boy, parents of disabled children. The module evaluated very positively, and was perceived to be very different from the patient exposure obtained through primary and secondary care (Appendix C). The module will be repeated in future years.</p>	<p>Experience event, who are now well briefed on Norwich Medical School's MB BS course.</p> <p>These lay people will be offered the chance to review the learning outcomes, PBL cases, schedule of lectures and other teaching, and invited to give feedback. In particular, the discussion will centre on how to communicate the patient experience and those aspects of prevention, diagnosis, treatment and rehabilitation which pertain to the wider social experience of illness. Module Organisers will be supported in this activity.</p> <p>c) One - two lay people will be recruited to the Admissions Committee, which has oversight of the Admissions process. They will be asked views on how to select students who have empathy and compassion, and will contribute to design of Multiple-mini Interview (MMI) stations and questions. The option of including lay interviewers is under consideration, although the logistics of numerous interview days makes this daunting logistically.</p>	<p>event for service users who contribute to UEA Faculty of Medicine and Health Sciences</p> <p><b>September 2016:</b> Deadline (MB BS Away Day) for all modules to have recruited lay people, or have an action plan in place to achieve this</p> <p><b>December 2016:</b> Deadline for completion of online training for FMH staff working with service users</p> <p><b>December 2016-</b></p> <p><b>March 2017:</b> Admissions cycle: to reflect input from lay people based on membership of Admissions Group and Experts by Experience Day feedback</p> <p><b>June 2017:</b> Review of progress with lay involvement at CDD</p> <p><b>February 2018:</b> Second Experts by Experience day held</p>	
[MSch] 2	Next scheduled report to the GMC	We encourage the School to continue to develop formative assessments in year two of the programme.	a) The Year 2 team (which consists of the Head and Deputy Head of Year 2, the Year 2 module leads for modules 3, 4 & 5 and the Year 2 Assessment lead), have met on three occasions since November 2015 (25 <sup>th</sup> January, 29 <sup>th</sup> February and 21 <sup>st</sup> March 2016) to discuss the formative	a) The SAQs that have been generated for Year 2 now need to be added to our electronic assessment platform, Rogo. The Year 3 and Year 4 formative papers are already in Rogo. By adding the Year 2 formative paper to Rogo, the	<b>November 2015 – April 2016:</b> Development of new formative SAQs for Year 2 modules (Dermatology/ Haematology, Circulation and Respiratory)	Dr John Winpenny – Head of Assessment Dr Pauline Bryant – Head of Year 2 Professor Lesley Bowker, Clinical Skills Director
					<b>April 2016 - May 2016:</b> SAQ	

Report Ref	Due Date	Description	Action taken by medical school to date	Further action planned by the medical school	Timeline for action (month/ year)	School lead
			<p>assessment for Year 2. Initially, the Year 2 team are going to develop a short answer question (SAQ) paper that contains 6 x formative SAQ questions (2 x SAQ per module) that cover the Year 2 modules [module 3 (Dermatology/Haematology), module 4 (Cardiovascular) and module 5 (Respiratory)].</p> <p>b) This SAQ paper for Year 2 will be similar in format and delivery to the formative SAQ papers we now have in Year 3 and Year 4 of the MB BS programme, which were introduced in the academic year, 2014-15. Year 1 has had a compulsory, formative written paper (consisting of 40 x single best answer (SBA) and 4 x short answer question (SAQ)) since academic year, 2011-12.</p> <p>c) To date the Year 2 team have generated the 6 x SAQ questions (2 x SAQ per module).</p>	<p>students will be able to access the formative paper at a time that is convenient to them. The Rogo platform also allows bespoke feedback to be given to the students once they have completed the questions.</p> <p>b) During the next academic year, the Year 2 team will develop several single best answer (SBA) (best of 5 multiple choice questions (MCQ)) to add to the Formative paper for Year 2.</p> <p>c) In future the formative SBA and SAQ papers for Years 2 will be available for each subsequent student cohort from April each year.</p> <p>d) the development of a formative OSCE for year 2 will be part of a coordinated programme of expansion taking into account availability of the Clinical Skills Resource Area and the availability of more senior years' students to give up a weekend to participate as mock-OSCE assessors. The pilot of year 3 formative OSCE on this module will run later this year and the outcome of that will determine the next steps as regards making this provision for year 2 of the MB BS.</p>	<p>Paper to be created in Rogo. Students to be uploaded into Rogo.</p> <p><b>May 2016 – July 2016:</b> Students given access to Paper in Rogo so they can utilise the formative paper during their revision before their summative written assessment. Feedback will be received automatically via Rogo on completion.</p> <p><b>18- 19 June 2016</b> Year 3 mock OSCE (formative)</p> <p><b>July– August 2016</b> review success of year 3 Mock OSCE to determine feasibility of introducing for year 2 (student feedback and timetable capacity)</p> <p><b>September 2016 – December 2016:</b> Development of best of 5 MCQ questions covering Year 2 modules (Dermatology/Haematology, Circulation and Respiratory)</p> <p><b>January 2017 – March 2017:</b> SBA paper to be created in Rogo. Students to be uploaded into Rogo.</p> <p><b>May 2017 – July 2017:</b> Students given access to SBA paper and SAQ paper in Rogo so they can utilise the formative paper during their revision before their summative written assessment. Feedback will be received automatically via Rogo on completion.</p>	

## Faculty of Medicine and Health Sciences

**Experts by Experience Day - Undergraduate Medical Education Day**  
**29<sup>th</sup> February 2016 09:30 NEAT suite (QB 1.09)**

Disabled people, patients, service users and members of the public are invited to the first of what we hope will become an annual event at Norwich Medical School. We want to share our ways of selecting, teaching and assessing medical students with a wider audience, and get feedback in small group discussion. We want to capture the views of “experts by experience”, about how we might improve our course. Our aim is to ensure that our students have the best possible understanding of the whole patient experience, and an understanding of working in partnership with patients to plan their care.

### Itinerary

09:30	Welcome and coffee – there will be information posters displayed and members of staff available to answer questions
09:45	Welcome: Dr Tom Shakespeare Introduction to the Course: Professor Richard Holland 'How we teach medical students and what makes our course special?'
10:00	Selecting students – a demonstration of the 'multiple mini interview': Professor Mary Jane Platt
10:15	Putting the patient at the centre: Consultation Skills and Interprofessional Learning: Sandra Winterburn and Susanne Lindqvist
10:30	Small group discussions (questions 1 and 2)
11:00	Coffee break
11:20	Teaching with patients in GP Practices and Hospitals: Dr Richard Young and Dr Lesley Bowker
11:35	'Fitness to practise' – how we ensure professional behaviour by students: Mr Carl Philpott
11:50	Small group discussions (questions 3 and 4)
12:20	Concluding comments: Dr Tom Shakespeare, Dr Richard Holland
12:30	Light lunch for those who wish to remain and talk with Norwich Medical School staff members. The event will end at 13:30

The two group discussion slots will be used to gather responses to the following four questions:

1. Admissions: What personal qualities make a good doctor? How can we identify that in an interview?
2. Scenarios and lived experience – can a role player be as good as a real person?
3. Patient feedback: What would make useful feedback for students, from patients? What feedback would be useful for experts by experience who contribute to teaching?
4. What make a doctor 'unfit' for practice?

PTO

### Acronyms and terms explained

Experts by Experience	By this we mean patients, or any members of public who have an interest in medical education, or perhaps have family members who have experienced care from the NHS, who wish to contribute to helping improve undergraduate medical education. UEA FMH has an Experts with Experience Committee to engage with service users.
MB BS	Bachelor of Medicine, Bachelor of Surgery. This is a five year, undergraduate course in all aspects of medicine that leads to the professional qualification of 'Doctor'. Graduates complete a further two years of general post-graduate training based in hospitals (often known as 'junior doctors') and can continue with further specialist training after this.
FMH	Faculty of Medicine and Health Sciences, one of four Faculties (or academic departments) in the University. The other School in our Faculty is Health Sciences (HSC) which educates nurses, and other health professions such as physiotherapists, occupational therapists etc
SPT	Structured Patient Teaching is when volunteer patients come and take part in teaching delivered in the hospitals; clinicians lead the session – for example a patient consultation or examination - and they answer questions from the students and provide feedback after the session.
Role play	To improve their consultation skills, students work regularly with specially trained actors to rehearse a wide range of situations where doctors and patients are in discussion, such as gathering information from a patient, children's health, assessing mental capacity and breaking bad news.

## Experts by Experience Medical Education event – 29th February 2016

### *Group Discussions*

Q1) Admissions: “What personal qualities make a good doctor? How can we identify that in an interview?”

Group discussions identified several themes that were considered to be important at the admission stage – some related to the candidate themselves - empathy, motivation, experience, and “other” personal qualities. Some related to the logistics of the interview panel itself.

#### **Empathy and Compassion**

Almost every group identified the “empathy and compassion” of the candidate as a good, if not essential, quality for a prospective student to make a good doctor. Eye contact, listening, relating to people, not looking down on them and seeing them “as a person and not a disease or illness” were all identified as essential traits in a good doctor. Being able to address differences in perspective and “understanding the qualities of disability” were also considered to be important. The ability to act as a ‘conversational partner’ with those that are socially anxious or have “whitecoat fear”, as well as the elderly, those with dementia, the deaf, the learning disabled or autistic was considered to be key. The ability to build and maintain rapport seems to be fundamental to this aim.

On a practical level it was suggested that asking potential students to reflect on an image of a disabled person and respond to the question “What is this image communicating?” would give some indication of their level of empathy.

#### **Motivation**

Several groups identified the need to tackle the fundamental question “Do you really want to be a doctor?”. The suggestion being that the interview for admission should be a chance to “tease out true motivations”. The importance of a candidates “gut feeling that it was a good idea” was in one case identified as an important factor in assessing their motivation.

#### **Experience**

One way to potentially measure motivation is “experience”. For example, can the candidate show evidence of previous experience with patients or show any previous interest in caring – volunteer work, intergenerational projects or helping younger students at school – were all identified as good signs of a demonstrated interest in ‘caring’.

## **Personal Qualities**

The qualities of imagination, lateral thinking, proactivity, resilience and humility – especially being able to admit when they are wrong, or don't know something – were all considered to be essential qualities for a good doctor.

## **Interview Panel logistics**

It was felt that both students and service users should be more involved in the admissions process. The feedback of these groups should form a much larger component of the admission and selection process. One group suggested multiple interviews with multiple opportunities for prospective students to show their qualities. A suggestion was also made for a group discussion in which all potential candidates participate. One group suggested that there should be a “wider perspective” on what makes a good doctor with a less “academically focused” view on selection.

Q2) Scenarios and Lived Experience - Can a roleplayer be as good as a real person?

This question raised several issues and the interesting conclusion overall was that people generally felt that there was a place for both good roleplayers and good service users.

Authenticity, Passion and depth of knowledge were identified as areas where service users were stronger. Roleplayers were considered to be less passionate and authentic as they did not share the same lived experience and ‘life history is very difficult to replicate’. A genuine service user was felt to have more impact as they can *actually* show some of the barriers and challenges that they face. Some groups identified the fact that non-verbal communication was an important part of understanding a service user's experience which could not be replicated with a roleplayer. The service user's view was also felt to be less “institutionalised”. It ‘brings the “outside” opinions in’ and gives more transparency’.

In terms of ‘depth of knowledge’ it was stressed that the scripts that roleplayers use need to be thorough to be of value so that they could deal with any “off piste” questions.

However, roleplayers were considered to be better when it came to the ‘structure’ of teaching – ‘using an actor you can gear it to the objectives of the session’ and ‘actors can be coached to bring the student back to a certain point, they can “behavioural shape” the wrong body language or they can reinforce it’. It was felt that a roleplayer could give a more controlled environment which could be useful for dealing with ‘awkward topics’ particularly for newer students.

A particular example of good roleplay was identified in ‘Barbara's Story’.

The conclusion of most groups was that a ‘variety of angles’ gave the best result and service users working in concert with roleplayers seemed to be the optimal solution for everyone as it gave depth and authenticity as well as control to teaching sessions.

Q3) Patient Feedback: ‘What would make useful feedback for students from patients? What feedback would be useful for experts by experience who contribute to teaching?’

Everyone emphasised the importance of feedback, both positive and negative, with a particular emphasis on offering “constructive” criticism. A suggestion was made that it would help if people were trained in how to give feedback as both groups would like to receive feedback. However it was recognised that although negative feedback can sometimes be the most useful, some people would be uncomfortable *giving* negative feedback. Training in how to give ‘constructive criticism’ would help allay

those fears. Supporting patients to be honest and give feedback at the time would also help.

Students were encouraged to design their own feedback forms in order to answer specific questions after the session, but certain groups suggested that feedback should be given from the start. Although suggestions were made that it would be important to ask for permission to give feedback in all circumstances.

Overall, both service users and students were keen to receive both positive and negative feedback as it was felt to strongly support their learning, and their ability to improve their skills no matter which group they belonged to. It was suggested that there were many formats for giving feedback and, as well as asking for permission to give feedback, it was also good practice to determine which mode of feedback the individual in question would prefer. Some questions were raised, however, as to the appropriateness of immediate feedback when students usually work in pairs.

Q4) What makes a doctor 'unfit' for practice?

Perhaps unsurprisingly the qualities that were identified in the groups as making a doctor 'unfit' for practice are the converse of those that make for a 'good' doctor. Lack of rapport, empathy and a lack of interest in the patient were identified as failings in a doctor. It was considered to be particularly important that the doctor have integrity – they “should do what (*they*) say (*they*) will do”. Poor timekeeping was also identified as a problem.

Humility was again identified as an issue, with 'unfit' doctors being those that 'think their expertise is better than their patients', 'make assumptions' and 'don't admit their limitations'.

Disregarding the code of ethics, not respecting others and a lack of clinical expertise were identified as practical, specific problems.

Interestingly most groups chose to focus on what they wanted from their doctors rather than perhaps what they did not want. Compassion, empathy, communication skills, rapport building and integrity were again strongly represented as positive qualities for a good doctor. In addition to this, curiosity, a holistic approach, a recognition of issues of equality, a non-judgemental demeanour and the ability to relate to patients at the same level were also identified at this stage as desirable qualities for a good doctor.

## Experts by Experience Medical Education event – 29th February 2016

### *Feedback form analysis*

There were 19 responses recorded  
13 Service Users  
3 Staff  
3 Students

### **Introduction**

The questionnaires that we gave out on the day were to try to establish how well we achieved our objectives of informing, creating an optimistic feeling about service user involvement, ensuring that people's access needs were met, running a well organised event and creating an event to which people would be interested in returning.

On all metrics we achieved a majority of positive results with most people reporting that they were "very" satisfied with our performance in each area. Perhaps most encouragement can be gained from the fact that our best scores were achieved on the questions "How informative did you find the day?" and "How interested would you be in attending again?" which achieved near perfect scores.

It is worth noting however that the sample size is too small for a particularly meaningful quantitative analysis but qualitatively the feedback was excellent. Some areas were identified in which we could make small adjustments to create an even better event next time. More staff feedback would have been nice in order to understand staff views on the two way exchanges that took place on the day.

Q1) How informative did you find the day?

The results were analysed on a scale of +2 to -2 where "Very informative" was given the score +2 and "Not at all informative" was given the score -2 with "Not sure" having a score of 0.

The average score for "informative" amongst all groups was Mean 1.6 (out of a possible 2 max score) / with a Mode of 2.

Most people therefore found the event to be "Very informative".

If we separate out the service user group on their own the average on the "informative" metric was even better at 1.8 – close to the maximum score on this metric.

### **Positive Comments**

"I was impressed at how much was covered".

### **Suggestions for improvement**

Smaller discussion groups with more time on each question. Feedback on the group discussions as part of the event. Information in different formats for a more diverse range of disabilities. An additional slot for an existing expert by experience to talk about their role and a student to talk about their perspective. A presentation of student support would be useful. Some people would have liked more emphasis on the professionalism committee as a supportive structure for students. Some people found that there was too much information to digest. I felt that it was a little bit 'us and them' regarding the students and those with lived experience. A lot of us are expert patients ourselves

Q2) How optimistic are you about service user involvement at Norwich Medical School?

The average score for all attendees was Mean 1.5 / Mode 2.

Again, the majority of people found the event caused them to be "Very Optimistic" about service user involvement

The average for service users was Mean 1.6

Q3) Were all your access needs met on the day?

Two people reported that their access needs were not met.

#### **Positive comments**

Thank you to Andrew for what he did manage to do.

#### **Suggestions for improvement**

Don't assume that everyone can see the screen / powerpoint display. Hard to hear in the room particularly for those that have single sided deafness – should use breakout rooms for smaller groups. More space to accommodate wheel chairs. More ethnically diverse focus groups for this event

Q4) How well organised was the event?

The average score for all attendees was Mean 1.5 / Mode 2

#### **Positive comments**

The care being taken is impressive,

#### **Suggestions for improvement**

Clearer signage to show where the event was being held. Water and biscuits to be provided on the table. A warning should be given that attendees would be "photographed intensively" during the session.

Q5) How interested would you be in attending again?

Mean score 1.7 / (1.9 for service users)

Mode 2

This is our best metric all round with the majority of people being “Very Interested” in attending again.

Q6) Is there anything we should have included that we didn't?

Copies of slides / presentations, more opportunities to draw on our own experiences, introducing the service users, a discussion on how to make patient profile more ethnically diverse.

Additional Comments

This event has opened my eyes on the many aspects that the Med School has to cover to make the UEA an outstanding place to be! I appreciated as a lay person how well my comments were received.

I am very pleased to have been invited to join this group. I just wished it was more diverse but I understand also that it depends on the diversity of the population

All in all, a very welcoming insight into the process behind the scenes, that we very often don't get to see. Looking forward to being involved at any level needed

An excellent experience.

The buzz of conversations said it all

**Events like this give me hope for the future of medicine**

**Studies Allied to Medicine (SAM) Feedback Form: Working with disabled people**

1. Please give a score for each of the speakers/groups who presented during this SAM  
 (1=terrible, 2=poor, 3=okay 4=good 5=great]

NAME REDACTED (hard of hearing)	Okay (2) Good (6)
NAME REDACTED (cerebral palsy)	Okay (4) Good (5)
NAME REDACTED Theatre company (learning difficulties)	Great (7)
NAME REDACTED (Deaf/BSL)	Good (1) Great (8)
NAME REDACTED (mental health)	Okay (3) Good (2) Great (4)
NAME REDACTED (mental health)	Okay (2) Good (2) Great (5) 1
NAME REDACTED (mother of boy with autism)	Okay (1) Good (6) Great (2)
NAME REDACTED (mother of disabled child)	Okay (2) Good (5) Great (2)
NAME REDACTED (mother of disabled child)	Good (4) Great (5)
NAME REDACTED (blind)	Good (3) Great (6)

**2. How well did the “telling my story” format of the sessions work for you?**

I enjoyed hearing each person’s story from the start point, i.e. birth, as it gave me a perspective on how they adapted through life as their needs changed.  
 Enjoyed it very much. It’s a rare opportunity to hear people share their story  
 Really good, it was so interesting and informative listening to the people talk about their stories. Some were more organized and systematic than others.  
 Good – I enjoyed listening to the stories.  
 Some were better than others but overall pretty good.  
 Very well.  
 Well.  
 I liked it, it was interesting, however sometimes it was a little long and tiring.

**3. Would you have liked more traditional lecture-style teaching?**

No (6)  
 No, it’s better learning from actual people than lecturers  
 Probably not, because I think what was great about this SAM is that it really well illustrated the impact disability has on people and that can’t be illustrated through a powerpoint.  
 No, this way it was more interactive and keeps you interested.

**4. What did you think about the use of short videos?**

Really enjoyed the videos/film used in the sessions  
 Very good. Enjoyed all of them, especially a short movie about the deaf health care assistant and patient.  
 Good ☺  
 Great, keeps your attention on the topic  
 Useful.  
 Very informative  
 Enjoyed the short videos  
 Some were useful to emphasise a point, but they took up time we could have spent talking to speakers.  
 Really good, as it gave us context to the disability in the wider world.

**5. Was there enough time for discussion?**

Yes, the floor was always open for questions and discussion, which left the sessions engaging.

Yes (6)

Plenty

Mostly, yes.

**6. Were there any topics which you would have liked to have learned more about?**

Paraplegics – an insight into their life

Dementia/Alzheimers

Down syndrome

Bipolar disorder

Not really

No, I think there was a very good range, however maybe we could have seen someone with a predominantly physical disability.

No

**7. What was the best thing about the module?**

Meeting so many different people/real people/people who were open and approachable

Meeting such a great variety of incredible people and learning about their life and work.

Really enjoyed this SAM. It was really enjoyable and I genuinely feel I've learned lots which can't be learned though lectures/PBL. Really lovely hearing everybody's story

Learning about other people's experiences and how they dealt with disability they or someone else they knew had.

Listening to people's stories

Meeting all the really interesting people and learning about their lives.

It made me think about how to implement what I have learned in my practise.

**8. What change(s) would improve the module?**

More people per session/shorter session

Speakers talk for less time in monologue so we can ask questions

Addition of more interactive sessions, e.g. Thalia theatre company

Perhaps more interactive events like Thalia Theatre Company

More variation in activities, like going to the theatre company.

More dogs!

Overall nothing to change really.

Option for one of the students to lead the consultation

The NAME REDACTED group trip was really good – maybe more trips to different groups of people.

**9. What's the difference between what you've learned on this module, compared to what you learn from patient contact in primary or secondary care?**

It's much more centred around patient needs over disease treatment

This course put many of the concepts we learn in theory about into practice and perspective of everyday life

Exploring the psychosocial component of people's lives and their interaction with the healthcare system and workers.

I've learned about the person as a whole, rather than a person as their illness/disease/disability.

It was a very open environment and you felt comfortable asking any questions. We haven't had a module in which we primarily focus on disabilities and if we did have patients with disability the main focus of the consultation wasn't it.

Learn more about their social life and them as a person rather than someone with a disease/condition

Really sitting down the guests for 30 minutes and understanding their perspectives in depth

People with disabilities are sometimes glossed over in teaching or when on clinical placement, you mainly focus on the disability. However this SAM makes you focus on the person instead of just the disability.

**10. Has the course changed your practice?**

It will do in future.

It has improved my understanding.

Yes, made me much more aware of things I should and should not do/say.

Yes, and the way I talk to/interact with them

Yes (2)

I hope so

Yes, specially with regard to interacting with deaf/blind people.

**11. Would you recommend the course to other students?**

Yes, disability and people with disability are a part of everyday life. Sessions in this course help make it more so and takes away from any awkwardness attached to it when a health professional first encounters a with a disability

Absolutely! Already did.

Yes (5)

Yes, I even think it should be compulsory for everyone to experience this SAM. It's really opened my eyes. Thank you very much.