Embedding Active Bystander Training Across Academic and Clinical Spaces

Sub-Theme: Active and Experiential Learning

Dr Kiran Bhavra, Dr Mashuda Khandokar, Dr Takunda Nhiwatiwa, Dr Amardeep Sidki and Dr Kike Solanke – medrace@le.ac.uk

MedRACE (Medicine Raising Awareness and Celebrating Excellence) is an award-winning staff and student collective working group who work together to challenge, improve and create a more inclusive medical curriculum and beyond. The group aim to understand and break down existing barriers around inclusivity. Our teaching has been recognised with the Times Higher Education Award for Outstanding Contribution to Equality, Diversity and Inclusion and the Collaborative Award for Teaching Excellence (CATE)**,** reflecting our commitment to inclusive, high-quality education.

The emergence of the MedRACE Alumni group, comprising of Leicester graduates now working as doctors, has been formed due to evidence that members could extend their impactful work beyond medical school into NHS trusts. Additionally, participation provides alumni with opportunities to develop their teaching skills, supporting the educational responsibilities inherent to the role of a doctor.

Active bystander training can increase confidence and capability to address microaggressions and discrimination and may support behaviour change. However, delivery often remains either classroom based or as e-learning, with limited attention to clinical hierarchy, time pressure and local escalation systems.

Our content was initially shaped by doctors in their 1st or 2nd year of training, but has now expanded using scenarios contributed by middle-grade and senior healthcare clinicians. Our distinctive feature is the continuous use of anonymised, up to date lived experiences, drawn from current clinical workplaces. This enables rehearsal of responses that fit contemporary teams, policies and reporting routes.

Since leaving medical school, MedRACE alumni have delivered the programme within NHS hospital trusts across the UK during clinical rotations. In addition to this, adapted versions have also been delivered locally, e.g. Scouts and Air Ambulance Services.

Sessions delivered are interactive and skills-focussed, combining facilitated discussion with structured rehearsal of bystander options appropriate to role and context (e.g. interruption, delegation/escalation, documentation and post-event check in). Evaluation uses immediate post-session surveys. Feedback gained highlights acceptability and relevance, improved confidence to act, and valuing a psychologically safer space to discuss discrimination.

Moving forward, our goal is to create a co-produced, clinically authentic, updated bystander curriculum that is feasible to deliver across trusts and learner groups in the UK, with potential to strengthen a sense of belonging and safety in clinical learning and working environments. Next steps include follow-up evaluation of behaviour change and evaluation of potential enablers and barriers.