

1 Introduction to simulated patient methodology

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Introduction

'Simulation is a technique to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate aspects of the real world in a fully interactive fashion'(1). This definition by Professor David Gaba, a pioneer of contemporary healthcare simulation, aptly describes simulated patient-based scenarios. A well-prepared simulated patient (SP) has the ability to draw learners into a scenario quickly, achieving deep engagement. Their mere presence usually prompts interactivity.

The terms *simulated* and *standardized* patients refer to largely similar simulation modalities, that is, a *well* person trained to portray a patient. The level of *standardization* varies according to the context in which the SP is placed. In learning settings, standardization is less critical and often its absence can be a feature. The tailoring of SP encounters can be used to meet the needs of individual learners, and also to introduce all the variation that characterizes human beings. In contrast, in summative or high-stakes (graded) assessments, SPs function as the examination question. Therefore, to permit a fair test, the SP must perform *consistently* within the character of the person they are portraying. Embodied in their role is factual information relevant to the clinical encounter. Whereas in Canada and North America the term *standardized patient* is commonplace, in the United Kingdom (UK) and Australia the commonly used term is *simulated patient*. In the latter tradition, simulated patients who perform in high-stakes assessments have their *behaviour* rather than their *being* described as standardized. These are nuanced differences and reflect historical practices. North America has witnessed a strong testing orientation of SP methodology whereas in the UK and Australia the origins are

rooted in supporting learning(2). Hereafter, the abbreviation SP is used to refer to either! Several other terms are used to describe the work of SPs and these include expanding roles too (Box 1.1). Our focus is on the role of SPs, although some chapters consider elements of expanded roles and others consider the role of the SP practitioner.



BOX 1.1 Alternative terms used to describe simulated or standardized patients and expanded roles for SPs

- **Role-player** – Sometimes used interchangeably with the term SP and often includes medical, nursing or health professional students as patients.
- **Clinical teaching associate** – Describes SPs who teach specific physical examination (e.g. breast, rectal, vaginal). The focus is on supporting learners in developing psychomotor, communication and other professional skills. This is a highly specialized role.
- **Trained patient** – Sometimes used interchangeably with the term SP and may or may not include a person who is using their experience of a particular illness to play their role.
- **Patient instructor** – May be used interchangeably with the term SP and may include a person who is using their experience of a particular illness to play their role.
- **Incognito or unannounced patient** – An SP who enters real clinical settings (e.g. pharmacy, general practice) with permission but without being identified as an SP – enabling judgements of clinician performance in action.
- **Volunteer patient** – A patient who is sufficiently well to attend teaching sessions. They may simply be themselves in role-play activities (e.g. an

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Objective Structured Clinical Examination) or they may play the role of another patient.

- **Hybrid patient** – The combination of an SP and a simulator permitting the practice of procedural and operative skills. The concept was first reported by Kneebone *et al.*(15), who described the blending of simulation modalities as ‘patient-focused simulation’, and is now widely used internationally.
- **Actor patient** – Used interchangeably with the term SP, although it may refer to professional acting skills of the SP.
- **Confederate** – An individual other than the patient who is scripted in a simulation to provide realism, additional challenges or additional information for the learner (e.g. paramedic, receptionist, family member, laboratory technician)(16). The voice of manikins can also be considered as a confederate role.

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Although healthcare continues to draw on training and assessment practices in high-reliability industries, simulation is likely to become embedded in all stages of education for the healthcare workforce. In the UK, the Chief Medical Officer reported that simulation was one of the top five priorities of the National Health Service in the coming decade(3). With this sort of strategic and high-level vision, simulation is clearly here to stay.

The contemporary history of SP methodology has many drivers. These are well documented and originate from humanistic, educational and external issues(4,5). The imperative of not causing harm to patients is a critical driver(6). However, we must also be aware of the risks to learners and SPs learning and working in this methodology. A theme throughout this book is the role of SPs as proxies for real patients. As such, they represent patient rather than clinician perspectives(7,8). Several chapters identify ways in which this patient proxy role can be strengthened. Some contemporary SP practices constrain the voice of real patients, which limits their potential in offering patient perspectives. We promote approaches that offer authentic patient voices and thereby

contribute to the development of patient-centred and safe care. Recent history is also witnessing better alignment of simulation-based education in health professional curricula, which means that SP practitioners are more likely to be working with other simulation practitioners. This creates exciting opportunities for practitioners of all simulation modalities to learn from each other.

Although the educational settings in which SPs work can vary widely, there are commonalities in simulation practice. Throughout the book, we refer to six phases commonly found in simulation-based educational activities. All are essential to creating effective educational experiences (Figure 1.1). This simulation framework has been adopted in a national training programme for simulation practitioners in Australia(9). The phases enable practitioners to share a common platform for designing and communicating simulation-based education. For the *Preparation* phase, we are referring to all the activities that take place before the session starts – recruiting and training SPs, database management, setting learning objectives, designing scenarios and so on. The *Briefing* phase refers to explaining the simulation process to all participants, including

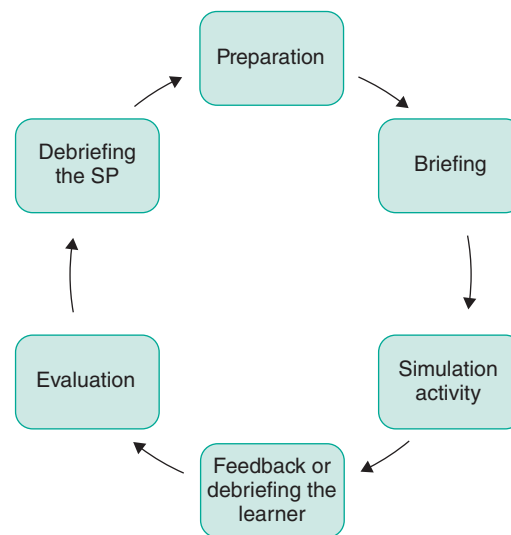


Figure 1.1 Phases in SP-based simulation. Source: *The NHET-Sim Program*, Nestel, D. Module S6: Patient-focused simulation, www.nhet-sim.edu.au (accessed 24 April, 2014). Reproduced with permission of Health Workforce Australia.

the scenario context, learning objectives and the approach to debriefing. Other activities during the briefing may include learners setting their own objectives, sharing prior experience and orientation to the learning environment. There are briefing activities for SPs too, such as checking that they know their role. The *Simulation Activity* is the next phase, and may take different forms, but is where the learner interacts with the SP. The *Debriefing and Feedback* phase follows, which complements the briefing. Learners' feelings are checked, objectives revisited, other perspectives sought and future learning is planned. During the *Reflection* phase, learners (usually individually) are encouraged to make sense of the simulation in the light of their own experience. Similarly, faculty and SPs are also encouraged to reflect on all facets of their contributions. The *Evaluation* phase refers to the success and limitations of the session in meeting its goals, not assessment of the individual. This phase benefits from learner, faculty and SP participation. For SP methodology, there is an 'additional' phase Debriefing the SP before they leave the session. SPs may need assistance in stepping out of their role (sometimes called de-rolling) and should leave the session with a sense of their performance and goals for the next encounter. If SPs are undertaking emotionally expressive roles, it can be especially important to de-role and debrief.

Cantillon *et al.* reported on SP programme development in medical education in four European countries(10). Their study sought to establish baseline information for planning regional collaborations. The survey-based study identified minimal sharing of expertise, ideas and scenarios within countries and even less across national borders. There were no consistent approaches to quality assurance in terms of training for role portrayal and feedback to learners. Respondents expressed interest in participating in a network. The cost of SP programmes was seen as a driver to sharing resources insomuch as avoiding duplication of investment in their development and learning 'best practices'. Although the authors acknowledged the challenge in sharing resources across national borders with respect to cultural differences in patients, health professionals and healthcare services, one goal of this book is to share theory, evidence and practice within and beyond the healthcare simulation community.

Unlike other simulation practitioners who work with task trainers, manikins and virtual environments, our simulation *modality* is comprised of real people. As such, we have particular considerations in our practice. One of these is to ensure that SPs are respected and cared for with at least as much respect as the most sophisticated manikin. We have tried to avoid the objectification of SPs(11) by referring to them as co-teachers rather than as objects to be *used*(11).

Although research on SP methodology is rapidly expanding, there are important fundamental areas of practice that have only limited *empirical* evidence, such as methods for effective training of SPs for role portrayal and in offering feedback. However, there is valuable *evidence* that is *experience* and *theory* based. An important example of the latter is incorporation of dramatic and performing arts theory into training methods for SP role portrayal(12–14).

For consistency, we have used the term *learner* to refer to any participant in an educational event. These may be undergraduate students or qualified clinicians. In case studies where specific learner groups are identified, authors have adopted more specific language. The term *faculty* is used to describe anyone involved in working with SPs and could include clinician teachers, facilitators, programme administrators, SP practitioners, educators or trainers. *SP educators* or *trainers*, *per se*, largely do not exist outside the Canada and the United States. The equivalent role is more likely to be incorporated into that of a clinical or communication skills academic role.

Authors in this book share with you their particular journeys and experiences. The book has four parts. The first part, *Foundational Frameworks*, includes the scope of contemporary SP practice through a themed analysis of published literature. An overview of simulation practice is described and then focus shifts to the professional community of the SP practitioner rather than SPs themselves. The second part, *Theoretical Perspectives*, includes an overview of selected theories that underpin SP-based education, before acknowledging the contribution of dramatic arts traditions, the use of a sociological analytic approach – conversational analysis – and finally the role of SPs in the discourses of health professions education. *Educational Practice* is currently the mainstay of SP methodology and as such constitutes the third part. The chapters cover

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elements of practice across planning, briefing, the simulation activity, debriefing and/or feedback and evaluation. The final part, *Case Studies: Innovations Across the Health Professions*, illustrate creative practice with SPs at their centre. The studies sample across professions, are designed for different levels of learners – undergraduate and qualified clinicians – and in different social and healthcare contexts.

The final chapter reflects on the contents and considers future opportunities and challenges in the theory, evidence and practice of SP methodology.

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