SAPC

Society for Academic
Primary Care

Championing Expertise in Academic Primary Care, Driving Improvements in Primary Care Provision

SAPC North 2025 Online Conference

20 November 2025

Widening participation in primary care research and education

– *abstracts collection*

Keele
UNIVERSITY

SAPC Foreword

Professor Carolyn Chew-Graham, OBE
General Practitioner and Professor of General Practice Research,
Keele University

Dear Colleagues,

SAPC North online conference was held on 20th November 2025.
As always, the conference offered the opportunity for early career researchers to present their work and respond to questions in a supportive environment.

This booklet includes the abstracts accepted for ten-minute presentations, poster+one-minute presentations.

You will see that we had a variety of work submitted and presented - representing the range of primary care research being conducted across the UK.

I think the future of primary care research is safe in the hands of our emerging leaders.

I would encourage you to look at the abstracts and reach out to people working in your area(s).

Best wishes
Carolyn Chew-Graham
Conference Organiser

Just a reminder that, if you are not a member of SAPC – do join. https://sapc.ac.uk/members/join

SAPC offers a range of Special Interest Groups - there will be one for you! https://sapc.ac.uk/special-interest-groups

The annual SAPC meeting 2026 will be held in St Andrews (24^{th}-26^{th} June) – hope to see some of you there. https://sapc.ac.uk/conferences

SAPC

Programme

		Chair(s)
9.30-9.40am	Welcome	Professor Carolyn Chew-Graham
9.40-10.10am	Keynote: **Professor Scott Wilkes** Head of the School of Medicine, Professor of General Practice and Primary Care, University of Sunderland ***A path to senior leadership and setting up a medical school: insights, philosophies and challenges.***	Professor Jo Protheroe
10.10-10.20am	The importance of Public Contributors to research. ***Jane Southam, Public Contributor***	Carolyn Chew-Graham
	Presentations: Widening participation in medical education	Professor Jo Protheroe, Dr Hassan Awan
10.20-10.30am	A community-based, longitudinal programme through all the clinical years: Feasible or one step too far? ***Professor Hugh Alberti, Professor of General Practice, Head of Primary Care, Newcastle University***	
10.30-10.40am	Nothing About Us Without Us: Exploring Medical Students' Experiences of Injustice in Clinical Education. ***Dr Marina Politis, Specialised Foundation year 2 trainee, Newcastle University***	
10.40-10.50am	Managing uncertainty in medicine: Student experiences of a simulated GP on-call day. ***Rhiannon De Ivey, Research Associate, Newcastle University***	
10.50-11.00am	The paradox of praise: how racialised praise and microaggressions shape the experiences of ethnic minority medical students in the UK. ***Kunika Khandelwal, 5th year Medical Student, Newcastle University***	
11.00–11.10am	Comfort break	
11.10-11.45am	Poster presentations with one-minute talk: **1. Liz Littlewood,** Research Fellow, University of York **2. Jane Vennik,** Senior Research Fellow, University of Southampton **3. Sarayu Shankar**, Medical Student, Keele University **4. Sian Beddows,** Medical Student, University of Sheffield **5. Lisa Collins,** Academic GP ST3, Queen's University Belfast **6. Chiamaka Anthony-Okeke,** FY1 Doctor, Newcastle-upon-Tyne NHS Foundation Trust **7. Carolyn Chew-Graham (for Kate Cowen,** Research Associate, Durham University) **8. Jessica Madden,** Student, University of Sheffield **9. Millie Ramsay-Jordan,** Student, Newcastle University **10. Stephen Wormall,** Nottingham & Nottinghamshire ICB **11. Preetha Biyani,** CCC co-lead, Academic Personal Tutor, Clinical Teaching Fellow, University of Leeds	Carolyn Chew-Graham, Farheen Yameen
	Presentations: Widening participation in research	Dr Claire Burton, Dr Helen Twohig
11.45-11.55am	Co-designing Culturally-Centred Mental Health Support with Muslim Communities: PPIE Impact on Research Design and Methodology. ***Dr Hassan Awan, NIHR Clinical Lecturer in Primary Care, Keele University***	
11.55-12.05pm	Expanding the role of peer researchers in health research. ***Dr Sarah Skyrme, Research Associate, University of Manchester and Mr Manoj Mistry, Public Contributor***	

12.05-12.15pm	Developing a Community Research Link Worker (CRLW) Toolkit: Bridging Academic and Community Research Practices. ***Dr Kate Fryer, Research Fellow, University of Sheffield***	
12.15–1.00pm	Lunch	
1.00–1.30pm	Keynote: **Dr Shoba Dawson** Senior Research Fellow in Inclusive Research, University of Sheffield ***Improving inclusion in primary care research.***	Professor Caroline Mitchell
	Presentations: Multiple long-term conditions	Dr Michelle Rickett, Dr Rosie Harrison
1.30-1.40pm	Preventing anxiety and depression in people with inflammatory rheumatological conditions: a qualitative study. ***Lauren Gray, PhD Student, Keele University***	
1.40-1.50pm	The consideration of inclUsioN and equalITy featurEs of Physical Activity digital interventions for people with Long-term conditions in primary care: A scoping review (the UNITE-PAL study). ***Dr Charlotte Woodcock, Lecturer in Applied Health Research, Keele University***	
	Presentations: Workforce	
1.50-2.00pm	GP workforce crisis – a realist evaluation of the new to practice GP fellowship scheme in England. ***Dr James Bennett, NIHR In Practice Fellow, Clinical Education Facilitator, Hull York Medical School***	
2.00-2.10pm	Beyond the Biomedical Model: Arts and Humanities in Shaping Advocacy, Empathy, and Equity in Medicine. ***Dr Marina Politis, Specialised Foundation year 2 trainee, Newcastle University***	
2.10-2.20pm	Primary care practitioners' perspectives on the delivery of workplace wellbeing interventions: A meta-synthesis. ***James Tawse, PhD Student, NIHR Greater Manchester Patient Safety Research Collaboration, University of Manchester***	
2.20-2.30pm	Comfort break	
	Presentations: Health inequalities	Professor Caroline Mitchell, Dr Evans Asamane
2.30-2.40pm	How and where do people in farming communities seek help for mental ill-health: engaging farming communities in research. ***Dr Tamsin Fisher, Research Associate, Keele University***	
2.40-2.50pm	Duration of care in Early Intervention in Psychosis services: A multi-perspective qualitative study. ***Dr Michelle Rickett, Research Associate, Keele University***	
2.50-3.00pm	How can we improve care for women with perinatal anxiety across primary and community care? A qualitative study. ***Dr Victoria Silverwood, NIHR Academic Clinical Lecturer in Primary Care, Keele University***	
3.00-3.10pm	Addressing cardiovascular risk after adverse pregnancy outcomes: a health equity-focused qualitative review. ***Dr Brook Hodges, NIHR Pre-Doctoral Fellow, Keele University***	
3.10-3.20pm	Reflections on the day from a Public Contributor. ***David Shiers, Public Contributor***	Carolyn Chew-Graham
3.20-3.30pm	Prizes	Carolyn Chew-Graham, David Shiers
3.30-3.40pm	Summary and Close	Carolyn Chew-Graham

A community-based, longitudinal programme through all the clinical years: Feasible or one step too far? What is the problem?

Benefits of Longitudinal Integrated Clerkships (LICs) are now well established and the reported J-curve of benefits to students suggests that the longer the placement, the more benefit accrued. Similarly, there is now a drive internationally for more community-based medical education programmes and in particular, in the UK with the recent announcement of the NHS long term plan. The logical next step would be a whole medical programme situated predominantly in the community, based on the principles of LICs. We are considering such a programme initially within the clinical years: Is it feasible or one step too far?

What we did

The aims of such a programme would be to increase patient exposure and simultaneously alleviate hospital saturation of students and thus address capacity issues. For the students the aim would be to enhance autonomy in learning in addition to developing empathy and other professional skills. The programme would be community-engaged and thus support healthcare delivery trends, aligning with the continued shift towards community-based healthcare and promote community-based career choices.

The clinical years will be based on a model of two days in general practice, two days of GP-led teaching and community-based placements, and one day in hospital. Discussion is ongoing regarding hospital assistantships in semester two of final year which may remain as preparation for foundation years. The programme will start with a pilot of twelve volunteer students, increasing the numbers to 24 after one or two years. We imagine the programme being attractive to students from a widening participation background.

What we found

We are planning to start in the 2026/7 academic year.

What does it mean?

We are aware of only one other institution in Australia that is considering a similar programme. We plan to formally evaluate and research the programme to inform other institutions considering similar initiatives. Could this be a future model of medical education?

Professor Hugh Alberti
Professor of General Practice Education, Newcastle University

Nothing About Us Without Us: Exploring Medical Students’ Experiences of Injustice in Clinical Education

Authors: Dr Marina Politis, Prof Hugh Alberti

What is the problem?

Year 4 medical students, during their first extended clinical placements, begin to experience tensions between the ideals of fairness, empathy, and professionalism and the realities of an overstretched healthcare system. Encounters with injustice, whether interpersonal, structural, or cultural, shape how students perceive medicine and imagine their future roles. Yet these early formative experiences are often overlooked in discussions of professional identity and systemic reform.

Why is it important?

Understanding how students recognise, interpret, and respond to injustice matters because this is the point where professional norms begin to crystallise. A particular challenge is students’ liminal position: they are often not listened to in the way people with lived experience are yet are simultaneously expected to adopt the language and authority of healthcare professionals. This tension exemplifies epistemic injustice and highlights how students can feel excluded from both patient and practitioner worlds. Addressing these issues is critical to shaping a more just and inclusive medical culture.

What we did

We conducted two focus groups with ten Year 4 medical students. Students defined and reflected on their experiences of injustice during placements. Data were analysed inductively using thematic analysis and interpreted through theoretical frameworks including Fricker’s epistemic injustice, Rawls’s theory of justice, and Filho and Hafferty’s pedagogy of connection.

What we found

Four provisional themes were identified: (1) hierarchy and power dynamics, where students felt silenced and undervalued; (2) bias and discrimination, including sexism and stereotyping; (3) systemic strain and working conditions, encompassing unfairness and poor placement structures; and (4) professional and personal identity tensions, such as pressures around appearance, pregnancy, and inappropriate boundaries. Epistemic injustice appeared across these themes, shaping how students’ credibility and voices were constrained.

What does it mean?

These findings suggest that injustice in medical education is systemic, not an issue for individuals to manage through personal resilience. Solutions require institutional will, cultural change, and financial investment, such as adequately funding placements. Next steps must involve students directly: *nothing about us without us*. Consulting students on their needs and co-creating reforms is essential for building a more just medical culture.

Managing uncertainty in medicine: Student experiences of a simulated GP on-call day

Rhiannon De Ivey[1] MBChB, MRCGP (2023), PGDipMedEd
Jenna Chambers [2] MBChB, MRCGP (2021), PGCert (HPE), PGDipMedEd
Charlotte Petrie, Marina Politis [2] MBChB, BSc Hons
[1] Population Health Sciences Institute, Newcastle University, UK
[2] School of Medicine, Faculty of Medical Sciences, Newcastle University, UK

Background: Clinical practice is inherently uncertain (1). The way clinicians manage this uncertainty is varied and complex, with significant implications for clinical care and patient safety. Recognising the uncertainty of real-life clinical practice, a new teaching intervention was added into the Newcastle University undergraduate MBBS curriculum within the existing year 5 primary care assistantship tutorials. The intervention involved a simulated GP 'on-call' day, during which students were asked to complete tasks replicating a typical day in general practice. Its purpose was to expose students to scenarios that demonstrated inherent uncertainty with the objective of enhancing preparedness for clinical practice.

Methods: Surveys were sent to all students who participated in the session. Focus groups were also conducted with purposively sampled (n=12) medical students who had participated in the teaching intervention. All focus groups were transcribed by Microsoft Teams and checked by 2 researchers. Qualitative data was extracted from the focus group transcripts and surveys, and thematic analysis was performed by 4 researchers using NVivo software.

Results: Participants expressed a sense of uncertainty and actively sought definitive responses to individual cases they encountered. They reflected on patient safety and how uncertainty in the clinical environment could be a barrier to this. Participants sought to deepen their understanding of general practice and explored the professional roles within the primary care team. Distinction from hospital-based care was also noted. Participants reflected on their own, emerging professional identities and the process of transition to clinical practice.

Conclusion: This innovative teaching session sought to expose students to uncertain scenarios in preparation for transition to clinical practice. Participants sought to find answers from the scenarios with our study reflecting the need for ongoing teaching around the management of uncertainty. Ongoing work is needed in this area to further consider how students can be best prepared for the uncertainty of clinical practice.

Title: **How do subtle microaggressions, such as identity-based questions and seemingly positive praise, shape the experiences of ethnic minority medical students in the UK?**

Abstract

Medical students from ethnic minoritised backgrounds encounter microaggressions in clinical and educational environments. While previous studies have explored the negative impact of overt microaggressions, there is not much emphasis on subtle or ambiguous forms, such as “racialised praise” (e.g., “you’re so articulate”), which may appear positive but can carry underlying assumptions. Understanding how these experiences shape medical students’ identity and professional development is important to foster inclusive learning environments.

We conducted one-to-one semi-structured interviews with nine clinical medical students from ethnic minority backgrounds (eight in year four and one in year three). Interpretative Phenomenological Analysis (IPA) was used to explore participants’ lived experiences, allowing for richer examination of the balance between personal and professional identities.

Initial findings suggest that subtle and overt microaggressions shaped students’ sense of belonging and professional identity. Key themes included racialised praise, power dynamics within clinical hierarchies, and professional vulnerability. Students described heightened anxiety, hyperawareness of ethnicity, and emotional labour when navigating these interactions. Experiences often led to feelings of inferiority, conflict avoidance, or bystander behaviour, with some students reporting disorientation and difficulty reconciling personal and professional identities. Many felt their professional role was diminished when reduced to symbols of their ethnicity.

Our findings highlight how microaggressions, even when framed positively, can negatively impact medical students’ confidence, professional identity and wellbeing. By drawing attention to the concept of racialised praise, this study addresses a gap in the literature and highlights the need for greater awareness of subtle forms of bias and their impact. These insights can inform future interventions, including developments in staff education and support structures, to enrich ethnic medical students’ clinical experiences and promote equity within medical education.

Authors

Kunika A Khandelwal, Hugh Alberti, Marina Politis, Enam-ul Haque (Newcastle University)

Co-designing Culturally-Centred Mental Health Support with Muslim Communities: PPIE Impact on Research Design and Methodology

Authors:
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Professor Carolyn A. Chew-Graham MD, FRCGP, Professor of General Practice Research, School of Medicine, Keele University, Keele, UK; Honorary Professor of Primary Care Mental Health, Midlands Partnership NHS Foundation Trust, St George's Hospital, Stafford, UK

What is the problem? Muslims experience significant mental health disparities, with only 2.6% referred for NHS Talking Therapies completing treatment, compared to 18.4% of Christians and 38.9% with no declared religion. Challenges are particularly pronounced for Muslim men, who face intersecting barriers including cultural expectations, traditional masculine norms, and systemic healthcare obstacles. British Muslim men preferentially seek support from faith leaders rather than healthcare professionals, yet 20% of Muslim faith leaders receive no mental health training, while 34% consider training inadequate. This leaves a gap in culturally-appropriate mental health support within Muslim communities.

What we plan We plan a mixed-methods study in Wales employing co-design principles. We have established a Patient Advisory Group (PAG) of eight Muslim men with lived experience and faith leaders and will conducted semi-structured interviews with faith leaders exploring their experiences supporting Muslim men's mental health. We will co-develop a culturally-centred training programme for Muslim faith leaders combining principles of Irshad Tazkiyat Care (coaching and counselling based on self-purification and growth) with evidence-based mental health practices. We will deliver three workshops to 15 faith leaders, with pre- and post-workshop assessments measuring changes in knowledge, confidence, and skills.

What we found Our PAG have acted as research partners from project inception. They conceptualised and prioritised the research idea and emphasised the importance of integrating Islamic principles rather than simply adapting Western models. The PAG group have been involved in refining research questions, develop culturally appropriate recruitment strategies, and informing interview guides.

What does it mean? Meaningful PAG involvement enhances research relevance and community ownership. Our experience demonstrates how co-design can transform traditional researcher-led approaches, creating more culturally-centred methodologies. This research has the potential to improve Muslim men's mental health by working with faith leaders and equally valuing knowledge systems and has potential applications to other faith groups.

Expanding the role of peer researchers in health research

Contributors: Manoj Mistry, Ajaz Chaudhri, Martin Rathfelder, Julie Bilsborough, Rita Chow, Sarah Skyrme, Jess Drinkwater, Caroline Sanders, Jon Hammond, Aneela McAvoy, Fahad Malik, Kelly Howells, Louise Gorman, Anna Wilding, Eric Lowndes, Angela Ruddock, Tadgh Blunt, Rebecca Morris, Russ Cowper, Sadia Mir, Nahida Parveen, Fehmina Parveen, Pat Walkington, John O'Doherty, Pat O'Doherty.

Abstract:

Patient and public involvement (PPI) is established as a key tenet of health research. Early PPI roles focused on consulting public contributors with lived experience. However, these approaches face criticism of tokenism, and many public contributors want opportunities to *do* research. We aimed to explore, how public contributors in established involvement roles can engage as peer co-researchers to reach diverse communities?

This participatory research project involves working with a group of experienced public contributors as peer-researchers to co-design a survey exploring public perceptions of the future of general practice. The peer-researchers will conduct the survey in voluntary, community, faith, and social enterprise (VCFSE) groups they are members of. This offers them a more active research role, while potentially reaching survey participants who are unlikely to take part, thus improving survey reach and diversity.

We have held three co-design workshops with 14 public contributors from different NIHR groups in Manchester. We have trained 9 public contributors to deliver the survey this autumn.

Throughout this process we regularly reflect on our work together, our relationships, and the university bureaucracy this approach entails. We will be presenting early reflections on the process.

Themes arising from public contributors taking on the co-researcher role include utilising wider skills (poetry), what is the role and legitimacy of researchers in a participatory project, when and how to challenge each other, juggling ethics of care (to the public contributors, survey respondents, the data), are we replacing researchers on the cheap, and limitations of the co-researcher role.

This project is evaluating the benefits and challenges of the peer co-researcher role. We will produce learning points and guidance that can be used by other researchers and public contributors, to build knowledge and approaches to peer research.

Developing a Community Research Link Worker (CRLW) Toolkit: Bridging Academic and Community Research Practices

Authors: Kate Fryer, Habiba Aminu, Henry Staples, Chukwuemeka Agbarakwe (University of Sheffield)

What is the problem?

Primary care research often fails to include ethnic minority and socio-economically deprived communities, which limits the relevance and impact of research findings. Community Researchers can bridge this gap by connecting academic, clinical and community knowledge, but there is a lack of clear guidance and standardised approaches for effective collaboration. This gap undermines the potential for truly participatory research.

What we did

To address this problem, we co-developed a toolkit with Community Researchers from various communities and academic researchers from different disciplines at the University of Sheffield. We conducted a literature review and held a series of workshops and focus groups to gain insight into the needs of both community and academic stakeholders.

What we found

Our collaborative process resulted in a comprehensive, interactive, and user-friendly toolkit that provides a clear framework for partnerships. The toolkit guides both academic and Community Researchers on how to work together effectively, addressing the previously identified gaps in collaborative research practices. The project showed that meaningful co-production is possible when the right resources and structures are in place to support equitable partnerships.

What does it mean?

This toolkit provides a practical and replicable model for other institutions to follow, offering concrete guidance that can help bridge the gap between academic research culture and community knowledge systems. By empowering Community Researchers with clear frameworks and resources, this work has the potential to transform how research is conducted with marginalised communities, promoting genuine partnership rather than extractive research practices. The result is more relevant, impactful, and ethically sound research outcomes.

Title: Preventing anxiety and depression in people with inflammatory rheumatological conditions: a qualitative study

Authors: Lauren Gray, Carolyn A. Chew-Graham, Samantha Hider, Nadia Corp & Tom Kingstone (Keele University)

What is the problem?

Anxiety and depression are frequently comorbid with inflammatory rheumatological conditions (IRCs) which adversely impact physical health outcomes and quality of life.

The aim of this study was to explore perspectives of people with IRCs and practitioners about prevention of anxiety and depression.

What we did

Ethical approval from Keele University Research Ethics Committee.

Qualitative study using semi-structured interviews with people with IRCs and healthcare practitioners recruited from team networks, community organisations and using social media. Iterative approach to data generation and analysis.

A Patient and Public Involvement and Engagement (PPIE) group has contributed to study design and interpretation of data.

What we found

Data collection and analysis are ongoing. Twelve people with IRCs and twelve practitioners have been interviewed.

Initial analysis suggests three themes: what support is needed? when is support needed? and barriers to prevention.

Having up-to-date self-management resources, appropriate social support and proactive healthcare utilising voluntary and community organisations are important for people to enable them to manage the impact of IRCs and prevent anxiety and depression.

Opportunities to provide preventative support include at first contact, at diagnosis and annually. Additional support from primary care is needed for people under investigation or awaiting referral for suspected IRCs where mental health is threatened. Barriers to providing support include an individual’s willingness to disclose concerns, practitioners’ confidence and NHS culture and capacity.

What does this mean?

Findings will identify targets for prevention interventions and mental health promotion - primary care practitioners could play a key role in this. We will use co-design methods to finalise what this pathway could look like.

Title: The consideration of inclUsioN and equalITy featurEs of Physical Activity digital interventions for people with Long-term conditions in primary care: A scoping review (the UNITE-PAL study)

Charlotte Woodwock, Tilli Smith, Nadia Corp, Sandra Woolley, Callum Leese, Jiao Liu, Cecilie Thøgersen-Ntoumani, Emma Healey (Keele University)

What is the problem?

Physical activity (PA) is important for individuals managing one or more long-term condition (LTC). Despite potential benefits, and low risk of harm, people living with LTCs experience barriers to PA at multiple levels. Some barriers can be addressed by digital interventions that are wide-reaching, low cost, and flexible. Digital interventions can however generate inequity in terms of access, adoption, and adherence. It is important for intervention developers to be inclusive-by-design and guard against engineering-in unintended inequality, yet what elements are incorporated to support inclusion are unknown.

What we did

Supported by our patient and public research user group, we conducted a scoping review of digital PA interventions for one or more LTC (asthma, dementia, depression, hypertension, osteoarthritis, osteoporosis, type 2 diabetes). We searched nine databases for relevant randomized controlled trials (RCTs). Title, title and abstract, and full-text screening were conducted. Linked publications of retained RCTs were identified to form intervention clusters for data extraction. Data extraction was informed by PROGRESS-Plus and Veinot's model for intervention-generated inequality (IGI) prevention and elements supporting inclusivity organised thematically.

What we found

108 intervention clusters were included in the review with at least one participant living with one or more LTC: type 2 diabetes (49.07%), osteoarthritis (25.93%), dementia (12.04%), depression (5.56%), osteoporosis (3.70%), hypertension (2.78%), and/or asthma (0.93%). We identified 315 inclusivity elements from 92 interventions that mapped to IGI phases of access, adoption, and adherence. Inclusivity elements mapped to all PROGRESS-Plus characteristics except for religion.

What does it mean?

Digital PA interventions for LTCs incorporate inclusivity elements that can support intervention access, adoption and adherence with the potential to reduce inequalities across most PROGRESS-Plus characteristics. Our review provides developers with example inclusivity elements to support future development of interventions that are inclusive-by-design and minimise exacerbating the digital divide.

GP workforce crisis – a realist evaluation of the new to practice GP fellowship scheme in England

Dr James Bennett, Prof Joanne Reeves, Hull York Medical School

What is the problem?

The ongoing workforce crisis in primary care significantly affects newly qualified GPs. The new to practice fellowship programme was commissioned as an innovative educational intervention to address the recruitment and retention of early career GPs nationally. It funded time away from practice to facilitate professional development. In 2024 the decision was made to cease funding with no planned alternative and no collective evaluation of the programme. The challenges newly qualified GPs face are persisting and more work is needed to understand and address these.

What we did

A mixed-methods realist evaluation combining data from asynchronous online focus groups, semi-structured realist interviews, and a survey informed by Theoretical Domains Framework. Participants were invited from across all primary care training hubs in England, including fellows past and present, and staff designing and delivering the programme. An initial programme theory was refined through iterative analysis to develop context-mechanism-outcome configurations.

What we found

A refined programme theory has been developed describing how, why and in what context the fellowship programme impacted on those involved. It describes variability in how fellows are able to engage with the programme depending on the contexts they find themselves. Key mechanisms include feeling valued, supported and growing self-confidence. This programme theory describes a set of foundations that newly qualified GPs need to prosper and stay in the workforce – addressing their fears, supporting learning in context, motivating them at work and redefining their professional role.

What does it mean?

We need creative approaches to tackle the workforce crisis in general practice. Retention of early career GPs requires a combination of strategies; education is likely to be one of these. Lessons from evaluating the current programme will help understand the benefits and challenges to using fellowship schemes in this way and inform decisions on future policies regarding this.

Beyond the Biomedical Model: Arts and Humanities in Shaping Advocacy, Empathy, and Equity in Medicine

Authors: Dr Marina Politis, Dr Sarah Graham, Dr Sarah Cope

Background:

Modern medicine is increasingly defined by complex social, cultural, and ethical challenges. Medical schools face growing pressure to train not only clinically competent but also empathetic, reflective, and socially conscious doctors. Arts and Humanities (A&H) have been proposed as powerful tools to foster these qualities. Engagement may deepen students' appreciation of the human condition, build emotional insight, and develop narrative and ethical reasoning. Despite these potential benefits, integration of A&H in medical education remains inconsistent. Reported challenges include time constraints, lack of clinical exposure, and resource intensiveness. Staff attitudes and institutional culture are critical enablers or barriers to successful implementation.

Methods:

Preliminary work included a scoping review that mapped existing literature on A&H in medical education, identifying 17 studies and highlighting benefits and challenges. This was followed by qualitative semi-structured interviews with 11 teaching staff from the Essence of Medical Practice (EoMP) module at Newcastle Medical School. Participants were recruited via Teams channels and snowballing. Interviews were transcribed, anonymised, and subject to member-checking. Braun and Clarke's inductive thematic analysis was undertaken using NVivo 15, with reflexive notes maintained. Descriptive open codes were grouped into five provisional themes and 19 subthemes, including structural inequality, professional identity, empathy and understanding, barriers, and facilitators.

Results and Discussion:

Educators valued A&H for their potential to highlight patient identity, systemic bias, and structural inequality. A&H were seen as vital for preparing students to engage with real-world issues such as racism, misogyny, migration, social deprivation, and marginalisation. Participants described A&H as a strategic entry point for introducing postcolonial and intersectional frameworks, reflecting on health inequities rooted in history and policy, and engaging students with patient stories of exclusion and neglect. Barriers included entrenched biomedical models, time pressures, and perceptions of A&H as "soft" or "politicised." Facilitators included faculty champions, interdisciplinary collaboration, and culturally inclusive resources.

Conclusion:

Arts and Humanities support the development of the doctor as a social advocate by fostering empathy, moral imagination, and critical reflection. They provide reflective spaces to confront uncertainty and moral ambiguity, preparing doctors to humanise medicine, bridge art and science, and address health inequities and global challenges.

Primary care practitioners’ perspectives on the delivery of workplace wellbeing interventions: A meta-synthesis.

James Tawse, Christopher J Armitage, Carolyn A. Chew-Graham, Maria Panagioti (University of Manchester)

What is the problem?

The high levels of burnout and turnover among Primary Care practitioners represent a critical challenge. In response, interventions have been developed to reduce occupational stress, promote wellbeing and improve retention. However, findings are inconsistent, and the interventions vary in terms of their theoretical underpinnings, design, mode of delivery, and implementation context. Given this variation, there is a need to synthesize these findings and identify key factors that influence the design, delivery, and effectiveness of wellbeing interventions.

What we did

We conducted a meta-synthesis of practitioner wellbeing and retention interventions in primary care, exploring their mechanisms and key stakeholder experiences to inform design and implementation, and guide future research studies. Searches were conducted across 11 databases and trial registries in April 2023 and updated in October 2024. The quality of included studies was assessed using the CASP tool for qualitative research. Meta-ethnography was employed to synthesise findings, generating an overarching understanding beyond individual studies, with analyses underpinned by behaviour change theories.

What we found

After screening 15,094 citations, 29 studies were included in the meta-synthesis. 9 interventions used psychoeducation, mindfulness and self-care techniques (31%), 9 tested shared learning and support networks (31%), 8 adopted organisational change and workload improvements (28%), and 3 provided rewards and incentives to staff (10%). Practitioners reported positive experiences of interventions, including improvements to wellbeing, work engagement, communication and connection within teams, and reductions in burnout and workplace stress. Key facilitators of interventions included leadership support, staff input and co-design of interventions, a compassionate and non-judgmental environment, and adequate time and resources to enable participation.

What this means

This review provides an overview of primary care practitioners’ experiences of wellbeing and retention interventions, offering insights into the feasibility, appropriateness and acceptability of these interventions in primary care settings. It is noted that data from numerous studies was impacted by design limitations, such as small-scale interventions, lack of post-intervention follow up, volunteer sampling, and low-quality qualitative data. As such, suggestions are made for future research.

How and where do people in farming communities seek help for mental ill-health: engaging farming communities in research?

Authors: Fisher T, Kingstone T, Ashford G, Clark M, Corp N, Durrant J, Hayes S, Michail M, Mughal F, Noble, H, Platt N, Saunders K, White J, Chew-Graham C.A. (Keele University)

What is the problem?

People who work and live within farming communities experience prolonged hours of isolation and stress which may lead to mental health difficulties, with increased risk of self-harm and suicide... There is a stigma in the farming community in relation to help-seeking, generally, but more so for mental health problems. Farming communities are under-served and under-researched. We are working with farming communities and support organisations to explore how farmers could be better supported to seek help for mental health difficulties.

What we did:

Ethics approvals obtained from Keele University Research Ethics Committee (reference 1026).

A multi-method qualitative study including semi-structured interviews with people with lived experience of mental ill-health in the farming community, health and social care professionals and veterinary staff who work with farmers. Non-participant observations of spaces such as cattle markets and farming shows, including go-along interviews to identify mental health support for the farming community and explore gaps in current provision. We have held "pie and pint" and "paint and pastries" events to bring farmers and families together in spaces familiar to them, to share their thoughts and feelings about the research and mental ill-health in the farming community.

A lived experience and expert advisory group has informed all stages of the research.

What we found:

People in farming communities may not seek mental health support from statutory services, including primary care, but are supported by veterinarians, chaplaincy teams, community organisations and social networks. Markets are a crucial space for socialisation and help-seeking. Health professionals do attend some markets to reach out to farmers and support help-seeking, however continuity of care is important to this population. There is a gender divide in help-seeking for mental health difficulties - with women feeling more able to ask for help. Farmers' wives also seek help on behalf of their partners.

What does it mean?

We will use our findings to co-design a framework to enhance support for people in farming communities with mental health problems at risk of self-harm and suicide, ensuring it reflects their needs, preferences, and help-seeking opportunities.

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The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Early Intervention in Psychosis services – is there an optimum duration of care? A multi-perspective qualitative study

Michelle Rickett, Tom Kingstone, Carolyn Chew-Graham (Keele University)

The Problem

Early Intervention in Psychosis (EIP) services offer a standard 3 years' treatment to people with a first episode of psychosis in the UK. Over half of Service users (SUs) are discharged to Primary Care. Our research aimed to understand and contextualise duration of EIP care - including individual differences, processes of care, discharge planning and shared decision-making.

The Approach

Longitudinal qualitative study. Ethics and HRA approvals gained. Semi-structured interviews conducted online/by telephone with SUs (x16 around point of discharge from EIP; x12 second interviews after 6 months); carers (x14); EIP healthcare practitioners (x24); GPs (x8); mental health commissioners (x6). Interviews recorded/transcribed with consent. Thematic analysis by multidisciplinary team. Patient and public involvement key at all stages.

Findings

The 3-year time limited service was perceived to work well if SUs felt involved in discharge decision-making, and prepared and equipped to move forward. However, SUs who did not feel ready for discharge described feelings of disempowerment and abandonment – "falling off a cliff". Flexible duration of care (extended or shortened) was described and personalised due to factors such as SU progress within EIP service, social/cultural factors, comorbid neurodiversity, and completion of therapies. All participant groups described the importance of person-centred and relationship-based care within EIP services and that there needed to be a well-supported transition from EIP.

Implications

This study suggests that a more personalised approach to duration of EIP care is required for SUs alongside more genuine shared decision-making. The opportunity to offer flexibility varies across teams and mental health trusts. An agreed framework for extending care would enable SUs, carers and EIP practitioners to work together more collaboratively around discharge. Greater engagement is needed between SUs/carers and primary care at the point of discharge from EIP to facilitate the offer of relational care and a smoother transition.

Title: **How can we improve care for women with perinatal anxiety across primary and community care? A qualitative study.**

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What is the problem?

Perinatal anxiety (PNA) is experienced by 21% of women worldwide, occurring during pregnancy or in the first twelve months after birth. PNA can have a negative impact on mothers, children and their families. This study aimed to explore a range of perspectives about usefulness and acceptability of non-pharmacological interventions for PNA across primary and community care.

What we did

Ethics approvals obtained. Semi-structured interviews were held with xxx. Interviews were digitally recorded, transcribed and analysed thematically within the team. A patient advisory group (PAG) was involved throughout.

What we found

30 interviews: 13 women with lived experience of PNA, 10 primary care healthcare professionals (HCPs) with a variety of professional backgrounds, 4 community organisation practitioners and 3 commissioners of perinatal mental health (PMH) services across England. Experiences of PNA vary. Barriers to help-seeking include stigma and fear of negative repercussions after disclosure. Participants described a range of intervention options including self-management strategies, peer and family support, online interventions, support from healthcare services and support from community based PMH organisations. Some women expressed a preference for support from community-based PMH organisations rather than from primary care. Representatives from community organisations and commissioners reflected that community organisations were often well integrated within local communities and able to offer flexible, tailored, and accessible support for women. HCPs and representatives from community organisations agreed that collaboration between healthcare and community services provides women with greater choice and reduces care inequity.

What does this mean?

Women with PNA choose to access a range of support more than what is currently recommended in clinical guidance. Tension exists between what services are commissioned and the types of intervention that women want to access, including support from community services. There is currently an evidence gap for the effectiveness of interventions delivered by community organisations.

Addressing cardiovascular risk after adverse pregnancy outcomes: a health equity-focused qualitative review Brook Hodges (Keele University)

What is the problem?

Cardiovascular Disease (CVD) risk increases following adverse pregnancy outcomes (APOs) including hypertensive disorders of pregnancy (HDP), preterm labour and foetal growth restriction. APOs disproportionately affect women of certain ethnic minorities and those who are socio-economically deprived. Risk of CVD after APOs is approximately doubled and two-thirds of women experiencing pre-eclampsia die prematurely from CVD. This review examines women's perspectives on postnatal lifestyle interventions to address long-term CVD risk, focusing on highest-risk groups.

What we did

Qualitative systematic review and thematic synthesis. A protocol was registered on PROSPERO (CRD420250654735). Papers were included if they contained qualitative components reporting views on addressing CVD risk in women experiencing APOs.

What we found

Of 1887 screened articles 33% of included papers demonstrated recruitment of an ethnically diverse participant group, 39% demonstrated diversity of socioeconomic status. Three studies interviewed women followed up in secondary care clinics, four discussed telephone/online support interventions, two assessed question prompt lists, and nine discussed women's views on making lifestyle change after APOs. 83% of papers were published in the last 5 years, illustrating growing interest in this field.

Themes from the synthesis were:

1.Pregnancy is a motivator for lifestyle change but many barriers exist, including lack of physical and psychological recovery and guilt at self-prioritisation.

2. Women felt abandoned, seeing a contrast between highly monitored pregnancies and inadequate post-partum care. They desire structured post-partum follow-up with formal recalls, those from higher risk groups are particularly unlikely to seek follow-up independently.

What does it mean?

Interventions require tailoring to high-risk women's needs, yet socioeconomically deprived and ethnic minority populations remain under-represented in research. Review findings will be shared at a stakeholder event with women and healthcare practitioners to establish research priorities for intervention development.

Managing Multiple Health Conditions in Older Adults (MODS): Process Evaluation and Development of Implementation Framework

Kate Bosanquet, Della Bailey, Peter Coventry, Suzanne Crossland, David Ekers, Simon Gilbody, Elizabeth Littlewood, Dean McMillan, Eloise Ryde, Leanne Shearsmith, Rebecca Temple, Carolyn A. Chew-Graham

What is the problem?

Older adults with multiple long-term conditions (LTCs) are at heightened risk for depression, impacting their health and quality of life. Behavioural Activation (BA), an intervention which encourages people to act on plans rather than mood, has been shown to be effective in treating depression. The MODS study evaluated the effectiveness of BA on older adults with multimorbidity. This process evaluation is a nested qualitative study which aimed to explore stakeholder intervention experiences and the potential for implementation.

What we did

We conducted one-on-one telephone interviews with 23 participants, 3 caregivers, 12 MODS support workers (MSWs), and 3 Primary Care Practitioners (PCPs). The interviews were transcribed professionally, and data were analysed thematically using constant comparison. The study also had ongoing patient and public involvement. (https://sites.google.com/nihr.ac.uk/basil/patient-and-public-involvement)

What we found

Four main themes were generated:

- Safe Place to Talk: Participants valued having a private space to talk with a MSW who was impartial about their feelings.
- Increasing Motivation: BA techniques helped participants change their mindset about tackling daily tasks and making life changes. Increased activity and social contact improved mood.
- Developing Confidence: MSWs worked collaboratively which enabled participants to feel more proactive and justified in seeking help and accessing healthcare and other services.
- Implementation Insights: There was strong consensus that the intervention should be translated into a real-world setting, preferably within primary care.

What does it mean?

The findings suggest that a MODS-style intervention could be more widely available for older adults with multiple LTCs and low mood. Its positive impact and the potential for remote delivery by non-specialist practitioners make it a viable option. Each stakeholder group (PCPs, MSWs, participants, caregivers) showed interest in talking about putting this intervention into a real-world setting. The next step is to explore barriers and facilitators to implementation

Working together with Autistic Adults to Widen Research Participation in Primary Care.

Jane Vennik, Sascha Miller, Kate Henaghan-Sykes, Primary Care Research Centre, University of Southampton

What is the problem?

Inclusive research design is vital to ensure findings are relevant and generalisable. However, autistic individuals face barriers to participation because of complex recruitment methods, inaccessible documents, and unclear instructions. To address these issues, we need to develop new, simpler and more inclusive ways to encourage participation.

What we did

Using an exemplar study (*StopAMR)*, we tested new approaches to inclusion. We adapted the Listening Café model—a format that encourages open, informal discussion—for autistic participants. Two groups were involved: an online group of six autistic individuals recruited through local networks, and a community group of 30 members run by the National Autistic Society. Listening Café sessions focused on relationship-building, reviewing recruitment documents, participant information, and informed consent processes. Insights from these sessions informed the development of guidelines to make materials clearer, more accessible, and inclusive.

What we found

Participants in both groups valued the opportunity of participating and gained confidence in contributing and sharing their ideas. The listening café model worked well but to ensure success, we needed to be flexible, adapt quickly, and try different approaches in response to the group’s needs.

The review of recruitment materials highlighted that small changes to structure, language, tone, and format can significantly enhance clarity and accessibility. Additionally, content that clearly explains processes, affiliations, and ethical considerations plays a key role in building trust.

What does it mean?

Ensuring research is accessible is a priority to ensure relevance and generalisability. Adjustments to recruitment materials has the potential to reach a broader group of participants. Involving autistic and neurodivergent people directly in designing these materials prevents unintentional exclusion and ensures their perspectives are represented. Ultimately, these adjustments not only support inclusion for autistic communities but also improve clarity and accessibility for all research participants.

SAPC Conference Abstract Submission

– Sarayu Shankar, Dr Hassan Awan, Dr Tom Kingstone (Keele University)

What is the problem?

Ethnic minorities, particularly South Asians, face significant disparities in mental health outcomes compared to the general population. Despite high levels of emotional distress, anxiety, and depression, South Asians often underutilise mental health services due to cultural and structural influences such as gender roles and societal stigma. Consequently, many seek help from alternative providers like religious leaders, traditional healers, and community figures, whose roles and accessibility are not well understood in existing literature. [1,2,3]

What we did

This scoping review explores the types of providers accessed by South Asians experiencing emotional distress and mental health issues, their motivations for choosing these providers, and the perceived impact. Following the Joanna Briggs Institute (JBI) methodology, a comprehensive search was conducted across medical, psychology, and social sciences databases, including grey literature. This review builds on previous research highlighting distrust in NHS services and reliance on alternative health paradigms. [3,4]

What we found

South Asians often seek non-traditional mental health support through family referral, worship spaces, healers, or community lay workers. Chosen for trust, cultural fit, affordability, and stigma avoidance, these providers offer spiritual framing, rituals, holistic remedies, or low-intensity psychosocial care. While they reduce isolation and increase help-seeking, risks include misdiagnosis, exploitation, and delayed clinical care. Family networks provide containment but may silence disclosure. Emerging hybrid faith–clinical models show promise in reducing stigma and creating culturally adapted pathways. [5,6,7,8,9,10,11,12]

What does it mean?

The interplay between faith leaders, community workers, and integrated care models highlights the importance of diverse access points and well-trained providers in supporting mental health. Worship spaces and community centres reduce stigma and create essential connections, while ongoing training could equip providers to effectively screen and refer individuals, fostering a more holistic and responsive system of care.

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Title: Access to and Experiences of Hormonal Contraception for Neurodiverse Individuals

Name: Siân Beddows

Abstract:

Background: Neurodiverse people experience barriers to healthcare in the UK, affecting health outcomes including life expectancy. Autistic adolescents are less likely to use hormonal contraception (HC) than their peers without autism. Symptoms of Attention Deficit Hyperactivity Disorder (ADHD) are affected by fluctuating progesterone and oestrogen levels across the menstrual cycle. Autistic people are more affected by pre-existing autism symptoms prior to or during menstruation.

Aims: This study aimed to improve understanding of the experiences of autistic people and people with ADHD when accessing and using HC, using qualitative methods.

Methods: A qualitative evidence synthesis (QES) was conducted to identify currently available evidence. 9 semi-structured interviews were carried out using an interview guide. Results were automatically transcribed and coded using NVivo. Themes were developed using thematic analysis.

Results: 2 themes were constructed from the QES, The healthcare professional and The impact of autism and ADHD. Thematic analysis of the interviews resulted in 4 themes. Being neurodiverse affected participants' choice of contraceptive method. Participants shared how HC use affected symptoms of autism and ADHD, as well as co-existing mental health conditions. Poor communication with the HCP, previous dismissive experiences, and a lack of continuity of care were barriers to healthcare access. Inadequate contraceptive counselling from HCPs led participants to seek information from other sources including friends and the internet.

Conclusion: This study addressed a gap in the literature by providing qualitative evidence of how being autistic or having ADHD impacts choice of contraceptive method, access to information about HC and side effects experienced while using HC. Accessible written information about HC and continued training for HCPs regarding accessible communication will help to address these barriers. Further research should validate these results using member checking and introduce a neurotypical control group to confirm which findings are unique to neurodiverse people.

Cultural Models within General Practice Training: a Scoping Review

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ABSTRACT SAPC North

What is the problem? Presenting to General Practice (GP) is often the first step that people take when seeking healthcare. GPs are increasingly working in cross-cultural consultations, so it is vital their care is culturally appropriate. A patient's culture is intrinsic to who they are, the beliefs they hold, and decisions they make. As healthcare professionals, culture impacts the care delivered. Cultural models have been developed as frameworks to better equip medical professionals towards more culturally appropriate health care, with potential to improve equity in healthcare systems.

What we did? We conducted a scoping review using Arksey and O'Malley's framework with the aim to map evidence on models of cultural competence, cultural safety, cultural humility and transcultural care within GP training worldwide. Searches were conducted across three databases, Embase, Medline, and WebScience Core Collection, and extended to include grey literature such as curricula. Articles were extracted, reviewed and analysed according to inclusion criteria.

What we found out? Nineteen articles met inclusion criteria. Publications ranged from 2008-2024, with 10 articles from Australia, 5 from USA, 2 Sweden, 1 Canada and 1 the Netherlands. Three themes were generated: Unlearning, Informal Learning, and Informed Learning. The literature illustrates that there are gaps in knowledge of what the models are and how best to practise and teach them within GP education.

What does it mean?
Cultural models advocate for cultural awareness, examine power imbalances, and encourage self-reflexivity and learning. Integrating cultural models into healthcare can better serve all patients, with potential to reduce health inequities. There also needs to be an adaptation to traditional GP consultations with a focus on how our own biases impact the care that we provide, and a more formal learning of cultural models best delivered by GP trainers in partnership with cultural mentors.

Abstract

The use of race in medical practice has been a point of contention for many years, with new studies challenging its inclusion as a variable in the research that determines medical guidelines. If race is now defined as a social construct, why do our teaching materials and guidelines still present it as having a biological basis?

The student-staff EDI committee at Newcastle University Medical School aimed to challenge the status quo by designing and delivering a teaching session during the primary care teaching block for final year medical students.

The aim of the session was to educate students on the potential dangers of race-based medicine. We ran a poll at the start of the teaching session which asked the question "To what extent is race biological?" and found that majority of students incorrectly believed race to be biological. We then explored the difference between race and ethnicity and discussed the lack of scientific study behind the 18th century definition of race which unfortunately persists.

The teaching session was based around four case studies:

1. The current use of race in the hypertension guidelines
2. Race as a factor in VBAC calculations
3. The inclusion of race in spirometry until 2021
4. Prior inclusion of race in CKD-EPI equation

Students were given the independence to explore the research that informed the medical guidelines above and concluded that race had been inappropriately used as a variable in all. The final poll results and discussions raised by the session revealed the impact of the one-hour session in challenging incorrect pre-existing societal notions held by both students and tutors.

We plan to foster a new generation of students that are aware of and able to critically appraise biased research that will shape future patient care positively and make medical research and education more inclusive.

Chiamaka Anthony-Okeke

Improving Primary Care Services for Imprisoned Women with Severe Mental Illness (IP-SIS)

Carolyn A. Chew-Graham, Kate Cowen, Jake Hard, Paula Harriott, Hannah King, Emma Mastrocola and Tammi Walker

What is the problem?

Women in prison with Severe Mental Illness (SMI often have complex physical and mental health needs which can be amplified by intersectional factors such as ethnicity. Little is known about the use of primary care services by imprisoned women and how ethnicity can impact on care experiences.

What we did

Ethics approvals obtained. Semi-structured interviews with prison primary care practitioners.

Study informed by a Lived Experience Advisory Group (LEAG) comprising women with experience of imprisonment. The topic guide was co-created with the project LEAG and includes prompts relating to current prison primary care provisions, barriers and facilitators to access, racial disparities, continuity of healthcare post-release. Interviews recorded with consent and transcribed verbatim. Analysis utilising a Framework approach. Data collection and analysis are ongoing.

What we found

Early findings highlight systemic barriers leading to unmet needs, particularly among racially minoritised women, with challenges intensified for those who do not speak English. The prison environment complicates access to services – including limited time out of cell and low staffing levels. Variations in primary care delivery between prisons and community services do not allow for continuity of care, These insights will inform the next phases of the study and the development of a culturally-sensitive framework to address inequalities in prison primary care.

What this means

This research will inform service planning, improve continuity of care, and promote culturally-responsive primary care for women with SMI in prison and on release.

Transmasculine people face unique challenges in accessing and using contraceptive methods, influenced by gendered embodiment, healthcare systems, and identity-driven decision making. These challenges are exacerbated by an increasingly hostile socio-political climate that threatens trans rights and access to care. UK-based qualitative research is minimal, so this project aims to clarify, identify, and understand factors influencing transmasculine people's experiences of contraceptive methods and services. A three-part approach was used. First, a literature review synthesised existing evidence on contraceptive use and needs among transmasculine people. Second, a qualitative evidence synthesis (QES) identified key themes across global qualitative studies, synthesising insights on decision-making, experiences, and barriers to accessing contraceptive methods. Third, primary data was collected through semi-structured interviews (n=6) and a focus group (n=4) with transmasculine individuals aged 18+ in the UK. Thematic analysis was used throughout, with a thematic framework developed from the QES and further explored in the qualitative study. The literature review and QES revealed a consistent lack of inclusive services, compounded by gender dysphoria, negative healthcare experiences, and concerns about side effects and interactions with testosterone therapy. Primary data echoed these challenges and further explored three overarching themes: 1. Gender Identity, Dysphoria, and Reproductive Embodiment: the relationship between contraceptives, gender identity, and dysphoria. 2. Experiences with Healthcare Systems: participants reported mixed experiences, from supportive clinicians to exclusionary care. 3. Contraceptive Decision-Making and Use: decisions were influenced by gender dysphoria, peers' opinions, side effects, and testosterone interactions. This study highlights the significant need for inclusive, identity-aware contraceptive care that affirms transmasculine people's needs. Contraceptive methods are not neutral - they are shaped by experiences of gender, identity, and power. How they are accessed, discussed, and delivered can either affirm or disempower wellbeing. Findings emphasise the need for non-assumptive, person-centred care, contributing new UK-based evidence to inform more equitable reproductive healthcare.

Jessica Madden, Rebecca Mawson, University of Sheffield

Abstract:

The introduction of artificial intelligence (AI) has sparked global excitement about its potential to transform various job sectors by increasing efficiency, reducing workload, and enhancing overall performance, yet the specific role of AI in undergraduate general practice teaching remains relatively unexplored.

A national survey was conducted with heads of undergraduate GP teaching across the UK to explore current usage patterns of GenAI. This was circulated by email with a reminder email sent. Three qualitative data collection methods were conducted: focus groups of year 4 medical students undertaking SSCs in medical education, semi-structured interviews with heads of undergraduate GP teaching (recruited via the survey) and GP teachers from our institution (recruited via email and word of mouth). Participant recruitment was by purposive sampling, asking for those with interest in GenAI use in education. Interviews were undertaken via video conferencing, recorded and transcribed verbatim by auto transcriptions and checked by MRJ. Interview transcripts were analysed thematically by MRJ after consultation with HA.

The national survey revealed limited formal GenAI integration, with only 24% of respondents reporting institutional use, though 54% described informal use by individual educators. Thematic analysis from interview transcripts identified three overarching themes: positivity focused on efficiency gains and educational innovation; mixed views emphasising the need for complementary use and comprehensive training; and negativity centred on accuracy concerns, skills erosion, and patient confidentiality risks.

These findings suggest that successful GenAI integration in medical education requires structured implementation frameworks that address educators’ concerns, preserve essential human elements of clinical practice, and provide comprehensive training for both educators and learners. The research also produced a recommendations list derived from GP interviews detailing practical AI applications and usage guidance for GPs considering AI implementation.

Millie Ramsay-Jordan

Asking preoperative patients to opt out of Stop Smoking Service referral via SMS: A controlled interrupted time series analysis

Stephen Wormall

What is the problem

The journey to elective surgical intervention starts in Primary Care, which has an important role in preoperative optimisation. Smoking tobacco is a risk factor for operative complications and chronic disease. The preoperative period may offer a window of heightened motivation to quit. Could a simple "nudge" intervention increase smoking cessation in this group?

What we did

Primary Care electronic health records were cross-referenced with a local district hospital's elective surgery waiting list in a clinical database. Patients who had completed their preoperative assessments and were coded as "current smokers" (476 patients, 52% female; mean age 52 years) were sent an SMS text message from a preoperative administrator. It read "*Stopping smoking is important before surgery. The hospital team will refer you to YourHealthNotts for support to stop unless you reply N within 14 days*". Patients who did not opt out by reply were referred to the local community Stop Smoking Service (SSS). The primary outcome was patient-reported smoking abstinence 28 days after an agreed quit date. A cohort follow-up study and controlled interrupted time series analysis (ITSA) were performed to evaluate the intervention.

What we found

Of all patients sent messages, 10.5% (50/476) reported 28-day abstinence. A quarter (25.4%, 121/476) booked an SSS appointment, while 16% (77/476) opted out of referral. 63.9% (304/476) were contactable by the SSS and 54.2% (258/476) confirmed they were still smoking. Among these, 19.4% (50/258) subsequently reported abstinence. ITSA indicated an immediate increase in weekly hospital patients referred who subsequently reported abstinence (5.83 patients, 95% CI: 2.50 – 9.16, $p < 0.001$), consistent with a pulsed intervention of limited duration.

What does it mean?

Leveraging Primary Care data to deliver an opt-out SSS invitation via SMS – a nudge intervention - appeared to increase smoking cessation. Similar interventions could be applied at larger scales, in different contexts and iteratively evaluated.

Stepping through the digital door: Looking at social determinants of health and impact on frailty

Dr Preetha Biyani, Dr Danya Haboubi, Dr Bryony Mathew, Dr Sadiah Lala

Background: Frailty is prevalent, and in 2020 it was estimated that 8.1% of adults in the UK over 50 were frail[1]. Medical Licensing Assessment states doctors are expected to manage patients with multimorbidity and frailty[2]. The Royal College of General Practitioners highlights the need to consider the impact of social determinants of health (SDH) to manage patients holistically[3]. However, research has shown that healthcare professionals feel they require more training on frailty[4]. Patients with severe frailty often require home visits from primary care. Home visits provide a unique learning experience. They allow holistic assessment of patients, providing contextual information regarding activities of daily life and aiding in identifying unmet needs[5]. Home visits have been shown to help students to build skills and confidence[6].The heterogenous nature of general practice means that the number of home visits attended, and the level of frailty of patients who are reviewed by medical students will vary greatly. Use of simulated or virtual home visits allow for a standardised experience for healthcare students. Students favour interactive and experiential learning methods[7].

Approach: We developed an interactive digital home visit in collaboration with the Digital Education team. Medical student and educators' feedback led to adjustments to the resource.

The innovative home visit allows students to explore the home of a patient with frailty, identifying SDH impacting their life. The scenario reflects the real-life complexity and multi-faceted nature of frailty deliverable in a large-scale standardised format. Students explore the home visit resource independently. Campus-based teaching will then explore SDH and frailty in greater depth.

To evaluate the educational value, students will complete pre- and post-session Likert questionnaires and also be invited to focus groups to provide qualitative data. A thematic analysis will be conducted to review the data.

This innovative resource engages students to consider the impact of SDH on frailty; providing a novel approach which can be adopted in other educational settings, locally and nationally.

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How do medical educators understand race and perceive its impact on their teaching practises?

Abstract

What was the problem?

Although race has no coherent biological basis, medical education often continues to present it as a biological determinant of disease. This risks reinforcing racial essentialism and obscuring the structural causes of health disparities. While student perspectives are increasingly studied, less is known about how educators themselves understand and teach race.

What we did?

We conducted a qualitative study with six General Practitioner (GP) educators at Newcastle University who facilitated sessions on race and health for fifth-year medical students. Using the Listening Rooms method, participants engaged in peer-to-peer conversations guided by prompts. Transcripts were analysed thematically using reflexive thematic analysis.

What we found

Educators initially conceptualised race in biological terms, but engagement with the sessions prompted shifts towards framing it as a social construct. Nonetheless, uncertainty persisted about explaining population-level differences without reverting to essentialism. Participants described strong emotional responses, including shame, fear, and concern about perpetuating racism. Delivering the sessions was experienced as daunting yet generative, with co-learning sometimes unsettling but also stimulating continued student engagement. Educators expressed dissatisfaction with existing frameworks such as the BioPsychoSocial model, highlighted tensions between critical teaching and race-based guidelines, and called for clearer institutional guidance on definitions, pedagogy, and curriculum placement.

What does it mean?

Medical educators grapple with reconciling scientific consensus and clinical practice when teaching about race. Findings suggest a need for institutional clarity, integration of Critical Race Theory into curricula, and alignment of educational practice with reforms in clinical guidelines. Supporting educators in this process is essential for advancing anti-racist medical education.

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Exploring Remote Consulting Teaching in the Newcastle MBBS Curriculum: Student and Staff Perspectives on Challenges, Effectiveness, and Future Improvements.

Cerys Davies, Reece Browne, Newcastle University

What is the problem?

Remote consulting has become increasingly common in clinical practice following COVID-19. It offers benefits such as potential cost reduction, improved accessibility, and aligns with government targets. However, the Newcastle MBBS curriculum remains largely focused on face-to-face consultation skills, raising concerns about whether graduates are prepared for the specific challenges of remote consulting. Evidence on how students and staff perceive this teaching gap, and desired improvements, remains limited.

What we did

We conducted a qualitative study using semi-structured focus groups with year 2 and year 4 medical students, and interviews with key staff members. Discussions were audio-recorded, transcribed verbatim, and analysed using codebook thematic analysis, with both researchers double-coding one student and one staff transcript to enhance rigour.

What we found

Eight year 4 students and seven year 2 students were recruited to four focus groups, and six staff interviews were conducted. Preliminary analysis indicated a strong preference for experiential learning, both in placements and formal teaching. Variation in teaching across regional placements was notable. Year 4 students generally reported confidence in basic remote consulting, whereas year 2 students desired more teaching and support. Staff observed that students were more nervous and often failed to build initial rapport remotely. Reported barriers included technology, communication, clinical limitations, placement variability, resource constraints, and learner factors, though many were seen as less significant in practice as face-to-face consultation skills were often transferable.

What does it mean?

Remote consulting teaching is valued by students and staff, but would benefit from adaptation to address confidence gaps, particularly among students in earlier years. Suggested improvements included simulation, roleplay, and formal assessment rather than didactic delivery. These findings highlight the importance of experiential learning and will inform curriculum development, with the potential to better prepare graduates to deliver safe, effective, and patient-centred virtual care.

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End of abstracts.

We hope the work shared here guides and motivates your journey ahead.

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