underlying causes of poor patient care in the National Health Service (NHS).[1] In Liverpool, rather than attempting to convey the importance of leadership and teamwork within the confines of the classroom, an innovative experiential approach to encourage self-awareness and team-working was developed using elements of the well established leadership programmes developed by the armed forces.

What was tried? Following months of organisation and planning with 208 Field Hospital (Liverpool), 280 Year 1 medical students were taken for an overnight stay at Altcar Training Camp. Prior to the trip, some students expressed concerns on health and religious grounds and felt that they would not be able to participate. However, with appropriate organisation to allow the provision of prayer spaces and alternatives for the more physical tasks, the vast majority of students attended the course.

Students were randomly allocated into groups in order to demonstrate the reality of working in teams. The roles of leader and team member were clearly defined, and students were required to listen to and communicate with each other in order to work effectively. Each student had the opportunity of leading a team. They faced command tasks building simple structures, planning exercises solving multidimensional logistical problems, and physical elements (undertaken by most participants) that emphasised the importance of working as a team and helping weaker members to complete the tasks. All of these tasks were overseen by experienced army staff, who offered constructive feedback and suggestions, and students were encouraged to critique one another's leadership styles and to identify their own strengths and weaknesses. After the event, all students completed a structured reflective assignment

What lessons were learned? Overall, the students' reports demonstrated that they had learned more than simply how to complete a task. They reported that they could work effectively within a randomly selected team; they realised that individually they possessed a range of skills that could help and motivate other team members; they had learned how to listen and how to observe other people's talents and limitations, and about how this meant they could complete tasks together as a team, thereby creating a sense of pride and shared achievement; they observed that the fact that someone is quiet in a team does not mean he or she has nothing to contribute, and, finally, they had found that it was acceptable to ask for help or to admit they were struggling. Fundamentally, they had learned that as doctors they will be required to serve as both leaders and team members, and that if they want to provide the best patient care possible, the ability to work effectively with colleagues will be essential.

The success of this joint initiative with the army has parallels with the recent experiential leadership development delivered by the NHS Staff College. It has reinforced our belief that leadership potential and team-working should be taught in a practical way and should be developed from the time students enter medical school. Simply teaching leadership principles in the classroom will not necessarily alter attitudes and behaviours.

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Towards entrusting medical students: recognising safety behaviours

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What problems were addressed? Ideally, medical school graduates need to be prepared to contribute to the health care system's culture of safety and improvement. Recently, the Association of American Medical Colleges proposed a set of core entrustable professional activities (EPAs) challenging medical educators to ensure graduate's readiness for internship, the 13th of which states that the student be able to: 'engage in daily safety habits, understand systems and their vulnerabilities, identify near misses and errors, speak up when faced with real or potential errors, recognise workarounds as opportunities for system improvement, and participate in system improvement activities such as reporting errors via system mechanisms or root cause analyses'[1]. We sought to determine to what extent medical students are currently able to identify system failures and strategise ways to address them.

What was tried? As part of an IRB-approved study of readiness for internship, we asked 36 graduating medical students to read a long vignette describing how an intern approached a series of common

safety challenges on an in-patient ward. Then, via written responses to open-ended prompts, participants were given 15 minutes to identify the interns' behaviours and attitudes that reflected a lack of systems thinking and interfered with a culture of safety, and to suggest actions needed for systems improvement. Responses were categorised using a rubric we developed based on EPA 13 with the following eight components: (i) overall view of the intern's ability to deliver safe care; (ii) lack of acknowledgement of his role in the errors that occurred; (iii) inconsistency in demonstrating common safety behaviours; (iv) tendency to be frustrated by system safety requirements; (v) tendency to be a passive observer; (vi) tendency to take a passive role in safety improvement activities; (vii) tendency to communicate in a rigid, rule-based manner; and (viii) global assessment of the participants' ability to identify behaviours and attitudes that contribute to errors, and suggest system improvement actions.

What lessons were learned? With a relatively simple tool, we assessed our medical school graduates' ability to recognise system failures and contribute to a culture of safety. All participants recognised the intern's lack of hand washing and his frustration when he was required to fill out a form as problematic, but only one participant noted the intern's defensiveness when critiqued for his errors as an issue that interferes with safety and improvement. No participant could suggest strategies to remediate workarounds, and overall only 37% of participants suggested there were any actions needed to prevent errors and improve safety. These findings suggest that although all graduates can recognise safety issues when prompted, most lack the ability to contribute to a culture of safety. This may be a result of limited opportunities for students to learn by actively engaging in safety-improvement activities. A standardised simulation-based learning approach could close this gap and enhance the practice-readiness of medical school graduates.

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Dignity in adolescent health care: a simulation-based training programme

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What problems were addressed? Respecting human dignity and tending to human vulnerability with an empathic attitude, should be an integral component of medical practice.[1] Education for dignity in health care should aim to achieve a culture of caring and behaviours that may improve effective communication. The medical literature has few publications focusing on training physicians to address human dignity issues in adolescent health care. We present a simulation-based training programme that focuses on a dignifying approach during encounters with adolescents and their parents, aiming to improve physicians' communicative competence in adolescent health care.

What was tried? During a period of 1 year, 97 primary care physicians attended eight 1-day simulation-based workshops at the Israel Center for Medical Simulation that focused on a dignifying approach when encountering adolescents and their parents.

Following an introductory lecture on human dignity in medical practice, each workshop presented seven simulated scenarios, presenting typical adolescent health care problems, with dilemmas that require a dignifying approach. The scenarios' topics included the following issues: opposing attitudes of parents and adolescents regarding a proposed medical treatment (parental objection to Ritalin and adolescent refusal to undergo chemotherapy); confidentiality requested by the adolescent patient that might either be kept (adolescent pregnancy and adolescent disclosure of homosexuality) or need to be breached (adolescent's suicidal plans and adolescent disclosing sexual abuse by parent); and parental aggressive behaviour toward the physician (parent discovering contraceptive pills prescribed to his adolescent daughter without parental consent). Following the simulation exercises the encounters were discussed with all participants of each workshop using video recordings of the encounters. Participants could observe different approaches toward each dilemma while the workshop's facilitators highlighted the human dignity aspects.

What lessons were learned? Assessment of the workshop's contribution to the physicians' use of a dignifying approach was based on pre-workshop and 3-months post-workshop self-report 5-point Likert-scale questionnaires that explored participants'

