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### Making it real

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CHAPTER 11

# Co-constructive patient simulation:

a learner-centered method to  
enhance communication and  
reflection skills

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## ABSTRACT

**Introduction:** In simulation sessions using standardized patients (SPs), it is the instructors, rather than the learners, who traditionally identify learning goals. We describe co-constructive patient simulation (CCPS), an experiential method in which learners address self-identified goals.

**Methods:** In CCPS, a designated learner creates a case script based on a challenging clinical encounter. The script is then shared with an actor who is experienced working as an SP in medical settings. An instructor with experience in the model is involved in creating, editing, and practicing role play of the case. After co-creation of the case, learners with no prior knowledge of the case (peers or supervisors) interview the SP. The clinical encounter is followed by a group debriefing session.

**Results:** We conducted 6 CCPS sessions with senior trainees in child and adolescent psychiatry. Topics that are difficult to openly talk about may be especially appropriate for the CCPS model—without overt guidance or solicitation, the scripts developed by learners for this series involved: medical errors and error disclosure; racial tensions, including overt racism; interprofessional conflict; transphobia; patient-on-provider violence; sexual health; and the sharing of vulnerability and personal imperfections in the clinical setting.

**Conclusions:** CCPS provides an alternative multistage and multimodal approach to traditional SP simulation sessions that can adapt iteratively and in real time to new clinical vicissitudes and challenges. This learner-centered model holds promise to enrich simulation-based education by fostering autonomous, meaningful, and relevant experiences that are in alignment with trainees' self-identified learning goals.

**It is true that storytelling reveals meaning without committing the error of defining it, that it brings about consent and reconciliation with things as they really are...**

— Hannah Arendt  
*Men in Dark Times (1970)*

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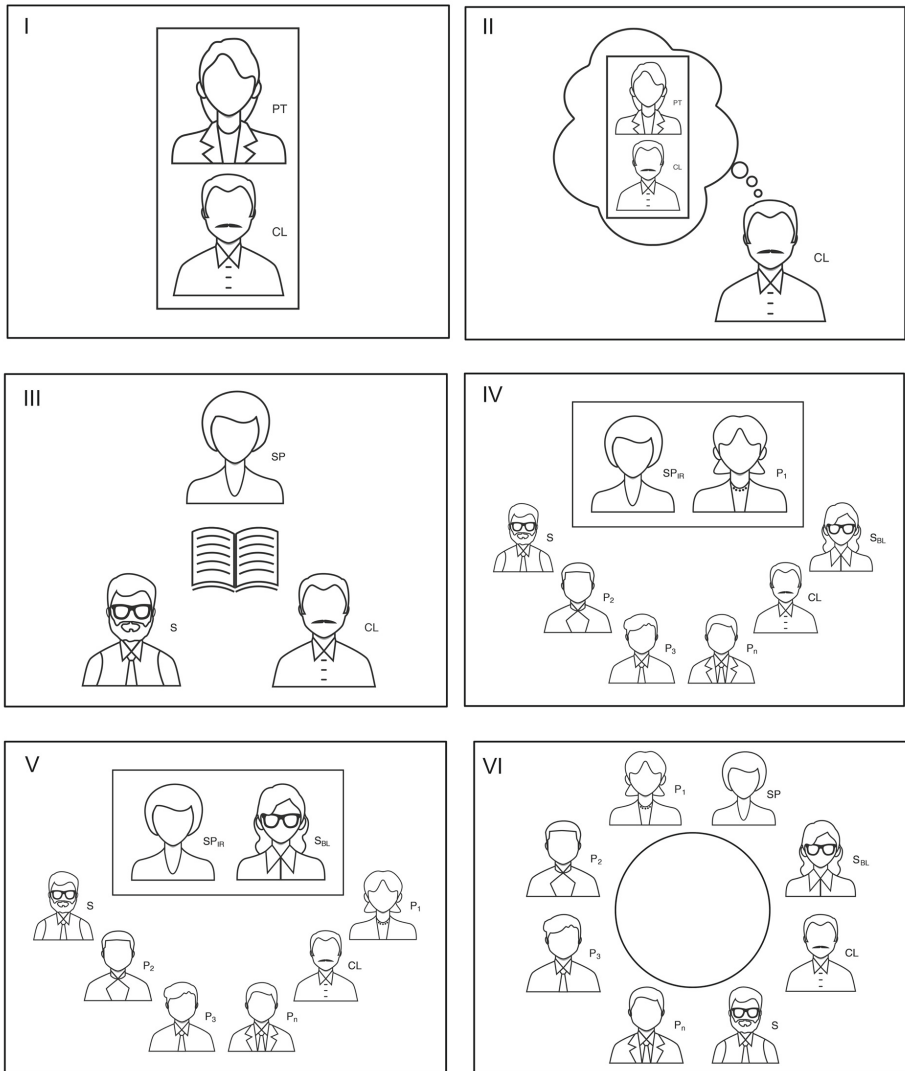
Simulation-based education with standardized patients (SPs) has become widespread in health care, particularly as a method to improve experiential learning environments.<sup>1-4</sup> Despite its broad uptake as an educational tool, existing models of patient-based simulation remain primarily instructor-driven. Few studies in the simulation literature have designed training that explicitly supports trainees' role in self-regulating their own learning experiences. Simulation-based learning stands to benefit from embracing an approach that makes explicit the "shared responsibility between the trainee and the instructional designer."<sup>5</sup> In preparing a simulation session using SPs, educators usually begin by setting clear objectives that provide guidance to achieve the desired learning outcomes.<sup>4</sup> Objectives are in turn identified based on national guidelines (such as those from the ACGME<sup>6</sup> or specialty societies), or through needs assessments of the learners or the curricular content. To engage with the challenges that learners encounter in their personal clinical practice, Schweller et al<sup>7</sup> described a model of simulation "turned upside down." In their approach, residents brought their challenging clinical situations to a simulation session, in which the educator (i.e., a senior supervisor), now "in the shoes" of the resident, played out the scenario with an SP. Critically, it was the learners who identified and wrote, together with professional actors, the clinical situations with which they struggled, and later articulated the learning gaps and established objectives. Through this approach, learners could see, in a controlled simulation setting, how their senior supervisors would deal with similar challenges in practice. Moreover, learners' self-directed learning<sup>8-10</sup> could be enhanced by incorporating their clinically relevant situations into simulated scenarios.

### **The co-constructive patient simulation model**

Seeing the potential that such an "upside down" approach could have on simulation with SPs, we replicated, expanded, and refined the work by Schweller et al<sup>7,11,12</sup> into a co-constructive patient simulation (CCPS) model. In the context of customization to a learner's specific needs, CCPS builds on the "training on the job" and "dramatic role playing" approaches, respectively, used to enhance communication and emotional awareness skills in patient simulation, as described by Rethans et al.<sup>13</sup> CCPS provides an opportunity for participants to collectively practice the six principles of active learning described by Brookfield<sup>14</sup> as essential for a teaching-learning transaction to be successful: voluntary participation, respect among learners, collaboration, praxis, reflection, and nurturance of a self-directed, empowered adult. The CCPS model also uses best practices from a flipped classroom approach,<sup>15-17</sup> in which the time shared

with learners is used to maximize practical application, discussion, and interaction, while offloading traditional content delivery into time allotted for case preparation. We developed the CCPS model informed by two main theoretical frameworks. First, self-regulated learning allows learners to have agency on their personal learning trajectories.<sup>18,19</sup> Second, critical pedagogy focuses on establishing a democratic and nonhierarchical learning environment that invites reflection toward action on real-world problems extracted from the learners' context.<sup>20,21</sup>

In the CCPS model, a designated learner (hereafter the "clinician") creates a case script based on a challenging clinical encounter faced during training or clinical practice, and this is used by an SP in a similar clinical setting.<sup>7,22,23</sup> A supervisor with experience in the CCPS model is involved in creating, editing, and practicing role play of the simulated case. During the preparation of the case, the learning goals are jointly elaborated and refined by the triad of clinician, supervisor, and actor. Case preparation includes a rehearsal, during which the SP can optimize the accuracy of their portrayal, and the clinician has an opportunity to replay and further reflect on the challenging scenario. In this context, the clinician, the supervisor, and the SP are collaborators, in that only the 3 of them know the specific details of the case. Next, a fellow learner (a peer or blinded supervisor, the "interviewer") is provided a "door note" with brief background information of the case, before interviewing the SP. The clinical encounter is followed by a group debriefing session involving all learners: beginning with the clinicians' experiences, followed by the accounts by the interviewer and peer learners, and ending with the de-rolled SP. The model can be divided into six distinct phases, as depicted in **Figure 1**.

**Figure 1. Co-constructive patient simulation model**

Co-constructive patient simulation phases: I. *Clinical encounter* between clinician (CL) and patient (PT); II. *Reflection*. CL reflects on the index encounter(s) and starts developing a script; III. *Scriptwriting*. CL finalizes the script, working in close collaboration with a standardized patient (SP) and a supervisor (S); IV. *Simulated encounter*. The first peer ( $P_1$ ) interviews the SP-in-role ( $SP_{IR}$ ), while other peers ( $P_{2-n}$ ) and supervisors (depicted wearing glasses) witness the encounter; V. *Blinded simulated encounter*. In a variation of phase IV, the interviewer is a different supervisor, not involved in phase III, and as such, blind to the clinical script ( $S_{BL}$ ); and VI. *Debriefing*. All participants take part in a debriefing session moderated by S;  $P_1$  is invited to share first, and CL and SP (de-rolled) contribute last. *Note*: the rectangular enclosures represent the confidential consultation spaces in which clinical encounters take place.

## METHODS

### Participants and session planning

We piloted the CCPS model during 6 sessions conducted at one-month intervals between November 2019 and May 2020. Participants were physicians enrolled in the final year of their ACGME-accredited fellowship program in child and adolescent psychiatry (CAP) at the Yale School of Medicine's Child Study Center. In collaboration with the fellowship program's training director, the project was designed to provide a formative educational opportunity. As such, it was intended to consolidate and refine advanced communication, diagnostic, and psychotherapeutic skills gained during postgraduate training in psychiatry residency and CAP fellowship.

We conducted a preparatory session two months before the first CCPS. In it, reacquainted fellows to work with SPs (including through an interactive experience with an SP) and reviewed in detail the goals, specifics details, logistics, and expectations for the project, including: (a) guidelines for establishing learning objectives<sup>24</sup> and writing scripts<sup>25</sup> for SP case preparation; and (b) guidelines for effective facilitation<sup>26</sup> and debriefing.<sup>27-30</sup> All fellows in the graduating class had the opportunity to participate during dedicated education time in the activity and to serve at least once in the different roles of clinician, interviewer, and debriefing group participant. As a capstone project designed to prepare the fellows' transition into independent practice, the CCPS sessions took place during the months leading to their graduation. This activity was provided as a complement to their existing educational training.

Each session required a mode of 6 hours toward completion: (1) an estimated two hours for case preparation and scriptwriting; (2) two hours for editing, case clarification, role play, and script finalization with the SP and supervisor; and (3) two hours for the simulation session itself. The time breakdown for the simulation session included: introduction (10 minutes); first interviewer (20 m); second interviewer, picking up seamlessly from where the first one left off (20 m); short break (5 m); debriefing (60 m); and evaluation (5 m). SPs were compensated at a standard institutional rate for their time in the latter two components. Faculty members participated as part of their supervisory and educational responsibilities and were not compensated separately. Several trainees needed more time than the allotted four hours for writing and editing.

### Outcomes and analysis

We asked all participants to evaluate the two components of each session: interviews and debriefing. For each of the two, we asked about perceptions on how challenging and how frustrating each component had been, using as anchors: "not at all," "a little," "just right," "a lot," and "way too much." We next asked for ratings on five categories for the overall experience: (1) conduciveness to learning and (2) self-reflection; (3) effectiveness at understanding another person's experience; (4) relevance and applicability to practice and training; and (5) realism in the SP's portrayal of the patient. For these five items we used as anchors: "not effective at all," "slightly effective,"



“moderately effective,” “very effective,” and “extremely effective.” Finally, we provided space for optional free-text comments from participants.

All participants completed evaluations through their preferred, WiFi-enabled personal devices during the last five minutes of each CCPS session. We collected information securely through Qualtrics (Provo, UT) and analyzed data using SPSS, Version 25 (Armonk, NY). We used the nonparametric Kruskal-Wallis test to compare ratings across sessions and between roles. Having found no differences ( $p > .05$  for all comparisons), we go on to present data descriptively as raw percentages. We did not conduct any other inferential statistics.

### **Ethics approval**

We obtained institutional review board approval from the Yale Human Investigations Committee (Protocol # 2000026241). We encouraged trainees to participate and informed them that their participation was neither mandatory nor pertinent to their fellowship performance evaluation. They were aware that sessions would be conducted as part of a research project and that all interviews and debriefing sessions would be audiotaped, transcribed, and deidentified toward a subsequent qualitative study. All participants consented to participate in the study.

## **RESULTS**

We invited all twelve graduating CAP fellows in the class of 2020 to participate, with eleven (92%) of them joining. Other participants included four supervisors and seven different SPs (one for each session, except for the final one, which involved two SPs for a father-son scenario). The supervisors included three individuals not previously known to the trainees: a physician with expertise in medical education and no formal training in psychiatry (MC), a child psychiatrist with experience working with SPs (DA), and an expert in narrative medicine (IW). The fourth, a child psychiatrist and medical educator well known to the fellows as their supervisor and associate training director (AM), served as blinded interviewer in two of the six sessions. Each of the six sessions had a median of 13 participants (range, 11 - 14); fellows attended a median of five sessions each (range, 3 - 6). Topics that are difficult to openly talk about proved especially appropriate for the CCPS model: without overt guidance or solicitation, the scripts developed by learners in this series involved medical errors and error disclosure; racial tensions, including implicit bias and overt racism; interprofessional conflict; transphobia; patient-on-provider violence; sexual health; and the sharing of vulnerability and personal imperfections in the clinical setting.

Upon completion, participants scored the sessions highly overall, with 94% of ratings in the “very effective” or “extremely effective” categories. There were no quantitative differences between sessions with or without a blinded supervisor participating as an interviewer. Free-text comments, like the select ones included in **Table 1**, provide a textured sense of the participants’ reception of the CCPS model. We organized feedback into five thematic areas: (1) regarding the sessions overall

(e.g., “how could we not have this in our training?”); (2) around peer interactions (e.g., “so great to see our colleagues deal with tough situations”); (3) by and about the professional actors (e.g., “most interesting experience I’ve had to date as an SP”); (4) opportunities for reflection (e.g., “one vital part of rehumanizing medical education”); and (5) critiques and recommendations (“could replicating the case with a faculty expert...reinforce content?”).

**Table 1. Participants' select free-text comments on co-constructive patient simulation sessions**

Theme	Participant	Session	Comment
<b>Overall</b>	P 1	6	A truly incredible learning experience and one of the most meaningful and wholehearted during my academic career. I believe this model has the potential to form one vital part of re-humanizing medical education.
	P 2	4	The debriefing session was safe and engaging, and the conversation was free and meaningful.
	P 3	3	I left thinking that this was such a fantastic experience, how could we <i>not</i> have this in our training?
<b>Peers</b>	P 4	1	It was so great to see how our colleagues deal with tough situations. That's not something we really ever get the chance to do.
	P 5	4	The best moment for me was when one of the interviewers forgot what time of day it was, because this was very human. It reminded me that we doctors are human, even if patients may experience us as special and incapable of making mistakes. Hopefully, in those moments, I can still join with the patient rather than beat myself up for not being perfect.
<b>Actors</b>	P 6	1	An actor can be only as good as the writing she is working off of. This actor was superb, and I suspect this had just as much to do with the actor as with the underlying hard work that went into the script. Thank you all!
	SP 1	3	This was an extremely illuminating experience for me as an actor. I found both interviewers to be deeply compassionate and thoughtful in their approaches. I wanted to be intentional about how I was able to best serve the character and backstory we co-wrote, while also allowing myself to be completely open and responsive to their energies and their words.
	SP 2	6	Thanks again for selecting me to portray one of the roles in this event. In total it was the most interesting experience I've had to date as an SP.
<b>Reflection</b>	SW 1	5	I have learned so much. From the actors, from my fellow learners, from being on both (all by now!) sides of the exercises, from the candor and depth and sincerity of everyone's contributions.
	P7	5	This simulation welcomed vulnerability on both sides, but also challenged me to be patient. These interactions bring me back to why I chose psychiatry. To be with the patient, meet them where they are, and as taught in Circle of Security, to serve as a possible base and haven for the patient. It reinforced the importance of body language and how the unspoken can be even louder than words.
<b>Critique</b>	P8	3	It would be interesting, if timing and programming allowed, to see one person do the full 40 minutes. Either way, a wonderful experience.
	P9	6	I loved the pairing of this lecture with the content lecture that followed. I wonder if recording a mini interview (<10 minutes) replicating the case but with a faculty expert addressing the subject could be incorporated into a reinforcing content lecture.
	P10	1	Even though this was presented as not being a "gotcha!" type scenario, it ended up feeling that way. The patient actor - granted with no psychiatric background, so we wouldn't expect him to know how our job works - came off as lecturing us briefly about how we didn't figure out his secret. Otherwise, a good learning experience. It was also great to see how our colleagues interview in tough situations. That's not something we really ever get the chance to do.

Abbreviations: P = peer; SP = standardized patient; SW = script writer.

## DISCUSSION

Co-constructive patient simulation is a new approach that redesigns traditional SP use in medical education, shifting the tasks of goal setting and scriptwriting from instructors to a responsibility shared with learners. We were able to implement this model in a series of six simulation sessions in the clinical field of CAP. Although our selection of CAP as a discipline was arbitrary and based on convenience sampling and our field of expertise, we were deliberate in our selection of learners. Specifically, we explicitly targeted as learners advanced trainees approaching graduation from fellowship and transition into “real-world” practice.<sup>8,10</sup> The scenarios that the learners developed were clinically, cognitively, and emotionally challenging, and based on situations they had faced and struggled with during their years in training. Of note, even fellows without a declared interest in medical education or academic writing were successful in creating evocative and realistic cases grounded in specific learning objectives. To that end, the availability of scripts from earlier sessions proved useful, with case writing and directions to actors becoming more standardized and consistently structured as time went on.

In keeping with self-regulated learning theory,<sup>20,21</sup> learners in the CCPS model had full discretion in the selection of their case(s), and of those issues they found clinically challenging in practice. Case preparation, interviewing, and debriefing sessions in which learners broke complex interactions into meaningful pieces helped deconstruct the source of what they found taxing<sup>31,32</sup> and place their struggles into a broader educational context of deliberate practice.<sup>33,34</sup>

Informed by the Brazilian educator Paulo Freire’s seminal work *Pedagogy of the Oppressed*,<sup>22,23</sup> critical pedagogy seeks to break common hierarchical divides between senior and junior, teacher and taught, or between supervisor and learner—providing instead a horizontal “two-way street” that fosters a virtuous cycle of mutual learning, curiosity, and growth.<sup>22,35</sup> By placing supervisors in the same “hot seat” as their trainees (a concept first introduced into psychodrama by Moreno and Perls),<sup>36</sup> CCPS engenders a horizontal disruption of traditionally vertical hierarchies and fixed educational roles that can hinder collaboration and community formation.

Framing our methodology as a co-constructive process integrates two additional theoretical strands in the literature. First co-constructivism, as defined in the teaching and pedagogy literature, speaks to the collaborative learning process of co-creating, negotiating, and maintaining meaning through self-reflection and dialogue in a classroom.<sup>37</sup> Second, narrative co-construction draws on narrative theory to describe the shared sense-making, structure, and story-building between, for instance, a psychotherapist and their patient<sup>38</sup> or between two spouses navigating the treatment course of an illness.<sup>39,40</sup> In the health and medical humanities, however, narrative co-construction primarily signifies the clinical encounter between physicians and their patients. Specifically, the physician’s task of close listening to a patient to coauthor their illness narrative and diagnosis to both center patient agency and remediate preexisting asymmetries of power and expertise.<sup>41,42</sup> With the exception of MacKenzie et al (2018),<sup>43</sup>

who advocates for the use of co-construction in simulation for occupational therapists, no research and instructional design in medical education has explored the potential to use narrative co-construction of a case study for patient simulation between a learner and an instructional design. Much like the clinical encounter, the learner's, and instructor's careful co-authoring of a case study, written as a composite of the learner's difficult experiences, humanizes the professional relationship, complicates power dynamics, and fosters an open mutuality of collaboration and learning.

Given the model's conduciveness to self-reflection and iterative skill-building, CCPS is particularly well suited to address, practice, and refine higher-order clinical skills with exacting emotional, affective, or cognitive demands. By providing a space that is emotionally supportive and educationally sound, by developing cases that "ring true" to the learners' experience, and by providing a setting in which learners can witness a "do-over" and debrief previously challenging or overwhelming experiences, CCPS can facilitate the refinement of critical skills and model collaborative inquiry. The input that the clinician receives in real time during the simulation—as well as in planning ahead toward it—offers a unique opportunity to reimagine the original predicament in new ways toward gaining knowledge, perspective, and mastery.

The CCPS approach provides an opportunity for deep experiential learning. For experts, the horizontal nature of this approach encourages a greater appreciation of the distinct struggles of their learners, which might otherwise remain undisclosed. Equally, learners can gain from a shared and self-directed educational activity in a way that traditional methods (such as observation across a one-way mirror, review of videotapes, traditional clinical supervision,<sup>38</sup> or paper-and-pencil examinations) cannot. The CCPS approach thus puts into practice core principles of self-regulated learning.

Critiques articulated by the learners in their free-text feedback included one interviewer feeling like the exercise was a "gotcha!" situation. This comment was provided after the first session and as such may reflect the learner becoming acquainted with a new model. However, this comment is worth pointing out, as we went on to clarify that for our sessions' purpose, the dual goals were as much about the process of interaction and engagement (in this case with an off-putting, minimizing, and challenging patient) as of conducting a specific psychiatric task (in this case, to assess the patient's safety and act accordingly). In a separate instance, during the debrief of the lead instructor's first experience in the "hot seat," he noted that he wished he had been given a more challenging case to model failure for the learners. However, one learner noted the advantages of witnessing the expertise of her supervisor, having never had a similar learning opportunity during her medical training. Being both explicit in our overall learning goals and open to reframing intended learning outcomes proved helpful in subsequent sessions and should be addressed early on by those considering adapting or replicate the CCPS model.

Even as we implemented this model using psychiatric scenarios, we recognize that the seminal work by Schweller et al<sup>7,11,12</sup> was first introduced to address specific challenges in internal medicine. Thus, we consider the CCPS approach to be discipline-

independent and believe that it can be meaningfully incorporated into any branch of medicine, nursing, or the health professions broadly defined. We view CCPS as a vital precursor and catalyst to the work of narrative co-construction in the clinical encounter, which lies at the core of the field of narrative medicine,<sup>44</sup> alongside field-wide attempts to support the well-being and professional development of trainees.

We recognize several limitations, as well as challenges ahead. First, this report does not include qualitative analyses of the planning, interview, and debriefing sessions; we will report these separately, as they are extensive and more narrowly relevant to psychiatric practice. Second, except for the sixth session, all our simulations involved a single actor. Because clinical situations often involve several interacting individuals, future adaptations of the model may explore these added layers of complexity. Third, none of our SPs were underage, a notable limitation when considering pediatric cases. Even as children can be played by young adult actors, we are exploring ways of incorporating child actors into future scenarios.<sup>45</sup> Equally, for cases that center on the use of instrumentation or devices, the model would need mixed simulations that integrate actors with medical equipment. Finally, recognizing that we developed sessions for trainees about to complete their fellowship, we do not mean to imply that the CCPS model could not be appropriate for more junior learners. Indeed, the opportunity to observe and imitate the behaviors and approaches of others and to learn to negotiate and construct meaning can prove critical in early stages of education.<sup>46</sup>

In summary, CCPS offers a novel approach to engage learners in a way that values the cultivation of their professional competencies alongside a compassionate reckoning with their challenges during medical training. The model seeks to right a balance, moving from the confined terms of teacher and taught to a practice of shared learning guided by the specific needs of the learners themselves, rather than the pedagogical assumptions of their instructors. The model provides, in a psychologically supportive environment, a real-world alternative to traditional supervision and training, and one that can adapt iteratively and in real time to emergent vicissitudes and challenges faced by clinicians. CCPS is a learner-centered approach to simulation that fosters lifelong, autonomous, meaningful, and relevant learning.

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