



Short Report

Communication-Focused Simulation to Enhance Paediatric Trainee Confidence in Difficult Conversations

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Abstract

Objective

To design, deliver and evaluate the impact of a trainee-led simulation programme focused on paediatric communication skills, addressing an identified gap in experiential training for difficult conversations.

Background

Simulation training is a core component of paediatric education, commonly used to rehearse emergency and technical scenarios. In contrast, communication skills are often learned opportunistically despite being fundamental to safe and compassionate paediatric practice. Trainees frequently report limited confidence in these situations. We developed a series of communication-focused simulation sessions, to provide a safe environment in which trainees could practice, observe and reflect on challenging interactions.

Methods

We delivered a series of trainee-led simulation sessions for mixed-grade learners. Each session involved 10–20 participants and lasted one hour in protected teaching time. Sessions involved pre-planned scenarios with detailed patient backgrounds and discussion points. Example scenarios included breaking bad news in the context of a new brain cancer diagnosis, explaining the importance of antibiotics to a mother who was not consenting to treatment for her septic baby and managing a disclosure of sexual abuse for a teenager presenting with non-specific symptoms.

A Senior House Officer (SHO) initiated with registrar support introduced part-way through. Sessions were facilitated by senior trainees and incorporated individual reflection, feedback from the actor, peer feedback and facilitated group discussion. Participants were invited to actively take part or observe. Written feedback was collected anonymously following sessions via online forms.

Results

70% of respondents reported increased confidence in managing challenging communication scenarios after attending the simulation, highlighting facilitation quality, safety and the value of structured debriefing. One participant reported feeling “grateful my first experience of this was a simulation rather than real life,” while others described the sessions as providing “practical and detailed advice” for breaking bad news.

Observers also reported significant learning, noting improved understanding of how to approach difficult conversations. Facilitation style and psychological safety were repeatedly cited as strengths, with structured feedback and debriefing described as the most valuable component, with one participant commenting that the feedback was “the best part of the sim.”

Conclusion

Communication-focused simulation is a valuable and underutilised educational tool in paediatric training. Our trainee-led programme is low cost, reproducible, and demonstrates that well-structured scenarios with skilled facilitation and reflective debriefing, can improve confidence and preparedness for challenging clinical conversations. Incorporating communication focused simulation, alongside traditional emergency training, equips paediatric trainees for the realities of clinical practice and ultimately enhances patient and family care. A trainee-led consultant transition programme is feasible, sustainable, and highly valued. This model transforms uncertainty into preparedness and is transferable across specialities.

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Introduction

Effective and empathetic communication between clinician and patient or family members is integral to paediatrics where clinicians frequently need to have difficult conversations. When done well, good communication builds trust and has been repeatedly shown to improve patient outcomes. However, poor communication directly impacts patient experience and is frequently a cause for complaint, accounting for the largest proportion of complaints by subject and 17% of all NHS complaints in 2022-2023.

Communication skills are a valued part of paediatric training and feature heavily in the RCPCH curriculum³. However, opportunities to develop these skills are often ad-hoc with service pressure limiting opportunities for senior observation and feedback⁴. Consequently, consultations requiring complex communication, such as breaking bad news and conflict resolution, may feel particularly challenging for trainees.

Simulation training is a core part of paediatric education in the UK, with strongly established local and regional simulation programmes⁵. These sessions often focus on the clinical and practical elements of emergency scenarios. However, they also can be used to model difficult conversations.

We developed a series of communication-focused simulation sessions as part of regular departmental teaching, with the aim of providing a psychologically safe environment in which clinicians could practice, observe and reflect on challenging interactions.

Methods

Teaching Structure

We organised monthly, one-hour communication simulations at a busy district general hospital in North London. Simulation followed morning handover and was protected from bleeps and other interruptions.

Each session followed a 'prepare, open, facilitate and close' structure⁶. We developed scenarios, briefed participants and prepared a suitable clinical space. The aims of the session were discussed before starting; with appropriate trigger warnings given should anyone wish to leave. The supervising registrar then facilitated the simulated conversation, as well as the discussion and learning points. Sessions closed with a debrief and participant feedback.

Scenario Development

Two paediatric registrar facilitators designed sessions around common scenarios involving challenging communication. Volunteer actors were briefed before each session, including relevant hidden concerns or motivations to enhance realism. Clinician role-players agreed to participate in advance and acted at their usual clinical level, such as paediatric SHO or registrar.

Example Scenarios

The scenarios covered: (1) parental anxiety and refusal of antibiotics for an unwell febrile two-week-old infant; (2) breaking bad news after CT imaging showed a likely brain

tumour in a two-year-old with new-onset seizures; and (3) safeguarding communication with a 14-year-old presenting with abdominal pain who disclosed that sexual images had been shared online by peers and prompting the use of a HEADSSS⁷ (home, education etc.) to elicit this information.

Simulation Structure

Each simulation was facilitated by a paediatric registrar, with paediatric doctors volunteering as parent, carer or patient role-players. Sessions were attended by 10–20 participants across training grades, including foundation doctors, GP trainees, paediatric SHOs and registrars, as well as nurses and nursing students, supporting a multidisciplinary approach.

A short outline of the scenario was shared aloud with the participants and observers including the age of the patient, clinical context and aim of the communication. For each scenario, the simulation was started by one of the SHOs. The simulation was paused midway to allow a registrar to join and support. This emulated routine clinical practice, where an SHO will often have a preliminary conversation with a patient, and escalate to a registrar or consultant if there is an element of complexity or conflict in the consultation.

Following each scenario, facilitators led a structured, learner-centred debrief. Participants were congratulated and invited to reflect on their own performance, followed by feedback from actors. Actor feedback focused on how the interaction felt from the patient or parent perspective, as well as perceived strengths and challenges. Finally, observers were invited to share any comments. Facilitators guided all discussions to ensure psychological safety, constructive feedback and coverage of predefined learning points, including relevant legal considerations, referral pathways and recommended further reading.

Feedback on Sessions

After each session, all attendees completed an anonymous online feedback form via QR code or WhatsApp link. The form collected professional role, pre- and post-simulation confidence ratings, qualitative feedback and suggestions for improvement.

Results

Across the three sessions, attendance ranged from 10–20 participants, with 6–9 feedback responses collected per session. All clinicians who volunteered to role play completed feedback. Mean confidence scores increased after each session: from 4.1 to 4.6 in session 1, 3.0 to 4.3 in session 2, and 2.3 to 4.3 in session 3. Overall, 70% of respondents reported increased confidence in managing challenging communication after the simulation, while the remaining 30% maintained high confidence scores of 4 or 5 out of 5.

The qualitative feedback was also positive. Participants described the simulations to be useful and helpful for future practice. One participant commented that they were "grateful my first experience of this was in sim rather than real life, I feel better equipped if faced with this in the future". Furthermore, observers also reported that, although they were not directly participating, the sessions were useful and educational.

The quality of facilitation and feedback, psychological safety and value of structured debriefing were also cited as strengths of the programme. Several participants praised the feedback, describing it as “helpful”, “well-structured” and “constructive”. One participant stated that “feedback was the best part of the sim”.

Discussion

These sessions met our objectives of providing a safe space for clinicians to practice and reflect on their communication skills, within a structured and observed environment. This was reflected in the positive feedback. We showed that running communication simulation as part of regular teaching for an hour every month is achievable and beneficial. Running these scenarios as part of mandatory departmental teaching reduces the risk of cancellation and maximises attendance. These local sessions are complemented by regional training days with full day simulation⁵

These sessions can be developed further, depending on the resources available. We discussed the feasibility of hiring actors to play the young person or family member role, which would have made the session more realistic. However, this is only possible with a teaching budget and would have added to the organisational workload. We found that having a clinician take on this role worked well in our experience but depends on a suitable person being willing to volunteer.

Feedback completion was highest among those actively involved in the simulation, with all role-players submitting responses. Response rates were lower among observers, highlighting the limitation of our evaluation process and the challenges of collecting feedback after teaching sessions. However, it may also suggest lower engagement among some observers. Future sessions could improve engagement by using smaller groups, allowing more participants to take an active role and enabling more focused discussion. Sessions could also be grouped by training stage, such as SHO or registrar level, to make participation less intimidating. However, this would require additional role-players and facilitators.

Future Potential Topics the team has discussed include:

- Discussing Vaccine Hesitancy
- Preterm Counselling
- Child needing transfer to PICU
- De-escalation of an angry parent
- Explaining to a parent that their child needed a skeletal survey

Conclusion

In conclusion, we have shown that communication simulation sessions can be successfully run as part of regular departmental teaching and are valued by clinicians who attend them. This is reproducible and provides clinicians with an opportunity to practise difficult conversations in a safe environment with constructive feedback and discussion.

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