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EDITORIAL

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Clinical Simulation

Clinical simulation is no longer viewed as a pedagogical supplement, a 'luxury' in teaching, but has established itself as a cornerstone of training and professional development in the healthcare sector. It is not merely a matter of high-fidelity manikins, virtual reality or mirrored rooms. Gaba notes that simulation is, first and foremost, a technique, not a technology, designed to replace or enhance real-world experiences with simulated ones that interactively replicate essential aspects of the real world[1]. This distinction is crucial, as it shifts the focus from investment in equipment to investment in learning methodologies, qualified facilitators, and a culture of safety and evaluation.

Over the last two decades, the literature has emphasised that simulation-based experiences promote the acquisition of technical and non-technical skills, such as communication, teamwork, leadership, clinical reasoning and decision-making, in a controlled environment that poses no risk to the patient[2]. Recent literature reviews point to consistent gains in performance, confidence and transferable skills, although many studies are local in scope, with methodological heterogeneity and results often centred on the student rather than on clinical indicators[3,4]. This finding does not diminish the value of clinical simulation; rather, it reinforces the need for more robust research and institutionally supported programmes capable of demonstrating an impact on clinical quality and safety.

This is where the INACSL Healthcare Simulation Standards of Best Practice become relevant, by specifying required criteria and elements, such as professional integrity, simulation design, objectives and outcomes, pre-briefing, facilitation, debriefing process, evaluation and operations. The standards help to reduce variation, increase reproducibility and safeguard pedagogical quality[5]. In particular, debriefing ceases to be merely a "post-scenario conversation" and establishes itself as a structured, intentional and evidence-based intervention, in which error is transformed into learning and deliberate practice takes on meaning[6].

Despite the consensus regarding its potential, clinical simulation faces predictable challenges such as implementation and maintenance costs, the time required from teaching staff and technical teams, the need for training in facilitation and evaluation, and the risk of confusing technological fidelity with functional fidelity.

Finally, the question that should guide institutional decisions remains: how can we ensure effective transfer to practice with a measurable impact on the quality of care?

Clinical simulation should be adopted as a policy for pedagogical quality and patient safety, rather than as a one-off project. To this end, the following is recommended:

- Governance and curricular intent, integrating simulation into competency-based curricula, with progression (from task-based training to team-based and contextual simulation) and measurable objectives;
- Pre-briefing and psychological safety, making clear the rules, boundaries, confidentiality and expectations, preparing the student to maximise learning and minimise cognitive load;
- Structured and evidence-based debriefing, adopting consistent models and guidelines, training facilitators and documenting processes and outcomes;
- Assessment and continuous improvement, combining formative and summative assessment, using data to refine scenarios and operations, aligning with recognised standards;
- Research and clinical cases, linking simulation programmes to clinical care indicators;
- Equity and access, combining modalities (low- and medium-fidelity, hybrid simulation, virtual simulation) to broaden access without compromising pedagogical quality.

As clinical simulation becomes established as a teaching method, it requires us to shift our mindset, moving from a focus on the ‘event’ to the ‘system’, viewing the equipment as a means to an end and educational quality as the outcome. Institutions that invest in standards, in the training of facilitators, in evaluation and operational safety, transform simulation into an ethical laboratory that allows for error, reflection and continuous improvement, before the error occurs in the presence of the patient. The challenge facing schools and healthcare organisations is not whether they should adopt simulation, but how to make it sustainable, equitable and demonstrably useful for clinical practice and patient safety.

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