UNIVERSIDADE CATÓLICA PORTUGUESA

TRAINING COMMUNICATION IN UNDERGRADUATE MEDICAL EDUCATION

HOW TO TRAIN AND ENSURE THE QUALITY OF THE CONTRIBUTION OF SIMULATED PATIENTS?

Project submitted to Universidade Católica Portuguesa to obtain a master's degree in Communication Studies – Media and Entertainment

By

Rita Viegas e Costa Oom de Sousa

Faculty of Human Sciences

September 2024

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"The ways in which simulated patients may be used are limited only by the imagination"

(Dudley, 2019, p.4)

Abstract

The importance of communication training in medical education has become more evident in recent years. Through the introduction of human simulation, in specific the Simulated Patient (SP) Methodology, students are offered the opportunity to develop and practice essential clinical and communication skills with Simulated Patients, in a safe and protected environment. The contribution of Simulated Patients in medical education includes their participation in Simulated Patient Consultations (SPCs), where they have three main responsibilities: perform a role portrayal of the given scenario, assess the students while performing, and provide feedback at the end of the encounter, based on their experience as a patient. It is the Simulated Patient Educator's (SPE) job to elicit more authentic performances and guide the SPs on how to provide constructive feedback, a goal achieved through effective training methods and the implementation of continuous evaluation methods on the SP program. This master's project aims to help SPs feeling ready for SPCs by covering all three main areas: role portrayal, feedback, and self-reflection. It works as a complementary tool of the work of the SPE by highlighting key information to help SPs further prepare themselves, individually. The project follows a design thinking strategy and uses qualitative methods to implement a human-centred, creative and innovative solution for any organisation working with Simulated Patients: "The SP self-guide for SPCs".

Keywords:

Communication skills; Medical education; Simulated Patients; Role Portrayal; Feedback;

Resumo

A importância do treino da comunicação em educação médica tem se tornado cada vez mais evidente nos últimos anos. Com a introdução da simulação humana, especificamente a metodologia de doentes simulados, os alunos recebem a oportunidade de desenvolver e praticar competências clínicas e de comunicação fundamentais, através do uso de doentes simulados, num ambiente seguro e protegido. A contribuição de doentes simulados em educação médica inclui a sua participação em consultas simuladas, nas quais possuem três grandes responsabilidades: representar o papel de acordo com o cenário escolhido, avaliar os alunos durante a sua *performance*, e oferecer feedback no final da consulta, baseado na sua experiência enquanto doente. O trabalho do coordenador de doentes simulados consiste em promover actuações realistas e orientar os doentes simulados no fornecimento de um feedback construtivo. Este objetivo é conseguido através da utilização de métodos de treino eficazes e implementação de processos de avaliação contínua do desempenho. Este projeto de mestrado tem como finalidade ajudar os doentes simulados a sentirem-se preparados para as consultas simuladas cobrindo as três grandes áreas: representação, feedback, e auto-reflexão. O projeto surge como um complemento ao trabalho do coordenador, através do destaque de informação importante, de forma a ajudar os doentes simulados a prepararem-se também individualmente. O projeto segue uma estratégia de *design thinking* e utiliza métodos qualitativos para implementar uma solução centrada no utilizador, criativa e inovadora, para qualquer organização que trabalhe com doentes simulados: "The SP self-guide for SPCs" (o guia de doentes simulados para consultas simuladas).

Palavras-chave:

Comunicação; Educação médica; Doentes simulados; Representação; Feedback;

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TABLE OF CONTENTS

Table of Figures

Introduction

In recent years, there has been a significant shift in medical education. With increasing evidence proving that effective doctor-patient communication produces better health outcomes and higher levels of satisfaction for both doctors and patients (Deveugele et al., 2005), the introduction of communication training in medical schools has become a crucial item in the agenda (Case & Brauner, 2010). Students are now expected to be active learners and develop a range of both clinical and communication skills, simultaneously. To do so, some medical schools started to introduce the simulation methodology, which represents a change from lecture-based to practice-based teaching and assessment of clinical skills (Cohen-Tigor et al., 2020). This student-centred teaching method, known as problem-based learning (PBL) places human simulation - the Simulated Patient (SP) - as a core element to the new educational strategy (Cohen-Tigor et al., 2020).

The introduction of the SP Methodology revolutionised the way medicine is taught. It has arrived to challenge fundamental concepts and prior facts of medical education by providing students with a great opportunity to learn in a safe environment with the contribution of Simulated Patients: individuals who are trained to portray a real patient in order to simulate a set of symptoms or problems used for health care education, evaluation, research and feedback (Lioce, 2020). Using SPs in medical education has proven to be more effective than using any other didactic teaching method (Madan et al., 1998). Therefore, the main question of this research study is: how to train and ensure the quality of the contribution of simulated patients (in undergraduate medical education)?

It is the Simulated Patient Educator's (SPE) job to administer and train the SP program. In Simulated Patient Consultations (SPCs), SPs have three main responsibilities: to perform a role portrayal of the given scenario, assess the students while performing, and provide feedback at the end of the encounter (Gliva-McConvey et al., 2020a), based on their experience as a patient. It is not an easy task and can sometimes come across as an overwhelming activity. Consequently, this project emerges as a helping tool to solve that problem.

Regarding the work's structure, this research study presents an extensive literature review that, at first, explores the importance of communication in healthcare and explains how an effective doctor-patient communication produces better results (Deveugele et al., 2005). The introduction of simulation, in particular human simulation like the Simulated Patient (SP) methodology, arrived to help students acquire several essential communication skills (Ker et al., 2005). It represents a revolution in medicine because it brought many changes and converted the traditional learning process into a student-centred pedagogy. Students are no longer seen as passive learners and are invited to think, following the PBL ideology (Cohen-Tigor et al., 2020). Therefore, SPs are considered indispensable 'tools' in the education and training of healthcare professionals (Ker et al., 2005). Their performances are framed by the dramatic arts and can vary along a Human Simulation (HS) Continuum (Gliva-McConvey et al., 2020b; Lewis et al., 2017), depending on the level of standardization required. The second chapter considers the program's management and administration issues. For the SP methodology to work smoothly, it is essential to consider the number of staff available, the process of recruitment and selection of SPs, how to work with the databases and deal with costs and payments, how to develop consistent scenarios and take into account security concerns, but also how to develop a joint SP philosophy (Adamo, 2003; Ker et al., 2005; Nestel et al., 2015c; Tierney et al., 2015). Most importantly, it is essential that the SPE develops effective training processes and quality assurance frameworks for the SPs. As such, the last three chapters of the literature review provide an overview on how different authors idealise the training process for SPs to perform realistic role portrayals, to offer constructive feedback, but also the quality assurance methods to ensure reliable results.

Chapter six explains the methodology adopted to elaborate the project. Following a design thinking strategy, a human-centred approach to problem solving (Brown, 2019), this project uses qualitative research methods that include review of the literature, document analysis, and participatory observation, aligned with three years of professional experience in the field, towards its completion. Furthermore, chapter seven unfolds the ideation and completion of the project, unravelling the context behind its creation, how the content is organised, the design choices made, illustrated by some images of the creative process,

ending with a reflection of its implementation and evaluation in a real world setting: Católica's Medical School.

Literature Review

1. Communication in Healthcare and the Simulated Patient Methodology

1.1 Importance of Communication in Healthcare

Over the past years, there has been increasingly more evidence that effective doctor-patient communication produced "better health outcomes, better compliance and higher satisfaction of both doctor and patient" (Deveugele et al., 2005, p.265). The relationship between healthcare providers and patients has become more of a partnership and, as such, the introduction of teaching communication skills in the field of medicine has become a major focus in recent years (Johnson, 2015). Nowadays, "teaching students and physicians how to interact with patients in a compassionate and empathetic manner while still attending to the more factual and scientific aspects of this communication is a crucial agenda item for both undergraduate and postgraduate medical curricula" (Case & Brauner, 2010, p.159). Students tend to learn communication skills and procedural skills as two separate things. Combining them is not a straightforward process for learners and, as such, it is important to provide opportunities within the medical curriculum for students to practice this combination in a safe environment, with the use of Simulated Patients, before they encounter real patients (Cleland et al., 2009).

Patient-centred care is focused on the patient's ideas, concerns and emotions (Deveugele et al., 2005) and to do so, doctors need to develop a diverse range of skills, which include active listening, the use of open-ended questions, provide summaries and check the patient's understanding with clear and concise explanations (Simpson et al., 1991). By showing empathy, emotional support, partnership building and friendliness, doctors are half-way to find a common ground of adherence to treatments and patient satisfaction (Deveugele et al., 2005). Since the early 1990s, in the Toronto Consensus meeting, reports had stated that "sufficient data have now accumulated to prove that problems in doctor-patient communication are extremely common and adversely affect patient management" (Simpson et al., 1991, p. 1387). These problems are often related to uncertainty and lack of information/feedback/explanation from the doctor, which results in overall patient dissatisfaction and anxiety (Simpson et al., 1991). They concluded there was a "clear and

urgent need for teaching of these clinical skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education" (Simpson et al., 1991, p. 1387).

The implementation of communication training in medical schools started by addressing generic skills first and then by exploring specific topics like "breaking bad news, genetic counselling, handling psychological problems or stop-smoking advice" (Deveugele et al., 2005, p.266). Students can no longer be seen as passive receptors of knowledge. Instead, they are invited to think (Diaz-Navarro et al., 2024), to talk about problems, to acknowledge their own feelings and emotions, to be respectful, to develop their own solving strategies and, therefore, to become problem solvers (Deveugele et al., 2005). In short, "communication within the medical education is seen as a core skill equally necessary to clinical skills like measuring blood pressure" (Deveugele et al., 2005, p.268).

1.2 Importance of Simulation in Healthcare

The introduction of simulation revolutionised the way in which medicine is taught (Bleakley & Bligh, 2008) (Cohen-Tigor et al., 2020). It represents a medical education shift from lecture-based to practice-based teaching and assessment of clinical skills, a departure from the traditional, known and comfortable (Cohen-Tigor et al., 2020). But what is simulation? The medical doctor Gaba (2007, p.126) explains that "Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion". Learners interact and immerse in these settings, admittedly fictional, as if they were in the real world (Gaba, 2007). Human simulation, more specifically, allows learners to apply their skills in real time and practice with real people in a safe (Sanko et al., 2013), yet realistic and learner centred environment (Ker et al., 2005) as well as having direct personalised feedback on their performance (Cohen-Tigor et al., 2020). This revolution in healthcare education, with simulation as the key factor, seeks to implement a model augmented for safety, quality and efficiency (Gaba, 2007). In short, "the major role of simulation has been, and will continue to be, to educate, train, and provide rehearsal for those actually preparing for or working in the delivery of healthcare" (Gaba, 2007, p.128). Essentially, healthcare simulation exists to serve a greater

purpose: “to elevate the performance of healthcare providers, teams and systems, ultimately leading to improved health outcomes for patients, communities and societies” (Diaz-Navarro et al., 2024, p.5).

Overall, the introduction of simulation brought 5 main “shifts” to fundamental concepts and prior facts of medical education (Cohen-Tigor et al., 2020). First of all, in a profession where there is no tolerance for error due to the devastating consequences that it may cause, simulation allows learners to make mistakes while at the same time ensuring that it causes no harm, providing a great opportunity for growth in a safe environment - a planned teachable moment (Cohen-Tigor et al., 2020; Higham & Baxendale, 2017; Howley & Martindale, 2004). Secondly, instead of having faculty members demonstrating learners how to do it “right”, peers are expected to practice and provide feedback as well (Cohen-Tigor et al., 2020). Leaners should observe peer’s performance, learn from others’ errors and achievements (Cohen-Tigor et al., 2020) while at the same time benefiting from trained Simulated Patients who provide constructive, reliable and valid feedback - one of the most effective means of solidifying skill acquisition (Fanning & Gaba, 2007). Thirdly, simulation emphasises the importance of self-reflection as part of acquiring life-long learning skills (Cohen-Tigor et al., 2020). Reflection not only builds self-awareness, a key element of Emotional Intelligence (EI), but it also has a positive impact on empathy, learning in complex situations, and participation in the learning process (Cohen-Tigor et al., 2020) (Johnson, 2015). In fact, the competency of communication that is brought by simulation falls under the umbrella of Emotional Intelligence. The skills associated with EI, which include “perceiving, understanding, using and managing emotions” (Johnson, 2015, p.183), constitute fundamental components of effective medical practice. As a result, EI is generating increasing interest in the healthcare field (Brannick et al., 2009; Johnson, 2015). At fourth, human simulation supports the teaching and evaluation of communication and interpersonal skills like active listening and empathy through effective feedback. At last, simulation has encouraged medical education to move towards participatory and experiential teaching methods. As represented by the Learning Pyramid (figure 1), different styles of teaching/ ways of obtaining information can produce different results. Even though the exact percentages of retaining information demonstrated in the learning pyramid have been refuted (Masters, 2013), it is the bigger picture that matters: when

learners are engaged with their mind and body in these interactive and dynamic teaching formats, the learning experience is more easily retained (Cohen-Tigor et al., 2020).

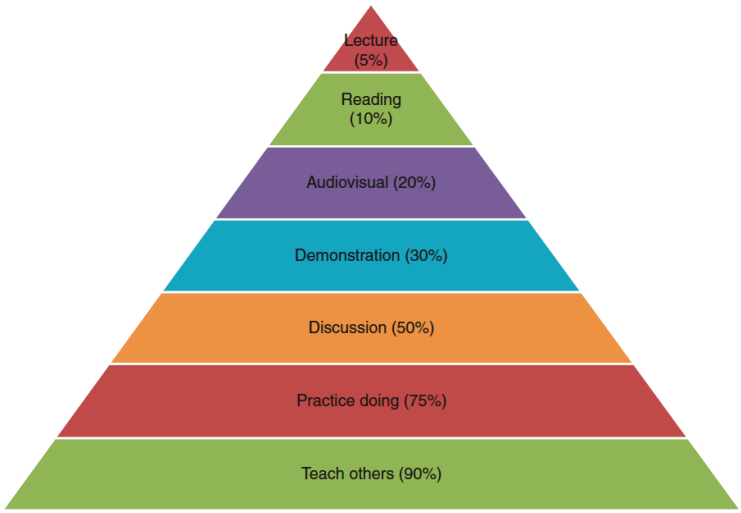


Fig.1 The Learning Pyramid (Cohen-Tigor et al., 2020)

This radical shift also brings a shift in power, role and meaning: "from the relationship between doctor (as teacher) and student (as learner) with patients playing a supporting role, to the relationship between patient (as educator) and student (as both learner and co-educator) with the doctor–educator playing a supportive role" (Bleakley & Bligh, 2008, p.95). As a result of these changes in healthcare education, concerns about reliability and validity in assessment, as well as ethical issues, started to arise in the 1960s (Cleland et al., 2009). As such, Barrows and Abrahmson (1964) proposed an alternative approach to the use of "real patients" in clinical skills learning by introducing the concept of "Simulated Patients" (SPs). According to the Healthcare Simulation Dictionary (Lioce, 2020, p.43), a Simulated Patient (SP) is "an individual who is trained to portray a real patient in order to simulate a set of symptoms or problems used for health care education, evaluation, research" and also feedback. They may be "young or old, fat or thin, tall or short, black, white or grey" (Dudley, 2019, p.3). They may have drama training and medical knowledge or none at all (Dudley, 2019). In Barrows' (1987) definition of an SP, he adds that "in performing the simulation, the SP presents the gestalt of the patient being simulated; not just the history, but the body language, the physical findings, and the emotional and

personality characteristics as well". In addition, some authors (Ker et al., 2005, p.4) highlight that SPs "are increasingly being used to develop, assess (Adamo, 2003) and research the clinical competence of health professionals (Collins & Harden, 1998).

The term SP educator (SPE) is "used to refer to those who work to develop expertise in SP methodology and are responsible for training and/or administering SP- based simulation. Some may be trainers who exclusively work with SPs, while some may be faculty or healthcare professionals who work with SPs as part of their clinical and/or academic roles" (Lewis et al., 2017, p.3). SP educators, also referred to as SP practitioners or trainers, have diverse backgrounds which include, but are not limited to, performing arts, education, clinical practice (especially nursing) and psychology (Nestel et al., 2015e). They usually have a leadership role within the SP program, as they are the ones responsible for educational management and administration, for working with clinicians on scenario development and high-stakes assessments, for working with SPs in recruitment, selection, training for role portrayal and for offering feedback, for working with students on SP-based sessions and also for working on research activities (Nestel et al., 2015e). Despite the complexity of this role, the SPE have no obvious formal career pathways.

Human simulation, especially SP methodology, "has been a continuous movement over the last three decades, leading to changes in the way we teach, evaluate, and ultimately practice the art of medicine" (Cohen-Tigor et al., 2020, p.20). Using SPs in medical education is very advantageous when compared to real patients (Cleland et al., 2009). Real patients may experience distress or embarrassment in a clinical encounter, may feel exposed to too many students, can demonstrate an unpredictable behaviour, may change their condition or physical signs over time, can be difficult to standardize and may even present great difficulty in adapting their medical histories (Collins & Harden, 1998). On the other hand, simulated patients are available when they are needed (Cleland et al., 2009). As described by Barrows (1993), SPs can learn how to simulate a wide range of physical findings. They are trained in various clinical scenarios which will ultimately provide students with a variety of experiences that they may not encounter with real patients. SPs play these scenarios as many times as required and their behaviour is predictable (Cleland et al., 2009). Also, a medical learner can practice skills that may be

inappropriate with real patients with terminal diagnosis, for example. Apart from proving this safe environment learning experience, SPs can also be trained to adapt their performance to the learners' level of experience and to give targeted feedback to them (Cleland et al., 2009). Consequently, some authors consider that using SPs in medical teaching, described as an interactive method, is more effective than using any other didactic teaching method for learning consultation skills (Madan et al., 1998). To put it in a nutshell, it is the difference between saying "I would educate the patient about the perils of soiling and facilitate them in slowing cessation vs. the actual words you would speak to this patient" (Adamo, 2003, p.265). The only main disadvantage of using SPs is the cost, as managing an SP program involves dedicated staff and having financial resources. If well trained, SPs are not usually detected from real patients, so that is not usually a disadvantage (Cleland et al., 2009).

1.3 Simulation and the Dramatic Arts

There are two prominent names when discussing the development of the human simulation methodology: Howard Barrows MD, known as the "father of Simulated Patients" and Paula Stillman MD, credited for expanding the role of Simulated Patients (Cohen-Tigor et al., 2020). The first, in the 1960s, pioneered a student-centred pedagogy called problem-based learning (PBL), a constructivist teaching method that seeks for life-long learning and that places the Simulated Patient as an integral element to the new educational strategy. The second, in the early 1970s, recruited mothers to simulate stories for her learners while providing feedback on their communication skills (Cohen-Tigor et al., 2020). In addition, Stillman created a comprehensive physical exam checklist and trained her first "patient instructor", individuals who had to teach and assess physical examination skills using their own bodies (Stillman et al., 1976).

The connection between western medicine and dramatic arts has existed since the time of the ancient Greeks (Wallace, 2007). Over the years, there have been increasingly more trainings of health professional learners that incorporate performance and dramatic arts theories and techniques (Smith et al., 2015a). In fact, there is much that is drawn from dramatic arts that informs SP practice: "SP methodology has adopted many terms from dramatic performance, such as actor, role, cast and script […]. SP performance elements

informed by the dramatic arts include creating character, enacting the narrative and relating to the audience" (Smith et al., 2015a, p.39).

Performance is a key component of the human simulation methodology that translates into SP encounters, described as being 'the most recognisable and productive use of performance in medical education' (Case & Brauner, 2010, p.160). However, the relationship between SPs and actor performances is complicated. On one hand, there are similarities:

> "SPs are often referred to as *actors*. *Cast* in a *role* written as a *script* or scenario containing *lines of dialogue*, *stage directions*, *intentions* and *objectives*, SPs are then *directed* or *coached* at *rehearsals* and *dry runs* where they are expected to be *off-book* in preparation for a performance with an *audience*, sometimes on a *stage* that has a *set* and *props*" (Smith et al., 2015a, p.40).

On the other hand, SPs and actor performances are distinctive genres with different purposes that in turn affect both the form and style of the technique. The purpose of an SPs performance is always the learner, because SPs are 'patients' as teachers, while actors are in service of the playwright, the director, and the producer (Smith et al., 2015a).

Nevertheless, effective SPs performances must be authentic, both in terms of clinical details and the human experience represented (Wallace, 2007), and rooted in the concept of realism, defined by the Oxford Dictionary as "close resemblance to what is real; fidelity of representation, rendering the precise details of the real thing or scene" (Smith et al., 2015a, p.40). In terms of character, SPs are trained to portray a role that makes students believe they are dealing with a real patient. For training sessions, as well as student encounters, having a bank of materials and props is extremely useful. Items like walking sticks, inhalers, wigs, dresses, bottles of tablets contribute to the authenticity of the scenarios (Ker et al., 2005). If learners believe they are in a real encounter, they become fully engaged and immersed, ensuring the realisation of the experiential learning process (Sanko et al., 2013). When the SPs transition from role-play to feedback phase, "the fourth wall breaks in a Brechtian manner as the SP directly addresses the audience" (Smith et al., 2015a, p.43), another reference from the dramatic arts.

Some authors (Sanko et al., 2013, p.215) claim that "theatre and acting methodology can provide simulation educators with a framework from which to establish an acting convention specific to the discipline of healthcare simulation". The SPE and SPs use of theatre and performance-based pedagogy in training healthcare learners has become an excellent resource for facilitating communication skills training sessions (Clark et al., 2020). The fact that both SPE and SPs may have an acting background becomes beneficial to SP programs in many aspects, like knowing how to safely portray and come out of emotionally or physically demanding roles and knowing how to improvise naturally (Clark et al., 2020). Many SPEs have been using the work of Stanislavski, Russian theatre practitioner considered the first modern acting teacher, to help SPs create believable patients (Wallace, 2007). In short, Stanislavski (Stanislavski & Robbins, 1956) provides guidance on how to portray characters authentically by exploring the given circumstances, the sub-textual information, the non-verbal behaviours, the physicality and body in order to find 'truth on stage'. The narrative is divided into major and minor units, objectives, and actions that are identified using an active, infinitive and transitive verb (Smith et al., 2015a). Regarding the narrative, even though SPs work from a semi-scripted scenario, they have to decide when and how to deliver the information, taking into consideration that learners often have different approaches (Smith et al., 2015a) and unpredictable needs.

Theatre-based exercises are creative ways to train SPs. Principles of improvisational theatre can provide guidance for SPs during these times of uncertainty and ambiguity, when they need to "create within the moment" (Sanko et al., 2013, p.216). Improvisation, as a theatre training technique and practice, is when actors need to engage in unscripted performances. In medical education, improvisation "is an active learning method that uses participatory group and paired theatrical exercises to support health care learners in building clinical communication skills such as listening, teamwork, building relationships, sharing information, emotion handling, and professionalism" (Clark et al., 2020, p.142). Health care providers need to be flexible, communicate clearly with patients, collaborate with teams and demonstrate willingness to participate in spontaneous activities even when the results are unknown, just as like when they participate in improv activities (Lehner, 1975). Being trained in the art of improvisation offers SPs a valuable skill set that helps

them to find and create different characters but also to interact and react to learners, according to their variable and unpredictable needs (Sanko et al., 2013).

Further examples of theatre-based experiences for SP training are the concept of emotional memory, the concept of sense memory, and the concept of empathetic imagination. The concept of emotional memory evolved from the work of the famous Russian actor and theatre director Konstantin Stanislavski, which invites SPs to draw on their own memories to create memories for the character they are portraying, even when it is something they may have never experienced before (Clark et al., 2020). Stanislavski also developed the concept of sense memory, a technique that focuses on creating memories for the body (like physical examination), as opposed to the previous concept of emotional memory that deals with creating memories for the heart and mind (Clark et al., 2020). The last example is a theatrical performance technique that facilitates character authenticity by the use of empathetic imagination: "a cognitive skill set that helps one to imagine the experience and responses of another person" (Sanko et al., 2013, p.217). There are plenty of other theatre-based exercises that the SPE can use in his/her trainings, like the "Mirrors" game. This exercise is extremely helpful to standardize both emotional and physical portrayal with SPs. It fosters eye-contact, promotes non-verbal communication, connection, and relationship building (Clark et al., 2020)[1]. In sum, "consciously applied strategies based on established dramatic arts theories and practices, to embody realistic characters, confidently enact the narrative with learners and relate to their audience, help SPs strengthen the integrity of the process and increase their potential to engage learners in mindful, sincere encounters" (Smith et al., 2015a, p.44).

1.4 Simulation for Training Communication - the SP Methodology

Patient participation arose with the introduction of early clinical practice in the undergraduate medical curriculum (Cleland et al., 2009). Nowadays, simulated patients are seen as indispensable 'tools' in the education and training of healthcare professionals, as they contribute for the development of specific skills, which include communication skills, consultation skills (history taking and physical examination) diagnostic skills and

[1] For further analysis, there are two books to consider: Boal's Games for actors and non-actors and Spolin's Theatre games for the classroom: A teacher's handbook.

professional skills (Ker et al., 2005). According to some studies (Cleland et al., 2009), even though patient participation is seen by teachers as an essential part of learning medicine and an enjoyable process for both the medical students and the SPs, it is not an easy task. Treating and taking safe care of complex patients requires high levels of proficiency skills, both technical and non-technical (Higham & Baxendale, 2017). Non-technical skills include communication, leadership, prioritisation, decision-making and task management, which can be achieved through simulation-based methods (Higham & Baxendale, 2017). There are 6 phases commonly found in simulation-based activities, which are essential to create effective educational experiences: preparation, briefing, simulation activity, debriefing and feedback, reflection, and evaluation (Nestel et al., 2015a). The first phase, preparation, deals with SPs recruitment and training, database management, setting learning objectives and designing scenarios. The second one, the briefing phase, refers to the explanation of the simulation process to all participants, including the scenario context, the learning objectives, and the approach to debriefing (Nestel et al., 2015a). After that, there is the simulation activity, the moment where the learner interacts with the Simulated Patient. Straight after, it is when debriefing and feedback happen by checking the learner's feelings, revisiting objectives, pursuing other perspectives and planning future learning goals (Nestel et al., 2015a). The next phase is reflection, a time when learners are encouraged to individually make sense of the simulation activity according to their own experience. Faculty and SPs are also invited to reflect on their own contributions. Finally, it is the evaluation phase, a time when learners, faculty and SPs measure the success and limitations of the session in meeting its goals (Nestel et al., 2015a). Specifically to the SP methodology, there is an additional phase called Debriefing the SP, a time to assist them to step out of their role, get a sense of their performance and establish goals for the next encounter (Nestel et al., 2015a).

Focusing on the simulation activity phase, there are various types of human simulation applications that depend on the context of the activity and the degree of standardization of SPs (Lewis et al., 2017) (Gliva-McConvey et al., 2020b). Therefore, experienced SPEs are constantly adapting these broad applications according to the objectives they serve, by partnering with SPs along a continuum (Lewis et al., 2017) (Gliva-McConvey et al., 2020b). The Human Simulation Continuum Model (HS) (fig.2) represents a working guide

that facilitates the SPE in meeting curricular objectives by coaching and training SPs accordingly. The HS continuum model incorporates human simulation that varies from low standardization like the Role Player, to high standardization, like the Standardized Patient for High Stakes Assessments (Gliva-McConvey et al., 2020b). “The terms simulated and standardized patient are sometimes used interchangeably but this is misleading” (Cleland et al., 2009, p.479). Perhaps, a better description of a standardized patient could be a standardized SP (Cleland et al., 2009), as it will be further discussed. Nevertheless, it is important to note that in Asia and Europe it is common to refer to an SP as “simulated”, as opposed to the US, where SPs are generally categorised as “standardized” patients (Cleland et al., 2009).

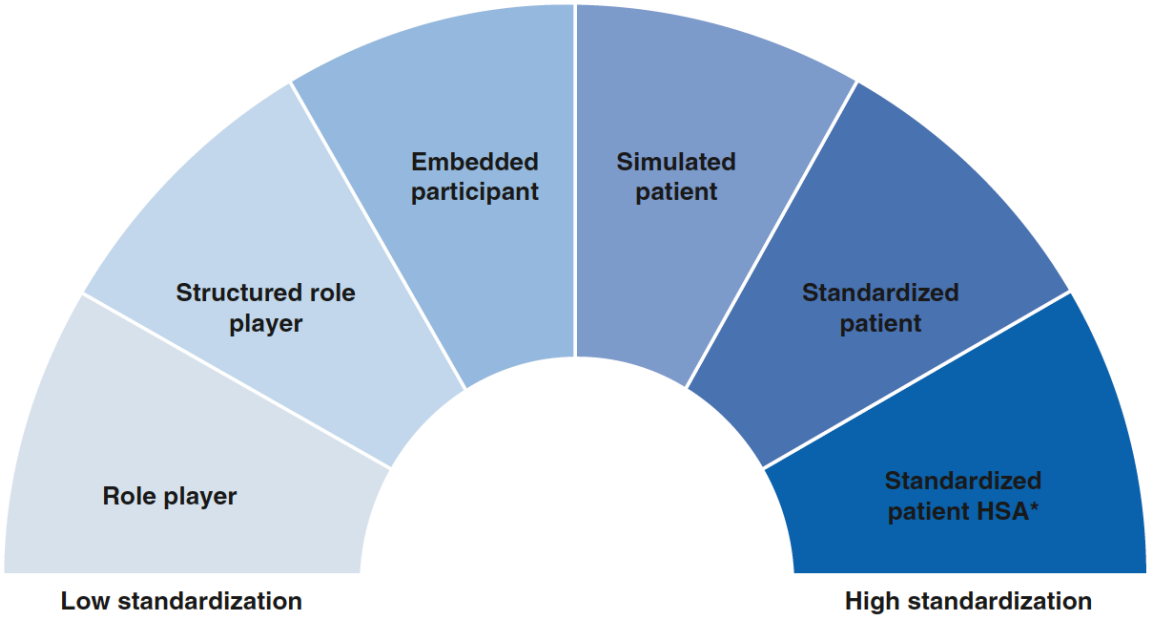


Fig. 2 Human Simulation Continuum Model (Gliva-McConvey et al., 2020b)

Starting off by the Role Player, it is the application of human simulation that has the least “structure”. The SPE provides broad guidelines but has little to no control of the SP’s performance, as the interpretation of the role is left to the Role Player’s imagination (Gliva-McConvey et al., 2020b). The Structured Role Player is where improvisation meets structure. The SPs need to be familiar with some scenario details but can still interpret the rest of the role from their own personal perspective (Gliva-McConvey et al., 2020b). Moving along the continuum, there is the Embedded Participant, an individual who is

trained to play a role in a simulation encounter in order to guide the scenario, which could be either positive or negative and used as a distractor (Gliva-McConvey et al., 2020b). Moving a little forward, there is the Simulated Patient: "a person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician" (Barrows, 1971, p.4, as cited in Gliva-McConvey et al., 2020b). These individuals are presented with increased detail and calibration of role portrayal and need to have some degree of reproducibility and repeatability, while at the same time offer flexibility in response to learners (Lewis et al., 2017). In contrast to the Simulated Patient, the Standardized Patient is an individual who is "trained to portray a patient with a specific condition in a realistic, standardized and repeatable way" (Lioce, 2020, p.49). Bokken (2009) used "consistency" as a defining factor in the standardized patient application with an emphasis on assessment (whether it is formative or summative). In other words, "a standardized patient encounter is a simulated patient encounter, but a simulated patient encounter is not necessarily standardized" (Adamo, 2003, p.262). At last, the Standardized Patient: High Stakes Assessment represents 'patients' that are extremely structured for repeated reproducibility and consistency, as well as reactions and responses highly scripted which do not allow for variance in portrayal to the examinee. For those, the SPE needs to provide intense training over many hours and perhaps multiple days (Gliva-McConvey et al., 2020b).

The successful use of the HS continuum model lies in the way it is applied, a careful process that depends on both internal and external factors. The SPE needs to respond to external factors and pressures like the subject matter experts' (SME) expectations, curricular requirements and resource availability, as well as internal factors like calibration of behaviours and level of standardization according to each activity and learning goals (Gliva-McConvey et al., 2020b). As such, when recruiting SPs for a general SP program, the SPE is looking for multiple skills and qualities (Gliva-McConvey et al., 2020b). as part of a "strategic selection" (Wallace, 2007, p.9) of the best suited SPs, which will be further discussed on the next chapter. SPE's decision-making process is facilitated by adopting this strategic approach and it helps different SPEs working collectively to establish a common language and practice in the broad field of SP Methodology (Gliva-McConvey et al., 2020b).

2. Program Management

From a management perspective, the administrative aspects of developing and maintaining a SP program include the SP program staffing, transparent and appropriate recruitment and selection of SPs along with a clever choice and maintenance of databases, effective training processes and quality assurance frameworks based on good communication, dealing with costs, payments and funding models (Tierney et al., 2015), developing scenarios/cases (Nestel et al., 2015c) and security concerns (Adamo, 2003). The development of a joint SP philosophy is also important to consider, in order to bring cohesiveness to the program (Ker et al., 2005). After all, "SPs are an important part of the educational team and commitment to supporting the SPs will enhance the team as a whole" (Tierney et al., 2015, p.93).

2.1 SP Program Staffing

In medical schools, "staffing plans are challenged by the need for multiple individuals to operate a successful educational program or event" (Adamo, 2003, p.266). The first step to develop and maintain a simulated patient bank is to locate staff who can dedicate time to do it (Ker et al., 2005). Most programs require two individuals: a coordinator and a trainer. It is expected from the coordinator to deal with recruitment policies, to develop and maintain the SPs' database, to take care of their welfare during activities, as well as travel and incident expenses and hospitality. For the trainer (educator or specialist) (Adamo, 2003), his/her responsibilities include assessment of training requirements and training itself, development of the training program, evaluation of the SP program, and also development of clinical scenarios (Ker et al., 2005). In some institutions, the SP educator (SPE) is recognised as medical school faculty (Adamo, 2003). In addition, staffing considerations should also cover administrative support, an event operations' manager, a camera operator along with a video technician, a timer, and hall monitors to secure and ensure the quality of an event that is being videotaped, if necessary (Adamo, 2003).

In addition, educating SP trainers and facilitators is also a major issue and labor intensive (Adamo, 2003; Tierney et al., 2015). New SP programs must develop their own SP educator and there are some resources available from other institutions to help with that,

like the 3 day course “Advanced Simulated Patient Course” from the University of Maastricht School of Health Professions Education (SHE), which occurs every two years. The course covers SP training techniques, selecting and building a case, checklist frameworks, training SPs in portrayal, feedback, and assessment tool completion, as well as quality assurance for them all (Aiello et al., 2020).

2.2 Recruitment and Selection of SPs

SP recruitment and training are the key elements to ensure a successful educational programming. (Adamo, 2003). Regarding recruitment and selection of SPs, there are, in general, two main options: recruiting SPs from the community or accessing trained actors (Tierney et al., 2015). As a starting point, it is important to consider the demographics of the SP roles. Targeting specific groups - gender, age, ethnicity - may be helpful. These selection processes are necessary because having a broad range of SPs available increases the program’s capacity to perform the different scenarios, by ensuring that the SPs hired are credible with respect to gender, age, weight, and so on (Cleland et al., 2009). Other characteristics to assess when recruiting SPs include languages, body habits, particular findings on physical examination (scars, stretch marks, physical functionality, etc.), level of education, level of literacy, agenda availability and flexibility (Adamo, 2003). Consequently, when planning recruitment, the SPE must be clear on the desired SPs qualities so that he/she can advertise it clearly. For instance, in complex roles that require highly emotional portrayals, the need for acting skills may be higher compared to less challenging roles. Acting skills are beneficial if SPs need to play multiple roles, to step into and out of role quickly and if the SPE changes aspects of the scenario (Tierney et al., 2015). Another aspect to be considered during the recruitment phase is SPs motivation because sessions should be an opportunity to focus on positive healthcare experiences and not the opposite (Tierney et al., 2015).

In addition, the SPE should also be looking for other skills and qualities: comfort with role play and improvisation, emotional and affective endurance, good memory, and comfort with physical examination (Gliva-McConvey et al., 2020b). Many expert SPEs talk about “strategic selection” (Wallace, 2007, p.9) of the best suited SP, especially because it helps cut down on training “primary because you will not have to spend a disproportionate

amount of time monitoring and assessing the SP to maintain the high standards you expect". In short, selection processes depend on many factors and the SPE should always consider the program's requirements when selecting (Tierney et al., 2015). Once recruited, SPs must be selected, as not all applicants will be suitable. An organised and well-maintained database is very helpful to manage and effectively meet all program's requirements (Tierney et al., 2015).

According to Cleland et al., (2009), the key elements when deciding who can be an SP are ability, suitability, credibility and consciousness. Ability refers to the capacity of SPs to memorise their roles, maintain focus when roleplaying and sticking to the scenario and their character, both in terms of medical and emotional facts provided. They have the dual task of performing a role and at the same time observe the students' performance, by remembering their verbal and non-verbal behaviours. Some SPs, usually professional actors, are also expected to have the ability to perform emotionally complex and demanding roles. Finally, SPs ability to portray a role is just as important as the ability to work as a member of the SP team (Cleland et al., 2009). In terms of suitability, SPs should demonstrate a positive attitude and clarify why each one of them wishes to be part of the team (Cleland et al., 2009). As highlighted by Ker et al., (2005), the SPE's priority is to protect the students and ensure their safety while trying to enlarge their educational experience supported by the SPs. Just as important as the previous factors, there is credibility. Simulated patients can be any age and any ethnicity but they should look and sound as much as the actual patients being portrayed (Cleland et al., 2009). In addition, being conscious about what it means to be an SP is fundamental. SPs need to know their responsibilities and commit to the training and teaching sessions. If SPs fail to attend any of these without notice is completely useless. Apart from that, he/she will have to be substituted probably by an untrained member of staff, leading inevitably to a loss of credibility and reliability. To avoid these circumstances, the SPE should consider having a "reserved" SP, particularly for assessments, in case anything goes as unexpected (Cleland et al., 2009).

Once an SP bank is established, further recruitment can be sufficient via word of mouth or accessing local contacts. Recruiting from the general public via advertised posters,

brochures, or websites is also an option. Nevertheless, screening applicants before introducing them to the SP program is extremely necessary and should be done sympathetically (Ker et al., 2005). It is extremely important to determine why an SP wishes to join the bank, in a way that will ultimately protect student's safety, while at the same time trying to maximise their clinical experience, being both the program's top priority (Ker et al., 2005). Some authors (Cleland et al., 2009) suggest four steps when engaging a new SP. SPE's should start by conducting a screening interview guided by core questions like the reason why such individual wishes to become an SP. Secondly, the interviewer should provide the candidate with information regarding the program and how it works during SP trainings and student encounters. Thirdly, it is important to reach a mutual agreement based on the program's educational goals. Finally, a trial period is essential so that the new candidate can understand if he/she enjoys to be an SP and the SPE can assess their suitability for the program, having the opportunity to disengage their services if necessary (Cleland et al., 2009; Ker et al., 2005).

2.3 Choice and Maintenance of Databases

An effective and efficient way of coordinating an SP program is to develop and carefully maintain a simulated patient bank (Ker et al., 2005). It enables tracking and training to be organised in a way that benefits patients, learners and faculty. For the SPs, apart from helping in identifying the most suitable for specific training requirements, it monitors their participation and avoids over utilisation but also underutilisation. For the learners, having a bank of SPs ensures that they can all be efficiently trained within the time constraints of the curricular program. For the faculty, a bank of SPs provides flexibility as it maximises not only their use of SPs but also their use of other resources (Ker et al., 2005).

Once SPs are fully engaged in the program, there are important considerations in order to use them effectively, which can be facilitated by the correct use of databases. One requirement is to use SPs frequently and not just occasionally, as it helps to maintain their interest, skills and motivation at high standards (Cleland et al., 2009). However, it is important to closely monitor each SP to avoid having them assume the role of a teacher, as they become more familiar with clinical skills, and to speak from that voice (Adamo, 2003). Another way to ensure motivation is to pay SPs but it should either be an

appropriate payment or their participation needs to be totally recognised as volunteering work (Cleland et al., 2009). Furthermore, in volunteer SP programs, the social interaction among the team is very important as it also contributes to maintaining interest and commitment on high levels. Another crucial consideration is to recognise SP's work and effort. This can be achieved by sharing results and feedback of their contribution and added value to the educational program, from both educators and students (Cleland et al., 2009).

Having a unified relational database that allows users to search by complaint, event, level of examinee, date, among other things, is very helpful. In addition, it will also reduce the need for extra personnel to deal with program and event administration in the future (Adamo, 2003). Some authors recommend the development of a profiling system that keeps a record of SPs expertise in each scenario, while offering the opportunity to meet SPs' individual requirements or wishes for a particular role (Ker et al., 2005). Different levels of competence and willingness to take on increasingly complex situations are also identified, as part of the profiling process. This means that each SP is able "to develop their own portfolio of interconnecting disease incidents", providing continuity in their illness profile and, therefore, enabling a more realistic and authentic learning environment for the student (Ker et al., 2005). As a matter of fact, "the more realistic the consultation experience with the simulated patients is, the more powerful the learning experience can be" (Ker et al., 2005, p.6).

2.4 Training, Quality and Communication

Regarding training and quality assurance frameworks, it is important that SPs are, as a starting point, fully briefed on the aims of the overall health professional training course and that they understand their involvement in the 'big picture' (Tierney et al., 2015). Generic training sessions of the overall program should emphasise the professional standards expected from the SPs, such as punctuality, commitment and effective communication with the program staff. It should also outline the SP's rights as an employee (Tierney et al., 2015). In general, "quality assurance of SP performance can be a problematic area and is sometimes neglected in SP programs" (Tierney et al., 2015, p.98). It is common that underperforming SPs are not only identified by informal feedback, but they are also dropped from the SP program without any kind of communication, meaning

that they are just not called again for another simulation encounter. Therefore, the SPE should always stress the importance of SPs receiving feedback from the students (Ker et al., 2005), a solution to avoid surprises and to demonstrate that SPs are part of a quality assurance process managed by the SPE (Tierney et al., 2015). Communication with the SPs is something that depends both on their needs and the program requirements and the SPE should establish if it is done by email, telephone and/or text messages (Tierney et al., 2015).

Another crucial aspect to take into consideration is time for de-roling. The SPE should be allocated specific time to de-role SPs and record their experience (Ker et al., 2005). The formalisation of this process enables the SPs to share their performance on complex simulated scenarios related to receiving bad news or any other psychiatric scenario, for instance. The SPE is expected to address any queries or difficulties experienced by the SPs (Ker et al., 2005). Further details on training processes and quality assurance frameworks will be provided in chapters 3-4 and 5, respectively.

2.5 Costs and Payments

Using SPs in a medical program requires training of skilled personnel and is labor intensive (Adamo, 2003). Defining SP costs remains a challenge but developing careful event planning and scheduling can considerably reduce costs (Adamo, 2003). So, it is fundamental to identify set-up and maintenance costs well in advance. These include the costs of running the bank as well as the costs associated to the training of SPs (Ker et al., 2005). Even though it all depends on the model of the program acquired, every model requires other costs too. It is important to consider annual staff costs that cover administration and training, bank coordinator costs that take into account the necessity of having an individual which demonstrates interpersonal, administrative and IT skills to manage the database and its developments, but also SP's potential travel costs and equipment expenses, like computers, printers and paper (Ker et al., 2005).

One of the most important decisions for any SP program is how much to pay SPs (Tierney et al., 2015). Payments and funding models will be influenced by institutional policies and other relevant employment laws, which can translate into payments by the hour/session at a

certain rate, which can also vary depending on the level of expertise of the assignment, or a fixed part-time salary. In any case, documentation, accounting and payment rates should be transparent to protect the SPs, the faculty and the program (Tierney et al., 2015). Some institutions pay different rates for highly emotional scenarios, psychiatric illness portrayals, physical examination assignments, and so on (Tierney et al., 2015). In some SP programs, SPs come as volunteers. Nevertheless, these SPs need to have the same comprehension of the entire program as paid SPs and should also participate in the same selection processes to ensure the program's quality. In terms of staff, each SP program can vary, being coordinated by one single person or having a large team (Tierney et al., 2015).

2.6 Scenarios/Cases

Another important element of the preparation phase of the SP program is the development of scenarios/cases, terms that are interchangeably used to describe the educational and clinical contexts that form the simulation encounter (Nestel et al., 2015c). The driver for the scenario may be an assessment requirement, a gap in provision of care, some patient safety concerns or it could just be part of the overall curriculum. In any case, one of the main goals of the SP methodology is to find ways to connect real patients with simulated patients. A scenario can be totally fictional or derive from several patient's experiences. In fact, the direct involvement of real patients in the process of scenario development is likely to result in truly patient-centred SP roles, with a more authentic representation of the patient's perspective. Without real patient involvement, SP-based work is "a mirror for the teachers' preconceptions rather than as an authentic reflection of a patient encounter" (Nestel & Kneebone, 2010, p.890). Unless there is involvement of real patients, one can not claim authenticity (Nestel & Kneebone, 2010).

There are some possible approaches in which real patients can contribute to scenario development: inviting them to attend SP training and teaching sessions, in which they observe and offer feedback about the case and the SP performance (Nestel & Kneebone, 2010); interviewing them, as a way to craft the scenarios based on their experiences, expectations and verbal descriptions (Nestel et al., 2008); inviting known patients to the faculty to participate in interview sessions at the medical school with the SPE (Nestel et al., 2015c). If real patients are willing to share their personal experiences by adding their

input in regards to real reason for the encounter, what is wrong, their concerns, their expectations from the doctor, their medical and social history, their attitude towards the health care service and their response to potential clinical processes, then the faculty can claim that their roles were efficiently created based on a real patient perspective (Nestel et al., 2008). Educators using simulation to support medical learning need to be clear to students about what they are simulating. The key is "to place the authentic patient voice at the centre of the learning experience" (Nestel & Kneebone, 2010, p.891). On the other hand, "involving real patients may be impractical to do for all scenarios, but it is a valuable process and goes some way to ensuring that SPs are proxies for real patients and not simply agents of the SP educator or clinician" (Nestel et al., 2015c).

Some useful practices to smooth the process of scenario development include: keeping the format simple by using a template; considering multiple perspectives (patients, learners, clinicians, specialists); keeping the language simple and appropriate for SPs rather than healthcare professionals; being concise by focusing on key information (Nestel et al., 2015c) and avoiding over-scripting, scripts that require line-by-line memorisation and can potentially affect SP's ability to respond to learner's questions, while appearing robotic and inflexible (Gliva-McConvey et al., 2020a).

2.7 Security

Security protocols should ensure that all materials are copyrighted and confidentiality agreements are signed by staff, faculty case writers (Furman et al., 2010) and students. Security concerns arise with the digital access to a video encounter file. Even with protected password access, there is a potential lack of control over the environment in which the simulated patient encounter is being visualised (Adamo, 2003). Taking into consideration that there are physical examination images and the fact that SPs can use their own real medical history, it is a factor that may contribute to reduce the size of the pool willing to become an SP (Adamo, 2003).

2.8 SP philosophy

At last, some authors recommend the development of a joint SP philosophy in order to bring cohesiveness to the program (Ker et al., 2005). This will minimise providing

conflicting information to students and will reinforce the identified skills they need to develop. Even though each scenario has particular clinical data that SPs incorporate in their role performance, they are also invited to create their own agenda in regards to the specific problem that brought them to the consultation. Consequently, through repeated practice, students will observe and learn that the same clinical case may present the same symptoms but the patient's concerns and reactions to it may vary (Ker et al., 2005). A common philosophy among all SPs will contribute to a more authentic environment in the consultation rooms (Ker et al., 2005).

In addition, developing a system of evaluation of the curricular program that involves the SPs can be extremely beneficial. Not only it provides students and teachers the patient's perspective of their performance, but it also leaves the SPs feeling they are involved and that they can contribute to the teaching program. This integration helps to maintain SPs interest in the program as well as showing them their value (Ker et al., 2005). Another successful way to keep their commitment and interest is to develop a system of reward and recognition, or even by just organising an annual dinner to celebrate and honour their contribution (Ker et al., 2005).

In short, "clear terms and agreement, governance and quality processes, coupled with ongoing training and development, will help maintain high standards and ensure that the SP program continues to meet the educational needs of the institution" (Tierney et al., 2015, p.101).

3. Training SPs for Role Portrayal

3.1 Logistics and Guidelines

During a simulation, SPs have three main responsibilities: perform a role portrayal of the given scenario, assess the students while performing, and provide feedback at the end of the encounter (Gliva-McConvey et al., 2020a). As highlighted by Stillman (1993, p. 466), it is evident that simulated patients "need to be very, very smart" as they need to demonstrate a range of sophisticated communication skills (Ker et al., 2005). During role portrayal, simulated patients are used to help students to develop their communication and consultation skills. (Cleland et al., 2009). Consultation skills include initiating the session, gathering information/history taking, giving out information to the patient related to diagnosis, test results, planning treatment, and closing the consultation (Kurtz et al., 2004). The aim of using SPs is to equip students with the necessary skills to deal not only with simple consultations but also with complex encounters, where they need to address and discuss topics like medical error (Halbach & Sullivan, 2005), sexual history (Haist et al., 2004) or even domestic violence (Haist et al., 2003), as if they were giving that information to real patients (Cleland et al., 2009).

This chapter focuses on training SPs for role portrayal, specifically. The nature of SPs role portrayal is complex (Smith et al., 2020a) and there are many approaches to training SPs (Nestel et al., 2015c). Unlike actors, SPs are part of an educational/assessment team, that is in service of the students, and need to achieve the learning objectives of each session. Yet, performance techniques derived from the dramatic arts and improvisation skills will certainly shape and strengthen SP training approaches (Wallace, 2007), as previously discussed. Just like actors, SPs need to live truthfully under imaginary circumstances, so that their performances of a simulated clinical encounter are somehow spontaneous and genuine (Wallace, 2007). These acting approaches influence SP work, which is commonly described in terms of authenticity (Schweickerdt-Alker, 2014), defined as genuine, based on facts, accurate and reliable, in a way that resembles an original (Smith et al., 2020a). As highlighted by Sanko et al., (2013, p.215), "the quality of role playing […] strongly determines psychological and emotional fidelity of simulation. However, SPs' portrayals can sometimes come across as stereotyped, superficial or even incongruent, "with no or

little thought to the meaning of the words being spoken" (Schweickerdt-Alker, 2014, p.541). Training SPs for role portrayal will help them to develop an inner thought process to deliver an accurate and authentic performance, based on a logical and believable story behind the scenario (Schweickerdt-Alker, 2014).

"The ultimate purpose of training is to equip the SPs with skills and knowledge that enable them to be full contributing partners to your organisation in a safe and effective manner" (Smith et al., 2020a, p.73). The SP Educator (SPE), the one responsible for training SPs, must ensure that training sessions are undertaken in a professional and safe manner and that by the end of it, SPs are role ready, meaning that they can carry out the required tasks and are aware of the expected benchmarks (Smith et al., 2020a). For role portrayal specifically, it is part of the SPE's job to "elicit more deeply nuanced performances… that are so consistently believable that not only the medical students, but even you, forget that they are simulations" (Wallace, 2007, p.4). One of the biggest challenges for the SPE is to guide SPs to create these authentic roles even when a high degree of standardization is required. As previously mentioned, SPs' behaviour can be calibrated along a HS continuum (Gliva-McConvey et al., 2020b), depending on the context of the simulation encounter (Smith et al., 2020a). Nevertheless, using props and costumes, equipment and setting the room environment are all aspects that help learners immerse in the scenario, as they provide an illusion of authenticity. Drawing SPs' attention "to these details will help to bridge inevitable gaps on the realism of any simulation" (Sanko et al., 2013, p.217).

3.2 Training Process

The Association of Standardized Patient Educators (n.d.), known as ASPE, is a global organisation dedicated to human simulation, founded in 2001 (Adamo, 2003). Their mission is to promote best practices of the SP methodology in education, assessment, research and scholarship, while also promoting and elevating the professional development of those who participate and contribute to the advances in the field. Therefore, it is their duty to establish and share the Standards of Best Practice (SOBP), as a way to ensure the development and integrity of any SP-based activity (Lewis et al., 2017). The ASPE SOBP are designed to provide clear and precise, but also practical and flexible guidelines for those who work with SPs (Lewis et al., 2017). These guidelines consider safety and

effectiveness of the activities and based on that, Smith et al., (2020a) propose a division of the training process for role portrayal into 3 main stages: preparing, leading the training, and ensuring quality.

Stage 1 starts with a first step of reviewing training materials, meaning that before recruiting SPs, the SPE should review case content (make sure there are clear goals and objectives, clear guidelines on the character, and clear instructions for SPs actions, gaps, risks), review adjunct materials (videos, notes and feedback from previous sessions), and review administrative and logistical details (like date, time, location, level of complexity of role portrayal, training sessions, number of SPs needed, and other special instructions) (Smith et al., 2020a). The second step aims to address knowledge gaps, both in the content of the case (general or specific information) and the SPs' training session (physical examination, for example). The SPE should conduct independent research (internet, books, evidence-based articles), consult with patient subject matter experts (SMEs), other SPEs and even experienced SPs that can quickly spot those gaps. A helpful tip is to document this resolution of gaps for future encounters (Smith et al., 2020a). The third step is aimed at creating a training plan, which involves creating a schedule (time management, number of trainings, at home or in person, SPs remuneration) and recruiting the SPs. A well-designed training plan should also consider educational theories (Smith et al., 2020a), for instance, working with adult learners (Cranton et al., 2010), where activities should be voluntary, self-directed, experimental and collaborative; experimental learning (Kolb, 2015), which focuses on learning-by-doing; and also constructivism (David, 2015), allowing SPs to draw on past experiences to co-create new knowledge and meaning along with other SPs and the SPE (Smith et al., 2020a). The last step of stage 1 is to gather resources like case specific materials (patient charts, electronic health records, station references, hybrid equipment, moulage, props, wardrobe), administrative documents (confidentiality and consent forms, payroll, sign-in sheets and schedules, cases if printed), but also to secure physical resources and technological equipment (training space, simulation and presentation material) (Smith et al., 2020a).

Stage 2 of the training process is dedicated to leading the training. The SPE should show curiosity, humility, sensitivity but especially enthusiasm and motivation to all participants

(Smith et al., 2020a). As a general tip, the SPE needs to put SPs safety first at all times, checking with them their level of comfort for each activity, as they can opt out of any case at any time (Gliva-McConvey et al., 2020a). At the start of the training session, the SPE should brief SPs on the case, outlining the details of the scenario (Nestel et al., 2015c) and check in with SPs about their knowledge or previous experiences related to that case (Smith et al., 2020a). It is important to avoid line-by-line memorisation, as it will impact SPs ability to improvise unscripted questions from the learner, as well as to manage medical terminology, by only using words that can reflect the case character (Gliva-McConvey et al., 2020a). To help maintain the training interactive, the SPE can have SPs read through the case as a group, all together. After that, the SPE comes across with the heart of the training process: developing the role portrayal with the SPs. This second step guides the SPs in stepping into the role they are portraying, paying attention to the "what" (facts) and the "how" (behaviours) (Smith et al., 2020a). The main tip here is to use the second person when talking about the symptoms and feelings of the person being simulated: saying "you feel" rather than using the third person "he, she, the patient feels" (Gliva-McConvey et al., 2020a, p.105). Taking that into account, SPs start by focusing on the development of the person's character, that is, their personality, separated from their illness (Nestel et al., 2015c). A way that help SPs to make choices upon how they should behave in a given circumstance according to their character is by inviting them to answer the following questions (Sanko et al., 2013, p.217):

- Who am I?
- Where am I?
- When is it?
- What do I want?
- Why do I want it?
- How will I get it?
- What do I need to overcome?

It is important that SPs, if not professional actors, learn how to commit themselves 100% to the given situation. One helpful way to generate appropriate emotion is by having SPs asking themselves (Sanko et al., 2013, p.218): "how have I behaved in situations like this?"

or “how have I seen others behave in situations like this?”. This acting technique, among all others previously mentioned, provides an understanding of the emotions of others and helps to imaginatively mirror the behaviour of someone else (Sanko et al., 2013). SPs must remember that their ultimate goal is to act to support the teaching objectives for the learners. The need to commit to ‘being the character’ while answering questions and guiding their learning, a skill that takes a lot of practice to master (Sanko et al., 2013). Dudley (2019) provides a list of some physical indicators of emotional states and moods that aims to help SPs find their own way of conveying emotions clearly, by consciously thinking about their non-verbal behaviour (annexe 1).

Moreover, SPs move to thinking about the person as a patient by exploring the clinical context (Nestel et al., 2015c). Some tips for the success of this step include engaging the SPs by using interactive learning techniques, which facilitates deeper learning and retention, like summarising the case highlights, having specialists/experts helping training SPs for specific roles (e.g. a psychiatrist for a mental health scenario), and using video/ digital recordings as a visual learning experience to assist in refreshing the SPs’ perception and expectations of the role to be portrayed. These videos constitute great tools for discussion and critical thinking as SPs learn a lot through observation (Smith et al., 2020a). On the third step, the SPE works with SPs to calibrate the role portrayal, according to the required level of consistency and accuracy. It is a time to have SPs observing each other, with lots of repetition and targeted feedback (Smith et al., 2020a). Some tips include training SPs as a group to develop team culture, creating a portrayal checklist to complete when watching other SPs performing, doing improv games, inviting SPs to take their own notes and ask questions, and so on. Indeed, "the SPs calibrate their performance while watching each other, developing a common vocabulary” (Gliva-McConvey et al., 2020a, p.106).

Another important aspect to take into consideration is cognitive load, a limit of how many layers of information SPs can absorb and incorporate into their role portrayal. Some strategies for managing cognitive load include simplify the script, the ability to improvise and to do spot quizzes (Smith et al., 2020a). The SPE should stay positive and limit their discussions to the key features of the case, avoiding the extensive list of symptoms the

patient does not have (Gliva-McConvey et al., 2020a). Moving forward, the next step is dedicated to role readiness, known as "dress rehearsal" or "dry run". The SPE should establish a transparent, clear and consistent criteria about the meaning of role readiness to avoid surprises. It is the step to informally assess the SPs and provide clear feedback on their understanding of role portrayal and case details. This phase of the training can be divided into four rounds (Nestel et al., 2015c). At first, all SPs assume the role of the person simultaneously while the SPE asks questions about the character, within the expected time frame. Then, the SPE asks about clinical information while the SPs start to take on the emotional part of the character as well. The goal is to calibrate expression among SPs (Nestel et al., 2015c). After that, on the third round, SPs do a small rehearsal with one SP playing the role of the learner, while the others are rotating in a 'hot seat' method with 30 seconds for each SP. The SPE calls 'swap' and the next SP tales the 'hot seat', continuing the consultation as if nothing has changed, until the next 'swap' is called. The fourth round consists on further practice with SPs as observers, providing feedback to each other (Nestel et al., 2015c). Finally, the last step of this stage 2 of the training process consists on de-roling and de-briefing the SPs. A simple way of doing it is to ask the SPs "how did that go today for you?" at the end of the session and making sure the SPs leave knowing what they did effectively and less effectively (Smith et al., 2020a).

Stage 3 is the last of the training process for role portrayal and focuses on quality assurance (Smith et al., 2020a), which will be further discussed in the next chapter. Overall, throughout the training session, it is important to provide regular and consistent feedback on the SPs' performance using verbal encouragement. Nevertheless, "it is worth noting that each program, SP practitioner and group of SPs is unique and the appropriate variations on these methods and other methods are encouraged" (Nestel et al., 2015c, p.69). SPs must be trained in a safe environment in a way that promotes authentic role portrayal that supports the learning objectives of a session (Smith et al., 2020a). There isn't a right way to train SPs but the models available provide not only a structure and a rationale for the creation of a high-quality SP role portrayal training, but also a shared coherent understanding of the SP role and scenario. Some other benefits of using these models include keeping the person at the centre of the training, reflecting patient centredness, and allowing SPs who become

familiar with their use to become SP educators themselves, contributing once again for SP-led training (Smith et al., 2020a).

As mentioned by Barrows (1999, as cited in Cleland et al., 2009, p.483) “the only limitation for topics/cases to be simulated by SPs is in one’s mind”. In fact, the author discusses more than 50 physical findings which can be simulated. All pain symptoms and syndromes described can be simulated by training SPs to carefully exaggerate or lower their reflexes.

3.3 Training SPs for assessment

“It is widely accepted that assessment drives learning, so if patients are involved in student’s learning, it follows that patients should be involved in assessment” (Nestel & Kneebone, 2010, p.892). SPs also play an integral role in assessment in many health education contexts (Cleland et al., 2009). The use of simulation allows learning and assessment ‘on demand’, standardization of the content in the assessment criteria and allows customisation for specific learning outcomes (Smith et al., 2015b). In fact, SPs are described by some authors as “crucial co-participants in an assessment, working as human ‘examination questions’ or proxies for real patients, at the centre of the care that learners are expected to demonstrate" (Smith et al., 2015b, p.86) They are commonly seen in an objectified manner, addressed as ‘items’, ‘tools’, or ‘instruments’ that are ‘used’ (Smith et al., 2015b). Nevertheless, it is important to distinguish the difference between SPs offering assessment to students following the perspective of a trained communications expert, or of a trained technical assessor, or of a real patient (Nestel & Kneebone, 2010). In medical education, all perspectives and experiences (clinicians’, teachers’, students’ and patients’) are important and should receive equal consideration. Therefore, what we call “the patient’s perspective” should, indeed, be based on real patient’s judgements. Having real patients working with SPs will offer clarity in the SP role for the assessment (Nestel & Kneebone, 2010).

3.3.1 Formats

There are various formats of SP-based assessments recently developed where students move along a circuit of stations with different scenarios and are asked to demonstrate their

skills via interactions with the SPs, such as the *objective structured clinical examination* (OSCE) and the *clinical practice examination* (CPX) (Smith et al., 2015b). The main goal of these standardized task-based stations is to assess learners' clinical and communication skills in a systematic and measurable way (Cleland et al., 2009). The scenarios can include practicing history taking of a focused complaint, performing physical examination manoeuvres, counselling and educating patients, reviewing patient records, interpretation of laboratory results or image studies, planning the management of patient care, collaborating with other health professionals and undertaking specific communication challenges (e.g. breaking bad news, ethical dilemmas) (Smith et al., 2015b) (Adamo, 2003). In the OSCE assessments, SPs are growingly contributing to the student mark (Adamo, 2003), especially in stations where the focus is towards patient counselling and health education (Ker et al., 2005). In fact, "the core concept of an OSCE as an assessment event is, through the addition of SPs, augmented to facilitate teaching and learning in addition to assessment" (Adamo, 2003, p.262). The use of SPs enhances the ability to offer high-quality clinical skills teaching and assessment while also contributing to the achievement of a desirable educational social goal (Adamo, 2003). Therefore, as described by Adamo (2003, p.262), the question now is "Why would anyone not use SPs to test for clinical skills". As such, the SPE needs to fully understand the principles of assessment (Smith et al., 2015b) so that he/she can prepare SPs to present an authentic portrayal just like a real patient, covering all aspects of the person they are portraying such as cognitive, affective and psychomotor domains (Cleland et al., 2009; Wallace, 2007).

3.3.2 Standardization

SPs, being the 'examination question', need to be standardized in a way that promotes a fair and reliable assessment process (Smith et al., 2015b). They need to perform in a consistent and standardized manner as a way to ensure that each student is presented with an equal test situation (Cleland et al., 2009). The principle of standardization, as previously mentioned, refers to the consistency (reliability) and accuracy (validity) of their performance over time and between candidates, to provide the same fair and equal chance to each one (Howley et al., 2013). To do so, they must memorise "the what", meaning the specific given information available in the scenario, and "the how", meaning the specific performance considerations (verbal and non-verbal behaviours, timing, quantity of

information provided and affect presentation) (Smith et al., 2015b). When SPs are being used for assessment purposes, they will inevitably need more time dedicated to practice how they can consistently perform their role following every specific criteria (standardization), instead of incorporating their own background and personal experience to an illness scenario (Baerheim & Malterud, 1995).

According to Tamblyn et al., (1990, p.S55), patient accuracy is "the proportion of important clinical findings the standardized patient presented correctly". The level of accuracy of a simulated patient representation of a clinical problem is an essential source of measurement error (Tamblyn et al., 1990). The inconsistencies in SP performance that may happen can vary from lack of appropriate cueing, withholding or providing misleading information, offering inaccurate physical findings or affect, which will inevitably impact scores (Adamo, 2003). These issues arise from either the selection and training of SPs (Adamo, 2003), the case selection, the training processes or even the test procedures (Tamblyn et al., 1990). Nevertheless, some studies found that "the use of patients with previous acting, simulation, and health problem experience and physician assistance during the training period would improve the accuracy of presentation in this area" (Tamblyn et al., 1990, p.S56).

3.3.3 Training Process

Training SPs for assessment performance is a complex process but, similarly to training SPs for role portrayal, there is no accepted set of training techniques established to do so and it frequently lacks specific details and transparency (Smith et al., 2015b). Stage 1 of the training process is preparation. Preparing for an assessment involves the development and trial of the cases and scoring tools that are linked to the objectives and competencies being assessed, the preparation of training resources like training guides (with guidance on expected portrayal, confidentiality, conflict of interest, examination security, procedures for dealing with error, etc.), assessment readiness forms (summary of the criteria that SPs need to perform to demonstrate assessment readiness), training videos (Ker et al., 2005), and it also involves recruiting suitable SPs (Howley et al., 2013; Smith et al., 2015b; Wallace, 2007). It is important to note that not all SPs can do all kinds of assessment (Smith et al., 2015b) and the SPE should take into consideration the following appropriate qualities:

"demographic details of SPs (gender, age, physical characteristics), practical factors (availability, conflict of interest, previous experience), skills (active listening, concentration, focus, attention to detail, ability to memorise), attitudes (openness to receiving feedback, flexibility, ability to reflect, professionalism, self-awareness of bias), intelligence and emotional stability" (Smith et al., 2015b, p.88).

Stage 2 of the training process is the training itself. Training sessions need to be carefully structured and there are several stages for that. It starts with an orientation session to discuss the role and assessment processes, preferably face-to-face with all SPs performing the same scenario, as it ensures consistency and supports benchmarking (Smith et al., 2015b). Just as with any other training session, introducing interactive and immersive techniques can be beneficial, as well as promoting moments that enable SPs to review their role both individually and in group (Smith et al., 2015b). After this initial session, it is very important to have a pre-assessment day rehearsal or dry run of the SP role, a moment where SPs demonstrate and confirm assessment readiness (Howley et al., 2013; Zabar et al., 2013). Using Assessment Readiness Forms, referred to as "diagnostic tools" (Smith et al., 2015b, p.89), can be very helpful to evaluate an SP's performance and consequently elaborate constructive feedback on their readiness to participate in the assessment. If SPs are not assessment ready by the end of this stage, transparent procedures should be undertaken like further training or even replacement (Wallace, 2007).

Stage 3 of the training process consists on monitoring the session (Smith et al., 2015b). On the assessment day, there is a final rehearsal to warm up both the SPs and the assessor, a chance to confirm the required level of standardization, including appearance (Tamblyn et al., 1990), and SPs are briefed just before time starts as a way to better orient them to logistics (Furman et al., 2010). Throughout the session, there is constant monitoring and support, via check-ins, direct observation and attention to errors, adjustments and immediate interventions, if necessary (Zabar et al., 2013). Finally, it is essential to debrief SPs right after the assessment period to help ensure their wellness but also to collect valuable feedback regarding roles and training information about students and faculty members' performance (Cleland et al., 2009; Howley et al., 2013; Wallace, 2007; Zabar et al., 2013).

The last stage is dedicated to continuous quality assurance (Smith et al., 2015b). SPE, SPs, and other quality assurance officers, like chief examiners or assessors, engage in a post-assessment process based on an analysis of the actual interactions that were recorded during assessment day and make judgements about standardization (Furman et al., 2010). Further details will be discussed in the last chapter.

3.3.4 Other roles of SPs in assessments

At last, in some contexts including high stakes assessments, SPs can assess and/or provide feedback to the learners (Smith et al., 2015b) while they continue in role. These simulated patients are known as instructors or evaluators (Barrows, 1993) and have been proved to be effective elements in teaching intimate examinations, both in terms of technical and interpersonal skills (Ker et al., 2005). "It is important to note that SPs functioning in the role of assessor or giving feedback are not necessarily doing so from a patient perspective but rather as proxies for clinicians. Therefore, the focus of the SP assessment or feedback needs to be carefully considered and clearly framed" (Smith et al., 2015b, p.90). In this context where SPs become assessors, training time should be significantly increased and group discussions with all SPs scoring the same role is also advised. Training should include the analysis of previous taped encounters for discussion, and also comparing and coming to an inter-rater agreement about scoring (Howley et al., 2013). SPs must be taught to "observe, interpret, recall and record the students' behaviour on the checklists" and to provide feedback according to the developed protocol (Wallace, 2007, p.183).

In short, SP methodology within assessment is highly influenced by individual interpretations of everyone involved and, as such, training plans should be strategically and rigorously designed with strategies that cover portrayal style of the scenario, level of standardization, and quality assurance processes. "Evidence supports SPs in this role if they are rigorously trained to ensure consistency and accuracy and their assessment work is closely supervised" (Furman et al., 2010; Howley et al., 2013; Smith et al., 2015b, p.89; Wallace, 2007; Zabar et al., 2013). The main benefits of having SPs as assessors include high availability, cost-effectiveness, easiness to train and accuracy. Some eventual

challenges include potential sources of error, favouritism, stereotyping, personal biases, and to give the student the benefit of the doubt (Smith et al., 2015b).

Even though it is not very common, SPs can also be used to evaluate a learner's performance without notice, which means that their presence is unannounced and practitioners actually believe they are real patients. These incognito standardized patients are known as ISPs (Cleland et al., 2009).

4. Training SPs for offering Feedback

4.1 Definition

"Some of the most important data we can receive from others (or give to others) consists of feedback related to our behaviour […] Such personal data feedback helps to make us more aware of what we do and how we do it, thus increasing our ability to modify and change our behaviour and to become more effective in our interactions with others" (Lehner, 1975, p.1). Feedback based on our behaviour has the power to create and improve learning opportunities, contributing for personal growth. To achieve that, it is fundamental to understand how we can make a better use of feedback, both as the giver and the receiver (Lehner, 1975).

Feedback is crucial in clinical learning education (Van De Ridder et al., 2008) and one of SPs' most important duty is to teach through feedback. In this educative role, SPs are the experts who provide feedback on patient centredness and therefore, educate the learner's understanding of the patient's experience. They are a unique contribution in offering feedback to learners (Bokken et al., 2009; Wallace, 2007) because SPs "act as proxies for real patients, allowing learners to hear about the patient's experiences and feelings from inside the encounter" (Nestel et al., 2015b, p.178). In addition, evidence shows that SP feedback produces a significant and beneficial impact in the student's learning process, promoting a more active and engaged attitude (Howley & Martindale, 2004). If feedback is left unnoticed, learner's mistakes are not corrected and their strengths and positive behaviour are not reinforced, which means that their acquisition of clinical and communication skills is threatened (Ende, 1983). However, it is not an easy task and requires specific skills (Nestel et al., 2015b). To do so, it is important that teachers, supervisors, students and trainees agree about its definition and use as an educational tool, as there is little consensus that leads to misinterpretations in daily practice (Van De Ridder et al., 2008).

Nestel et al., (2015b, p.178) define feedback "as the single most important element that supports learning in a simulation". Based on the work of Ende (1983), feedback is classified as an "informed, non-evaluative, objective oral appraisal of performance

intended to improve clinical skills" (Howley & Martindale, 2004, p.2). Some authors tried to propose a consensual, research-based and operational definition of feedback in clinical education, defined as: "Specific information about the comparison between a trainees observed performance and a standard, given with the intent to improve the trainees performance." (Van De Ridder et al., 2008, p.193). In other words, feedback is referred to as exposing and closing the gaps between the actual and expected performance, which for SPs translates into what they expected versus what they experienced in the encounter (Nestel et al., 2015b). Ultimately, in clinical education, feedback is perceived as a form of communication: "the word 'feedback' does itself suggest movement (process of feeding) and cycle ('back' refers to a return) (Van De Ridder et al., 2008, p.194). From this perspective, it is beneficial to keep this view of feedback as a cycle and take it as a point of departure for further training and research (Van De Ridder et al., 2008).

Consequently, the SPE's job is to "support learners by training Simulated Patients (SPs) to provide feedback constructively on a consistent basis, utilising rigorous processes that include meticulous preparation, routine observation, and creativity." (Clark et al., 2020, p.118). Training SPs to record learner's behaviour is not the same as training SPs to evaluate their level of competence. Judging a student's performance is a much more complex task and requires additional training, focused on how to offer feedback to learners (Cleland et al., 2009).

Based on an analysis of 49 studies on feedback by simulated patients in undergraduate medical education, Bokken et al., (2009) found that most SPs offer feedback on clinical and communication skills rather than focusing on feedback given from a patient's perspective. When SPs provide feedback on medical issues and the domain is not purely patient centred, they are described as patient-instructors or even teaching associates (Bokken et al., 2009). Yet, as previously highlighted, there is uniqueness and strength when SPs provide feedback from a patient's perspective (Bokken et al., 2009; Wallace, 2007). When doing so, SPs can focus on how they felt during the consultation, in regards to the nature of questioning and the attitudes they encountered (Whitehouse et al., 1984). The feedback process is then defined by "mirroring", which means that the patient recalls what

he/she experienced and relates it back to the student based on his/her behaviour during the interview (Batenburg & Gerritsma, 1983, p.237).

Even though there is little research regarding the simulated patient-student feedback process in comparison to professional instructor-student feedback (Howley & Martindale, 2004), some authors found that direct oral feedback from a well-trained SP is preferred to faculty feedback based on a videotaped SP-student encounter (Levenkron et al., 1987). In fact, the study conducted by Howley & Martindale (2004) supports the validity and quality of the SP's feedback, as these individuals are carefully trained to offer non-evaluative and descriptive feedback to learners. Students find SPs feedback safe and insightful and, as such, the inclusion of an immediate feedback phase after the simulated patient-student encounter in pre-clinical medical education is highly recommended. Nevertheless, the authors highlight that SPs can be used as a supplemental resource for feedback delivery, and not as a substitute for any clinical faculty member's feedback. In other words, "if our goal is to foster active, lifelong, and internally motivated learners, we must expand our avenues of instructional delivery. Standardized patient feedback is one mechanism for doing so" (Howley & Martindale, 2004, p.6).

4.2 Concepts

Before thinking about training SPs to provide constructive feedback, it is important to establish a common vocabulary of concepts and terms to ensure consistency throughout the process (Clark et al., 2020). First of all, as a teaching tool, the great value of the SP encounter is to create a safe learning environment (Case & Brauner, 2010) that promotes feedback, not criticism (Clark et al., 2020). There is a difference between providing constructive criticism versus providing constructive feedback. Constructive criticism is passive aggressive, very subjective and confusing, and it could imply disapproving of factors that were or were not directly observed (Clark et al., 2020). On the other hand, constructive feedback can still be either positive or negative, but it is a process in which "the SP builds verbal or written statements based on educational objectives in relation to observed performance of the learner to support them in strengthening or modifying specific behaviours contributing to their skill development" (Clark et al., 2020, p.120). The main difference between constructive and non-constructive feedback is about the style and how

the feedback is given, whereas the main difference between positive and negative feedback is related to the content of the feedback which is based on observable behaviours. In short, both positive and negative feedback are eligible for learners, as long as it is provided in a constructive way by the SPs (Clark et al., 2020).

4.3 Logistics and Guidelines

In practical terms, there are some general SP feedback delivery guidelines to follow. First of all, SPs need to have time between each role portrayal and the feedback phase to reflect and write down their thoughts (Clark et al., 2020). Secondly, SPs should always come out of their role when providing feedback in order to avoid confusion and sounding a little too robotic (Clark et al., 2020). Thirdly, SPs should establish the transition between role portrayal and feedback, by introducing themselves right at the beginning of the feedback session (Clark et al., 2020).

In addition, when Simulated Patient Consultations (SPCs) are recorded, students also have the opportunity to later review the SP feedback as part of their reflective learning process (Cleland et al., 2009). Also, after each session, the student can receive feedback both from his/her tutor and peers during the tutorial group. In this educational format, the quality of the video-taped encounters and the feedback provided are crucial to ensure the educational quality of the program (Wind et al., 2004).

4.4 Principles

Some authors provide clear and helpful descriptions of core guidelines on how to effectively give and receive constructive feedback. As a starting point, feedback should be based on common goals, by having both the teacher (or the SP) and the student working as allies (Ende, 1983). According to these principles, feedback should focus on behaviour and not the person, referring to what a person does rather than what he/she is. This implies that the feedback is related to a specific task or situation that can be changed and not related to the individual or any personality traits (Bokken et al., 2009; Clark et al., 2020; Lehner, 1975). Constructive feedback is only effective and meaningful to learners if it is rooted in observable (and modifiable) behaviours (witnessed-viewed or seen-by another person), on what the SPs literally and actually observed, saw and heard as opposed to their inferences

(what they interpreted or assumed) (Clark et al., 2020; Ende, 1983; Lehner, 1975). It should also offer a suggestion of behaviour change for the next encounter (Clark et al., 2020). In addition, feedback is expected to be specific rather than general and provided in a more objective rather than subjective way (Clark et al., 2020; Lehner, 1975). Constructive feedback is also supposed to be timely and expected, which means that is related to a specific time and place, "here and now", preferably straight after the encounter and on a regular basis (Bokken et al., 2009; Clark et al., 2020; Ende, 1983; Lehner, 1975), but also focused on time and place, a sensitive choice as it may involve emotional reactions (Lehner, 1975).

Also, feedback should focus on neutral descriptions and not judgments, interpretations or evaluations, described in a way that documents what occurred, in a neutral tone and style, rather than having an evaluation of "good or bad", "right or wrong", "nice on not nice" (Clark et al., 2020; Ende, 1983; Lehner, 1975); Consequently, it should be provided in terms of "more or less" terminology, which implies a continuum, seen as objective and meaningful (Lehner, 1975), but also provided in small digestive quantities (Ende, 1983), limited to two to three points (Bokken et al., 2009), focused on quality rather than quantity. It is preferable to have "short well-designed pieces of feedback about observable behaviours constructively delivered rather than a lengthy and disorganised montage of feedback delivered in a non-constructive manner" (Clark et al., 2020, p.129); If possible. provided with positive aspects first, followed by a negative afterwards (Bokken et al., 2009). Moreover, feedback should be focused on the sharing of information and not giving advice, leaving the person free to decide how to use those ideas and information, in the light of his/her own learning goals (Bokken et al., 2009; Lehner, 1975); It is focused on exploring alternatives and not trying to find answers or solutions, for which there are no problems (Lehner, 1975); The focus is also on the value it may add to the recipient and not the needs of the giver, seen as an offer and not an imposition (Lehner, 1975). It should be guided by the amount of information the person can use and not the amount the giver wants to provide, avoiding overload of information (Lehner, 1975); It is supposed to be relevant to the learner level and the learning objectives (Clark et al., 2020), dealing with decisions and actions (Ende, 1983). Furthermore, feedback should be delivered using "I" statements to focus on the patient's own perspective (Bokken et al., 2009; Clark et al.,

2020); Finally, feedback should focus on what is said and not on the reason why it is said. Observable characteristics answer questions like what, how, when and where, as opposed to questions of intent and motive (Lehner, 1975).

Additionally, based on Nicol and Macfarlane-Dick's (2006) seven principles of good feedback, Nestel et al., (2015b) translated these into SP-based education principles of good feedback. The first principle is to clarify the meaning of good performance, as both SP and learner should know the expected level of performance. The second principle is to facilitate self-assessment, a moment when both facilitator and SP ask the learner questions, as a way to promote reflection of their behaviour. The third one is to deliver high-quality feedback information, which means that both facilitator and SP offer timely feedback based on specific criteria that includes information on strengths, weaknesses, corrective advice and prioritise areas for improvement. At fourth, it is important to encourage teacher and peer dialogue, promoting discussion related to SPs and learners' experiences. In addition, the fifth principle is to encourage positive motivation and self-esteem, as facilitators and SPs should leave learners inspired to improve their skills on the next encounter. Then, provide an opportunity to close the gap and give learners the opportunity to rehearse again with the SP considering the communication strategies previously discussed. At last, the seventh principle is to use feedback to improve teaching, promoting facilitators and SPs' reflection of their own practices.

Furthermore, based on the previously mentioned analysis of 49 studies on feedback by simulated patient, (Bokken et al., 2009) included some more detailed recommendations for providing feedback in medical education. The authors highlighted the importance of promoting a safe learning environment while clearing student's expectations and emphasising confidentiality; feedback should start with the student's self-reflection and end up with established learning goals for future encounters. In short, when SPs provide feedback following these guidelines, it is easier for learners to understand and receive the content of their feedback (Clark et al., 2020).

4.5 Training Process

Feedback is described as 'hard to give and hard to take' (Nestel et al., 2015b) and, as such, providing feedback requires "courage, skills, understanding and respect for self and others" (Lehner, 1975, p.2). Therefore, SPs should be supported in gaining these skills through training (Nestel et al., 2015b). Even though there is some debate on whether SPs stay 'in role' for feedback or not, some authors recommend that SPs should clearly step out of role for that phase to avoid any possible learning limitations as a consequence of the type of patient being portrayed (Nestel et al., 2015b). SPs should start by introducing themselves to the learner and then share their personal experience (Nestel et al., 2015b), according to the principles highlighted earlier. Some authors (Bokken et al., 2009) found significant heterogeneity in the ways in which SPs are trained to offer feedback, with no clear established standards. Some of the studies included in this research described SP training on feedback using videotaped interviews and practice in delivering feedback with the SPE, or even live interviews followed by feedback practice (Bokken et al., 2009).

As already mentioned, the ASPE SOBP are designed to provide clear and precise, but also practical and flexible guidelines for those who work with SPs (Lewis et al., 2017). The SOBPs are organised into 5 domains and each domain is divided into principles with accompanying key practices. Domain number 3 is partly dedicated to SP training for feedback and Clark et al. (2020) based their feedback training model on those principles. Even though training processes may vary from different institutions, this 3 stage model combines common stages of many processes, which includes preparing for training, leading the training, and ensuring quality for the ongoing SP work.

Stage 1, the preparation, starts by identifying communication skills curriculum and assessment tools (step 1). The SPE and clinical experts should co-create a meaningful and coherent communication skills program, by collaborating on SP cases, training, and assessment tools. It is important to identify a communication framework in which learner's individual skills are structured. If necessary, it is recommended to consult with other experienced SPEs (Clark et al., 2020). After that, the SPE should select and develop well-structured training materials (step 2) like a blueprint case-specific feedback with guidelines for each encounter. Reestablishing the main SP feedback delivery guidelines is also

extremely helpful (Clark et al., 2020). By this time, the SPE should clarify the timeframe, the logistics, and the role of the SPs. In addition, the SPE needs to determine criteria and the process to assess SPs readiness (Clark et al., 2020). The SPE is responsible for providing feedback on SPs' developing feedback skills and that can be achieved by using or developing an observation form that SPs are familiarised with. Consequently, if the SPE creates, gathers and organises all training materials prior to the training sessions, he/she can maximise the time and promote optimal learning and skills' development for all SPs (Clark et al., 2020). Key material to be included in feedback training sessions is: training agenda, feedback manual, standard verbal and written feedback framework, emotional/ feeling word vocabulary sheet (annexe 2), a list of constructive feedback examples supported by video or audio examples (Clark et al., 2020). Also, there is a wide range of possibilities when generating and selecting feedback training exercises, including quizzes, dynamic games, and video reviews. These exercises aim to promote a purposeful practice of feedback frameworks and a deep understanding of feedback content in a creative way (Clark et al., 2020). Finally, the SPE shouldn't forget to develop a training plan (step 3). Creating a training agenda helps the SPE practically by keeping track of both time and content, which ultimately translates into respect for the SPs (Clark et al., 2020).

Stage 2 is dedicated to training and is divided into 7 steps. At the beginning of the session, the SPE can start by reviewing the principles of feedback, highlighting why feedback matters and why SPs give feedback (step 1) (Clark et al., 2020). It is also important to include common terms and concepts in case-specific trainings (step 2) like the ones mentioned above: observable behaviours, criticism, non-constructive, bias, positive and negative, constructive feedback and its characteristics (step 3) (Clark et al., 2020). On the other hand, it is also critical to address barriers to provide constructive feedback (step 4). The SPE should help SPs to develop a robust and functional vocabulary not only to improve the quality of feedback but also to avoid them using the same words every time (Clark et al., 2020). Also, SPs should be prepared to eventually handle conflict. A learner may be defensive when receiving feedback and SPs shouldn't take that as a personal attack. However, aggressive or disrespectful behaviour will never be tolerated (Clark et al., 2020). In addition, most SP programs use a structured and collaborative framework to approach feedback delivery that often begins with the learner's self-assessment and

finishes with suggested changes in relation to observed behaviours that do not meet learning objectives (step 5) (Clark et al., 2020). When offering feedback, SPs need to consider their own unconscious bias and there are plenty of workshops and exercises that encourage them to reflect on them (step 6) (Clark et al., 2020). Finally, similarly to training for role portrayal, the key is to practice and practice and practice. The SPE should keep training sessions interactive and include demonstrations, role plays, quizzes, games, peer practice, and video review (Clark et al., 2020).

Watching a recording of an SP-based encounter (video review) is one possible approach to be used during SPs' training to develop their feedback practices. It is a valuable method to be used with a group of SPs and functions as the basis for several exercises (Clark et al., 2020). These might include using rating forms and ask SPs to fill them out as if they were the SP in the encounter; asking SPs to write their feedback using their own words, as a way to improve their vocabulary and practice precision in language; ask SPs to complete the sentences using a list of emotions; asking SPs to watch a recording and pretend they are the SP who is going to give feedback to the learner, as a way to practice structuring content (Clark et al., 2020).

There are some guidelines and tips to help SPs improve their feedback skills. Encouraging SPs to think about the answers to the following questions can help them on providing targeted feedback for patient-centred communication (Nestel et al., 2015b, p.73):

- How did I feel throughout the encounter?
- What did the learner do that led to my satisfaction?
- What did the learner do that led to me feeling dissatisfied?
- Did I feel listened to?
- Did I get the chance to share my ideas?
- Was I able to share my concerns?
- Was I given a chance to ask questions?
- Did I feel comfortable enough to ask questions?
- Was I given the opportunity to make specific requirements?
- Were my feelings acknowledged?

- Did I feel respected?
- Was I treated as an individual?
- Did I seem important or valued?

In addition, giving SPs a list of communication skills can facilitate the process of describing to learners the impact of specific communication issues during the encounter. If SPs are familiarised with the relevant communication skills and concepts of patient centredness, it is easier to develop their feedback skills (Nestel et al., 2015b). Annexe 3 illustrates some examples of communication skills SPs may refer to when offering feedback (Nestel et al., 2015b).

Stage 3 is dedicated to ensuring quality feedback delivery from SPs and is divided into 4 steps (Clark et al., 2020), highlighted in the next chapter. Nevertheless, there are, inevitably, challenges associated with SPs offering feedback (Nestel et al., 2015b). For instance, if SPs are not prepared to give feedback or find it difficult to use appropriate feedback phrasing to address the areas that need improvement, the SPE should offer extra training and assistance by carrying out drills and exercises, and fully brief the SPs on what they are expected to do (Nestel et al., 2015b). Another situation is when the learner has done a really good job and the SPs don't know what to say. In those cases, it is essential that the SPE explains how important it is to still offer information on what learners have been doing well so that they keep those skills for future encounters (Nestel et al., 2015b). On the other hand, if the learner has performed poorly and there is a lot of negative feedback to provide, the SPE should explain to SPs the importance of identifying priorities and just focus on those issues, and not give too much information to the learner. If the learner leaves feeling flat/uninspired, the SPE should promote SPs' self-reflection on the words they used during feedback and provide feedback on their feedback (Nestel et al., 2015b). If it is the SP leaving the encounter feeling flat/uninspired, the SPE needs to debrief SPs, a process that is widely practiced and is considered a vital element of simulation (Nestel et al., 2015b). Also, if SPs give feedback related to medical content (from a clinician's perspective), the SPE should provide regular opportunities for SPs to review their feedback skills and explain how to address it from the patient's perspective (Nestel et al., 2015b).

Another important aspect to consider when training SPs for offering feedback is the unconscious bias. When offering feedback, SPs need to consider their own unconscious bias, things they are unaware of but influence judgements and assessments of people and situations (Clark et al., 2020). Biases are influenced and shaped by our personal experiences, backgrounds and the cultural environment that surrounds us (Clark et al., 2020). Training SPs to acknowledge these is becoming a top priority in feedback trainings, as it doesn't allow SPs to fall back on their own personal likes and dislikes.

5. SPs Evaluation and Quality Control

Medical programs that use simulations for education and assessment in the healthcare professions must consider quality assurance methods to ensure reliable results (Furman et al., 2010), even though many of them still lack the personnel and resources to pursue those quality assurance methods (Adamo, 2003). Trained SPs should "look, sound and behave as patients with the condition being studied. Clinical reasoning, physical examination, investigative, procedural, operative and therapeutic skills all represent facets of SP-based work achieved through the SP alone or in hybrid simulations" (Nestel et al., 2015d, p.8). In addition, SPs navigate numerous boundaries when interacting with their audience (the learner). They are constantly in role and out of role, meaning that while they are embodying a realistic patient, they also need to monitor what the learner is doing to provide constructive feedback (Smith et al., 2015a).

5.1 SPs Evaluation

According to Clark et al., (2020), SP programs need to make SPs' evaluation a priority. As a general overview, there are some SP traits which can be observed to ensure quality control. The first ones are related to professionalism. SPs should demonstrate punctuality, good behaviour, good communication with the SPE and other SPs, and case-specific attire (Clark et al., 2020). In terms of training, it is important that SPs demonstrate self-awareness, ability to receive feedback on their performance, and engage in the training process (Clark et al., 2020). The transition from volunteer SPs to paid SPs made it easier to quality ensure the work they do (Adamo, 2003). By following quality-assurance guidelines, paid SPs are eligible to be released when failing to meet training standards. These can include lack of performance, tardiness, inaccuracy, inappropriate responses to students and unpredictable attendance (Adamo, 2003).

When training SPs, it is important to assess some characteristics like their level of promptness and preparedness, their ability to adapt to different interviewer styles and sustain emotive role portrayals, their capacity of behaviour adaptation in relation to feedback/coaching and also their skills of active listening (Adamo, 2003). During post-training assessment, SPs need to be recognised as suitable either as simulated or

standardized patients. They need to be able to demonstrate stable findings during physical examination, record accuracy, and deliver constructive patient-centred feedback (Adamo, 2003).

Apart from these general SP traits, evaluation of SP's performance, both in terms of role portrayal and offering feedback, is important to ensure the educational quality of a faculty program (Wind et al., 2004). SPs need to have the capacity to manage the dual task of performing their role while remembering the student's performance at the same time (Cleland et al., 2009). In terms of role portrayal, "a well-prepared simulated patient (SP) has the ability to draw learners into a scenario quickly, achieving deep engagement" (Nestel et al., 2015a, p.1). SPs need to show accuracy when portraying case details and patient affect (Clark et al., 2020). In order to create an authentic and accurate role portrayal, away from stereotyped and superficial performances, SPs should create a reliable story behind the scenario (Schweickerdt-Alker, 2014). According to Wallace (2007), SPs need to think about the person behind the patient by creating subtext, which will enable them to respond in an authentic way no matter the circumstances. Schweickerdt-Alker (2014, p.542) explains that "subtext consists of thoughts that bring on feelings that influence all aspects of non-verbal communication. Taking into consideration that non-verbal communication stands for 93% of the consultation, one might conclude that subtext and the consequent congruent non-verbal behaviour is what gives rise to an authentic portrayal". The best way to create this subtext is to have SPs derive from their own history and experiences, guided by the acting exercises already mentioned in previous chapters. By doing so, their concentration and focus will automatically improve (Schweickerdt-Alker, 2014). Finally, it is also important to take into consideration for quality purposes that each SP can only perform successfully for a limited number of times before inevitably beginning to make performance mistakes or giving feedback errors (Adamo, 2003).

Concerning the feedback phase, SPs need to demonstrate readiness, to maintain and follow the institutional feedback delivery framework, to show accuracy and reliability in assessing learners through communication skills scales, and also to be able to provide constructive written and verbal feedback (Clark et al., 2020). In order to ensure quality feedback delivery from the SPs, the first step is to have the SPE reflecting on his/her training.

Secondly, after an introductory training, new SPs should be observed and assessed while providing feedback (Clark et al., 2020). As an SPE, it is good practice to routinely observe and provide feedback to each SP when they work, even the most skilled ones (Clark et al., 2020). The SPE can also use some sort of evaluation form for this activity and also benefit from the help of more experienced SPs. In fact, SPs appreciate timely and regular feedback on their performance (Clark et al., 2020; Ker et al., 2005), which can be facilitated straight after an encounter or as part of their training. This process can also involve clinical teachers and should be seen as a crucial part of the development and maintenance of the program and the SP bank (Ker et al., 2005).

Just as the SPE is invited to self-reflect, so do SPs. The following questions aim to help SPs' self-reflecting on their feedback skills (Clark et al., 2020, p.141):

- Did I ask the learner to reflect on the encounter before providing my feedback?
- Did I acknowledge or respond to the learner before moving ahead with my feedback?
- Given the time frame, did I address the relevant, case-specific feedback points?
- Did the feedback address specific, observed behaviours?
- Did I give specific examples to support suggestions for behaviour change?
- Did I provide the most bias-free feedback possible?
- Did the student leave with constructive information to support behaviour change when needed and reinforce behaviours that meet learning objectives?
- Did I offer a polite conclusion informing the learner of what, logistically, to do next?
- Did I deliver feedback using the institutions' guidelines and standard framework?

In order to provide an individual SP evaluation, the Medical School in Maastricht, the Netherlands, saw the need to develop an instrument capable of evaluating SPs' performance in a valid, reliable and feasible way, as there were no published reports about this until then (Wind et al., 2004). At Maastricht, the undergraduate medical curriculum includes video-taped sessions that involve one SP and two students, a doctor and an observer. By the end of each session, the student playing the role of doctor receives feedback both from the SP and from his/her tutor and peers during the tutorial group. In this educational format, the authenticity of the role-play and the quality of feedback are

crucial to ensure the educational quality of the program. In fact, "the quality of the feedback provided by the SP increases when the SP is allowed to play an authentic role" (Wind et al., 2004, p.40). The instrument capable of evaluating SP performance based on role portrayal authenticity and feedback quality is known as the Maastricht Assessment of Simulated Patients (MaSP) (Wind et al., 2004). By the time it was tested, all SPs were very positive and pleased to receive feedback on their performance (Wind et al., 2004). Training SPs is a continuous process and SPs take advantage and enjoy receiving feedback to make improvements (Nestel et al., 2015c). As such, faculty or SP educators should observe and provide feedback during and after each simulation activity (Nestel et al., 2015c), benefiting from instruments like the MaSP.

5.2 SPE Evaluation

Part of maintaining quality control within an SP program is also related to SPE's self-assessment. Maintaining quality in SPE's work starts with reflection on their own training (Smith et al., 2020a), a way of showing professional commitment (Clark et al., 2020). Having tools with benchmarks can help guiding the self-reflection process and assessment of the SPE's work (Clark et al., 2020), such as the use of "Trainer Attributes: Competence Self-Assessment" form (annexe 4), a self–assessment tool for the SPE to evaluate his/her strengths and identify areas for improvement, and a "Trainer's Skills: Competencies Checklist" (annexe 5), a checklist for the SPE to evaluate his/her presentation skills. These documents were developed by the SPE Jamie Pitt to assess the effectiveness of her own work (Smith et al., 2020a) and are available to download from the International Training and Education Center for Health (I-TECH)'s website (2006). Secondly, the quality of an SPE's work can also be defined by the performance of the SPs. Reflecting on SP performance may be via direct observation during simulation encounters and/or post video review, processes that allow the SPE to identify and distinguish between the different kinds of performance errors, random or systematic, as the latter provide a valuable opportunity to improve the quality of their training. Finally, the last step on quality assurance is informed by feedback from other sources. Having evaluation forms for SPs, learners, faculty and other trainers gives valuable information for the SPE regarding the effectiveness of the role portrayal, the feedback, the overall impact of the session and therefore the future training outcomes (Smith et al., 2020a).

Some SPEs, when interviewed, were asked to describe their most frequent "challenges" during training sessions and which creative solutions they may have tried to effectively solve the problem (Smith et al., 2020a) and therefore, to keep maintaining quality within the SP program. If an SPE feels under resourced while at the same time over-extended, it could be useful to: include their most experienced SPs in the training sessions to help with quality assurance measures, or even prepare them to become lead SP trainers; to recruit medical students to help in enacting training sessions; to develop an annual refresh session to review core principles and to celebrate the effectiveness the SP team; to strategically cast SPs for future roles and cut down on training times; to create online material so that SPs can review prior to training or access the recording of the training session if they were not able to attend; and to create SP workshops to complement the regular trainings (Smith et al., 2020a). Secondly, if an SPE struggles to keep SPs focused, it is important to bring the training sessions back to the learning objectives and the purpose of the case. To keep SPs engaged and motivated, it helps to vary training techniques, to address naturally the existent discrepancy between the group of SPs by also inviting questions from the newer SPs and welcoming mentoring from the more experienced ones (Smith et al., 2020a). Thirdly, if an SPE feels that an SP is struggling with role readiness, it could be useful to reverse the roles and have the SP being the medical student, in order to change the way they perceive the role (Smith et al., 2020a). In addition, it is important to remind SPs not to answer medical terminology, just as a lay person would not. In fact, just because an SPE feels like an SP is ready, it doesn't mean they are good to go. It can be difficult to monitor every single SP for quality in a simulation session, so the SPE should prioritise which events need more of that (Smith et al., 2020a). Finally, another big concern is related to dealing with the unexpected. To help SPs feeling ready to deal with that, the SPE may draw on their experiences of what learners usually do, then ask experienced SPs to portray different types of learners and practice, practice, practice (Smith et al., 2020a).

5.3 Development of Cases and Scoring Instruments

The best practices for quality assurance start with case or scenario development. Well-written cases are essential to ensure comprehensive content for everyone who uses them, especially the ones responsible for training SPs or programming mannequins (Furman et al., 2010). To ensure quality in case development, the process should start early on and

assessment objectives should guide it. Having a committee-based approach is strongly advised and early participation in the process of all case users and not just the content specialist is strongly advised (Furman et al., 2010).

Also, extra attention needs to be paid in relation to case content. The first way to ensure quality is to present timelines for SPs in generic or universal terms, so that their story can be adjusted easily regardless of the time of the day/season (Furman et al., 2010). In addition, using realistic language rather than clinical phrasing and jargon avoids having SPs interpreting what has been written in the scenario. Using standardized descriptions across similar cases simplifies the required learning for all stakeholders, and therefore, contributes to quality assurance during role portrayals (Furman et al., 2010).

In terms of scoring instruments for assessments, writers should avoid including items that combine two tasks together, as it is more difficult for the rater to assess if only one is completed (Furman et al., 2010). They should also avoid items that include physical examination manoeuvres that raters cannot observe, or even items that focus on SPs responses instead of analysing examinee's actions (Furman et al., 2010). It is also advised to exclude items which have been addressed prior to the starting of the simulation, as participants are less likely to demonstrate content under those circumstances (Furman et al., 2010). Nevertheless, the best way to try all these content development strategies is through pilot testing of new cases with live examinations (Furman et al., 2010).

5.4 SPs as Examiners

Quality assurance in assessment training practices is achieved when the variance of multiple portrayals and raters is minimised, preventing examinees to be unfairly assessed (Furman et al., 2010). For rater's training, it is advised to hold refresher sessions routinely, as a way to increase their reliability (Harik et al., 2009), accuracy and consistency in their scoring (Furman et al., 2010). In these orientation sessions for examinees, it is fundamental to make sure that they are aware of the format, timing, and procedures of the assessment (Furman et al., 2010). When organising a multi-station performance assessment, timing systems and clear protocols are essential. In addition, using trained proctors minimises the security risks during assessments (Furman et al., 2010). Nevertheless, irregularities and

human error may always occur, despite the amount of time spent on preparation. As such, it is important to document and follow-up any incidents that may occur during an examination administration (Furman et al., 2010).

For case training, the goal is to ensure a sufficiently realistic simulation, through a consistent and accurate portrayal of the scenario. To do so, the SPE should be creative and use a variety of training modalities, use standardized training protocols, document SPs' progress throughout the session, and assess SPs' readiness by providing a rehearsal of the case performance (Furman et al., 2010). If by any reason the SPs aren't ready, solutions might involve extra training replacements by having a spare SP for each role. SPs exist to support learners and their learning goals and so, the SPE does not serve anyone by letting unprepared SPs work just because they don't want to hurt anyone's feelings (Nestel et al., 2015c). Furthermore, SP-based objective structured clinical examinations (OSCE) can be influenced by an SP or rater illness, rudeness, or even lack of training. In order to avoid administrative irregularities that impact the fairness of these examinations, faculty should provide detailed protocols and job descriptions for every position while also monitoring the performance of all involved (Furman et al., 2010). These staff trainings should occur regularly, within the expected time-frame, and accompanied by the use of different modalities. If needed, refresher and remediation sessions are also effective and necessary (Furman et al., 2010).

In order for SPs to give assured performances and not breaking character, the SPE needs to ensure that each role contains relevant detailed information for that particular scenario, that there are protocols to deal with unexpected questions and on how and when to give out information, and also that SPs are training with different types of learner performances in advance to gain a sense on how to tell their story effectively (Smith et al., 2015a).

In sum, quality assurance practices should be routinely implemented in any simulation. "Having quality control processes is critical to running valid and reliable assessments of clinical skills using simulations" (Furman et al., 2010, p.230).

Methodology

1. Approach: Design Thinking

The research problem "how to train and ensure the quality of the contribution of Simulated Patients" in undergraduate medical education is divided into two main subjects: how to train and how to ensure the quality of Simulated Patients. The chosen approach to tackle these subject areas is described as Design Thinking. The concept of Design Thinking was introduced a decade ago and hasn't just been used by the so-called creative industries (Brown, 2019). It is a methodology that converts need into demand, "a human-centred, creative problem-solving approach" that helps people and organisations become more innovative with new effective solutions (Brown, 2019, p.1).

The contribution of Simulated Patients (SPs) in undergraduate medical education seeks to implement a more patient-centred model of education, just as the design thinking methodology proposes a more human-centred approach to problem solving. The alignment of these two perspectives culminates with the creation of this project, a creative and innovative solution to help simulated patients and their organisations to better perform and quality ensure the study of medicine in undergraduate curriculums.

2. Method: Qualitative

"Design Thinking relies on our ability to be intuitive, to recognise patterns, to construct ideas that have emotional meaning as well as functionality" (Brown, 2019, p.10). In order to achieve these, this project benefits from a qualitative research. This method is described as "a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations" (Denzin et al., 2024, p.14). Through an inductive, interpretative and naturalistic approach, qualitative researchers typically collect data in the participant's setting and make interpretations of the meaning of that data (Creswell, 2009; Denzin et al., 2024). As described by Creswell (2009, p.19), "Qualitative approaches allow room to be innovative and to work more within researcher-designed frameworks. They allow more creative, literary-style writing, a form that individuals may like to use".

Data collection and analysis procedures include, at first, a review of the current available literature on the importance of communication in medicine, what I believe is the core information that sets the ground for this project. This first step is followed by a review of the current available literature on the SP Methodology, specifically on training Simulated Patients for Simulated Patient Consultations (SPCs) and assessments, but also quality procedures for the SP program in general. Through document analysis, I have divided the information into three main themes: training for role portrayal, training for offering feedback, and quality assurance methods. These documents represent previous research conducted by field experts from around the world that have made interviews themselves to SPs and Simulated Patient Educators (SPEs). Being the current SPE at Católica's Medical School in Lisbon and also an SP myself, I have always had a participatory observation of the entire SP program. My personal experience as an SP provided me the necessary tools to comprehend what was missing and what could be implemented to effectively train and evaluate SP's performance. According to Creswell (2009, p.181) data collection through observations "are those in which the researcher takes field notes on the behaviour and activities of individuals at the research site […] Qualitative observers may also engage in roles varying from a non-participant to a complete participant".

In addition, this experience also allowed me to visit the University of Maastricht, in the Netherlands, for a couple of times. The Maastricht University is a role model for SP Methodology and helped with the foundation of the department SkillsLab at Católica's Medical School, in Lisbon. The first meeting, in May 2022, was important to know how to be an SP. I also met SPs from the Netherlands, understood how they work and defined what we could bring back and implement at Católica's Medical School. The second time I visited Maastricht, in April 2024, was to attend a course from the Graduate School of Health Professions Education (SHE) on training and working with Simulated Patients for teaching and assessment. This experience enlightened me on how to coach SPs for the different curriculum activities, touching on key aspects like the HS continuum and the expected level of standardization, acting games to improve SP's role-play, understanding the five rules of constructive feedback taught at Maastricht, but also how the SP methodology is implemented in other countries all around the world. Finally, in June 2024,

my last trip to Maastricht University allowed me to bring my four most experienced SPs and teach them how to become SP coaches themselves, benefiting from all learning materials developed in April. In short, these training courses made me become more aware of all the necessary tools that SPs should have access to, in order to deliver an exceptional work at our institution.

3. Researcher's Role

As described by Creswell (2009, p.175), in qualitative research, the researchers are the key instrument. They are the ones who actually gather the information from multiple sources of data, review all of it and then make sense of it. This inductive process is made by organising the data into categories or themes and creating patterns from all sources. Decisions about a choice of design are influenced by the issue being studied and the target audience. Furthermore, the researcher's own personal training and experience will inevitably influence their choice of approach too (Creswell, 2009).

In this particular case, I have made an attempt to present in the literature review all different views on SP methodology, even if it is not what we strictly follow at Católica's Medical School. My goal is to elaborate a project that helps any institution working with SPs to meet high standards of performance. I believe my choices are inevitably influenced by how I interpret the needs of SPs and my owns as their SPE. However, there is no right or wrong and, as previously mentioned, "it is worth noting that each program, SP practitioner and group of SPs is unique and the appropriate variations on these methods and other methods are encouraged" (Nestel et al., 2015c, p.69). My intent is to create a helpful and innovative tool to help SPs during SPCs, both in terms of role-portrayal and offering feedback, and therefore to help maintain a quality standard of any SP program. I encourage other SPEs to use and adapt this SP self-guide for SPCs according to their own needs, if necessary.

4. Validation procedures

There is a general consensus that qualitative researchers should demonstrate that their work is credible by establishing various procedures for validity (Creswell & Miller, 2000). Validity is defined as "one of the strengths of qualitative research, and it is based on

determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers (Creswell, 2009, p.190).

The first strategy to establish credibility for this study is through member checking (Creswell, 2009). At this initial stage, I discussed my project with Sandy Nelissen, the SP coordinator at Maastricht. After receiving her valuable insights, I have also presented and discussed it with the coordinators of the SkillsLab at Católica's Medical School in Lisbon: Professors Rodrigo Sousa and Paulo Oom. The input received from the SPs will be further discussed on the limitations section.

The second strategy is achieved by having an open and honest narrative (Creswell, 2009). My self-reflection on the possible bias of this project are only regarding the chosen approaches that I have included in the project. I believe there is no right or wrong and the self-guide constitutes a possible (but not the only) tool to improve training and self-reflection among the whole SP bank. It is inevitably shaped by my background in Design, Acting and Communication and it is also tailored to our needs for the curriculum at Católica's Medical School.

The third strategy consists on spending prolonged time in the field (Creswell, 2009). As a member of the Simulated Patient team since 2021, I believe I have developed an in-depth understanding of the phenomenon being studied. As highlighted by Creswell (2009, p.192), "the more experience that a researcher has with participants in their actual setting, the more accurate or valid will be the findings".

The fourth and last strategy is achieved by peer debriefing (Creswell 2009). I have asked my tutor and another professor at Católica University to review and ask questions about my project. This strategy involves an interpretation beyond my own, thus adding validity to the study.

5. Ethical considerations

Research includes collecting data from people and about people (Punch, 2005). For the research problem, it is important to select a theme that is meaningful to others besides the

inquirer, one that benefits the individuals being studied (Punch, 2005), which in my particular case represents both the SPs and Católica's Medical School. Regarding data collection, this study does not put anyone at risk, nor it disrespects vulnerable populations or groups (Creswell, 2009). For the data analysis and interpretation, there is no need to protect the anonymity of individuals as all research has been conducted just by myself. It is important to highlight that there is a lot of data collected from other sources that aligned with my personal experience and insights from other colleagues has led me to complete this project. The book itself does not include any references. These can be found throughout this document and are correctly named after each author.

"In qualitative research, the intent is to explore the complex set of factors surrounding the central phenomenon and present the varied perspectives or meanings that participants hold". (Creswell, 2009, p.) As such, this master's project presents a small collection of the literature available on simulated patients, exploring the different perspectives of many authors Therefore, the final project is an attempt to present the varied training tools that can be offered to simulated patients, as a result of my own interpretation of the literature, connected to my personal experience and findings on the matter.

6. Limitations

The main limitation of this study is the assessment phase, which will only be made possible at the end of the next academic year. From September 2024, the simulated patients at Católica Medical School will start to use this self-guide as a complementary tool for their performance (both role portrayal and offering feedback) and self-reflection. It is only with user experience that we will be able to modify the current project to a better version. Consequently, by the end of July 2025, I will evaluate the quality and utility of this project, as it will be further discussed on the next chapter.

Project

1. Context

For the past 3 years, I have been part of the Simulated Patients' team at Católica's Medical School. Starting out as a Simulated Patient (SP) and growing into coordinating the whole team made me realise that there was something missing. When we join the program as an SP, we receive more or less 12 hours of training before even getting into contact with a medical student. The amount of information that we receive during those sessions can be overwhelming, both in terms of role portrayal and providing constructive feedback. It is comprehensible that, after a while, SPs tend to forget some parts of that information. As such, it becomes necessary to constantly remind them what was learnt and practice over and over again. But even after all that training and practice, there is still place for improvement. More experienced SPs can still challenge themselves to play roles differently and more authentically, or provide concise feedback using different and more accurate expressions. For all these reasons, I started to reflect, as the Simulated Patient Educator (SPE), on how we could effectively train both new and more experienced SPs and maintain their work quality throughout the year. The answer is simple: through the addition of self-training and self-reflection. Through training and reflection we achieve quality and that is exactly why this project is brought to life. There is an urgent need to provide SPs with flashcards for the time they are doing Simulated Patient Consultations (SPCs), something that works as a complement of the general training they already received from the SPE. In other words, the aim of this project is to create a book containing guidelines to foster SP's self-reflection on role portrayal and feedback and, therefore, increasing their quality when working. SPs need to be more independent and have a regular access to the training materials they are exposed to, which are carefully selected and presented in a condensed and clear way in this new guide.

2. Content

Entitled "the SP self-guide for SPCs", this project aims to help SPs feeling ready for simulated patient consultations (SPCs) by covering all 3 main areas: role portrayal, feedback, and self-reflection. The guide is written in a practical way, addressing the SP as "you, the patient, feel" rather than using the third person "he/she, the patient, feels". By

using this tone, SPs can potentially connect at a deeper level with the characters they are portraying, as they refer to them using the first person and not as someone who is distant and lives in a fictional world. All subjects are based on the theoretical framework presented in the literature review. It consists on a mixture of information provided by various authors combined with my own personal experience. It is a book that is created for all existing SPs that are dealing with formative assessments, rather than summative ones. This means that it is not a guide tailored for Clinical Skills Examinations (CSEs) or Objective Structured Clinical Examinations (OSCEs), when patients have to be standardized and provide no feedback to the student. Instead, the SP self-guide offers a condensed list of information to help create more authentic representations and to provide consistent feedback during SPCs.

Regarding role-portrayal, the book starts by addressing the character's personality traits. After answering some of the questions, the SPs can check a list of emotions and choose the mood for their consultation. Each emotion provides a small list of non-verbal behaviour and how to act it out in a realistic way. After making all these decisions about their character, it is time to reflect on the patient they are portraying and their illness. This part of the chapter helps to identify and organise the patient's clinical history, symptoms, medications, expectations, and so on. It comes along with a pain rating scale that varies from none to severe pain. This scale constitutes an exceptional tool as, very often, students ask "on a scale from 0 to 10, how would you describe your pain?". It offers SPs the opportunity to reflect on their individual pain but also to compare it with each other, a way of unifying the group's level of representation. At the end, there are also some questions about physical signs and how to effectively simulate them.

After each consultation, there is the feedback phase. In order to provide patient-centred feedback, SPs needs to know by heart several core rules. These rules were shared by the Maastricht team right at the beginning of our course and were implemented at Católica's Medical School. The rules come associated with some principles, which are briefly described in a list of 'dos' and 'don'ts' when providing feedback to the student. It deepens the SPs' understanding on their posture when offering feedback. In addition, when SPs become more experienced, it is common to watch them refer to the same thing over and over again, demonstrating a lack of english vocabulary or, perhaps, creativity. In order to

improve that, the book offers an extensive list of feelings, divided into positive and negative to facilitate their choice. Then, SPs are invited to recall the SPC and put into words how they felt during the consultation and afterwards. The list of questions aims to help SPs identify the reasons why they felt that way by using specific examples. Another important aspect of the feedback phase is the final moment when SPs are allowed to add on to the previous feedback. At first, the SP is only allowed to answer the student's questions but by the end of the feedback phase, if there is time, SPs can provide additional feedback. To do so, the book highlights some important moments of the consultation and provides examples of aspects the SPs could provide feedback on. It is additional information that does not need to be used, but is there to offer additional insights. At last, there is also some information on logistics as well. This last section merely exists to remind SPs on how to re-enter the consultation room and how to react towards the student's questions. It concludes by inviting SPs to forget what they have just experienced and become ready to start a fresh new consultation.

The last part is dedicated to self-reflection, a section that aims to promote self-awareness and behaviour changes. First of all, SPs should practice what is called "de-roling", a moment when they are invited to come back to reality and let go of what they have just experienced. In other other, to detach from the character they were playing. To do so, they must reflect on how they acted their character's personality and their patient's illness. Afterwards, it is important to do a "de-briefing" regarding the feedback phase. This provides an opportunity for SPs to identify the areas that need improvement and establish their personal learning goals for future encounters. For that reason, the last section of the book contains a blank space for personal notes, where they can write down what they learnt and what they want to improve for future SPCs.

3. Design

For a start, I believe it is important to refer that my academic background is in Graphic and Media Design and that I graduated from the London College of Communication in the University of the Arts London. For that reason, I have decided to include in this section some details towards my design decisions. It is important for anyone picking this project to understand that behind every design design choice there is a reason. I have made an

attempt to justify every single one and produce a project that somehow aligns with Católica's Medical School brand identity, as I will further discuss.

First of all, regrading the format, this guide is created as a "pocket book". The decision of adopting these dimensions (9cm x 14cm) aligns with the whole idea of having a small, practical and helpful guide in every SP's "pocket". In that way, SPs have access to a bunch of helpful information at any time of the SPC. If by any reason they don't know how to say or don't remember any detail, this guide will prove to be an essential tool.

Regarding typography and colour, the book presents a neutral but at the same time impactful layout. Católica's Medical School is recognised by its yellow logo, a colour that was adopted throughout the book, specifically to mark each new chapter and subsequent sections. The font chosen is InstrumentSans, a sans-serif geometric font that looks clean and elegant, built from straight lines and simple circles. It conveys a contemporary look as opposed to many medical documents that typical go for a more traditional font like Times New Roman.

This project was designed using Adobe InDesign. The following images (figures 3 to 19) are screenshots taken during planning and development of the book, just before submitting it to printing:

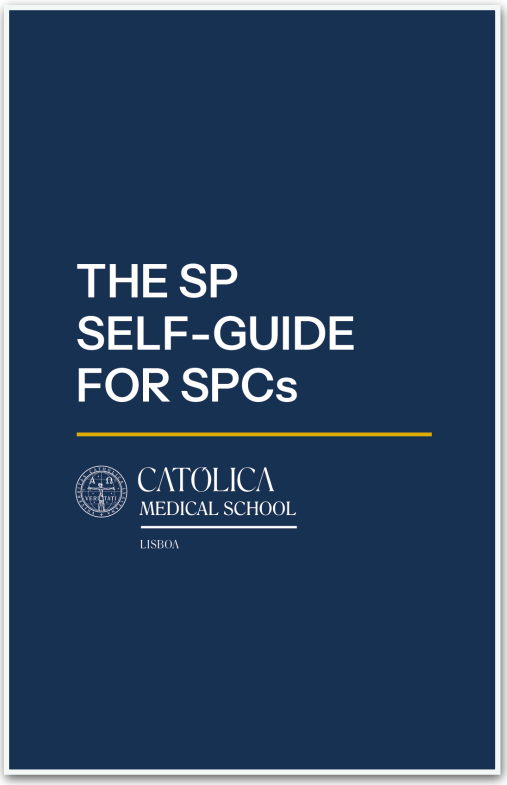


Fig.3 Front book cover

Fig.4 Spread

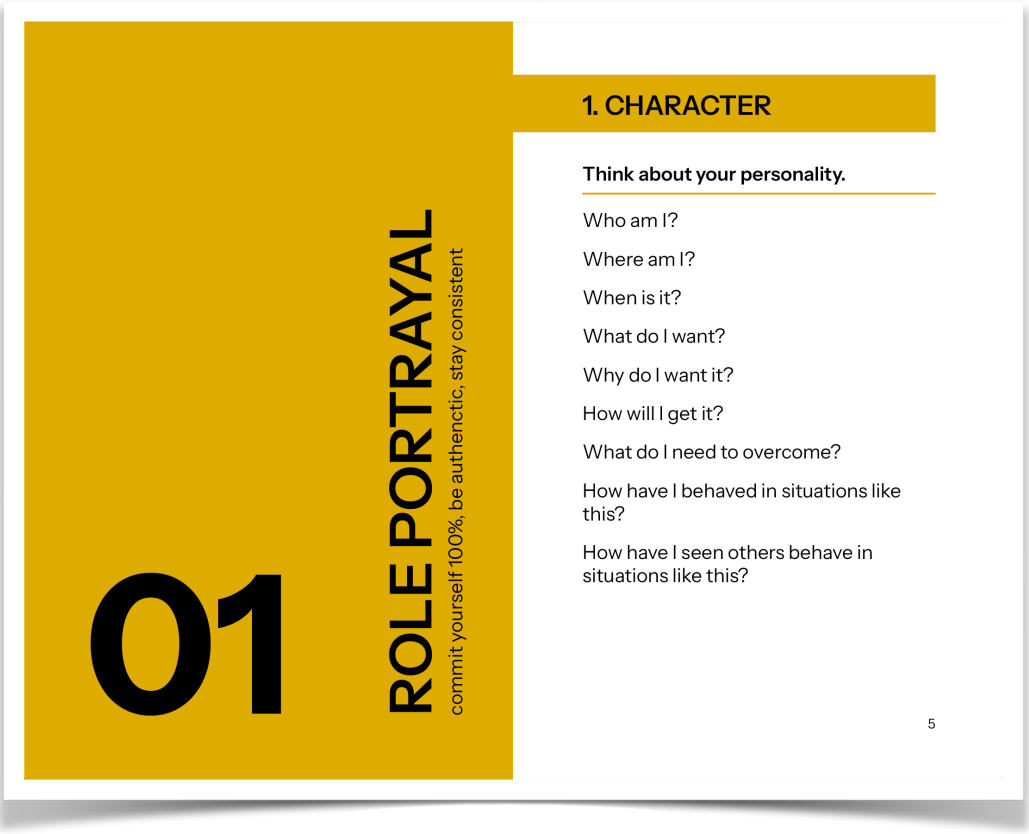


Fig.5 Spread

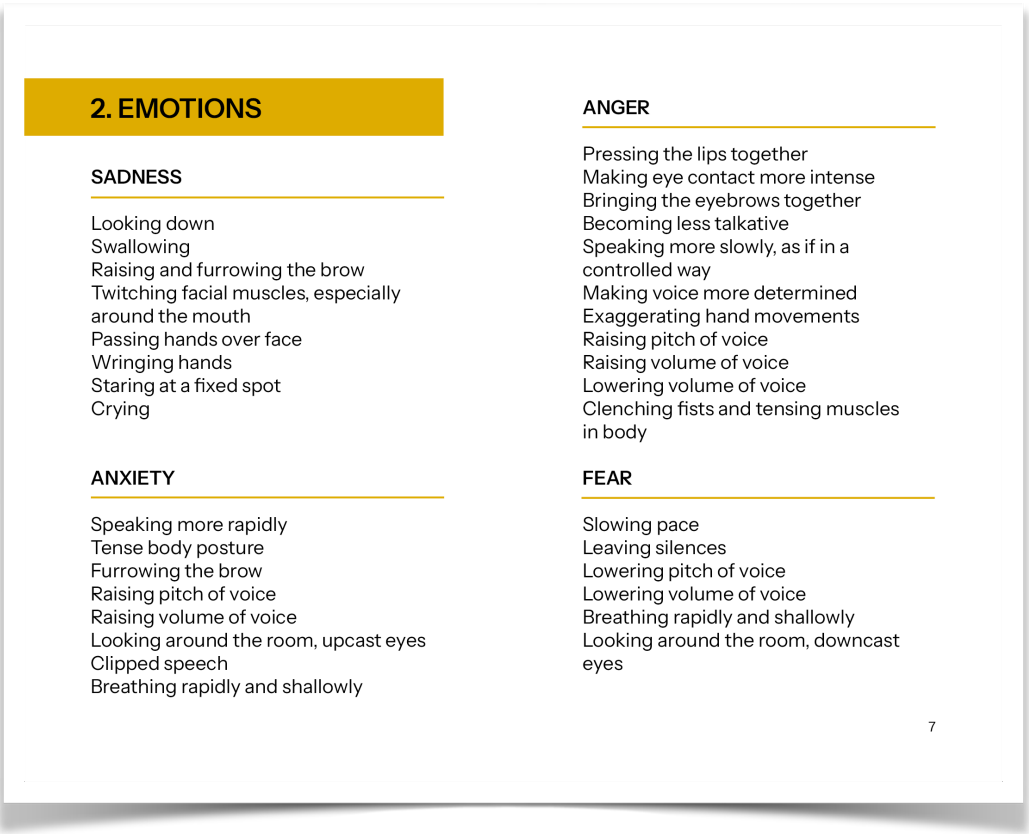


Fig. 6 Spread

SHOCK

Silence
Stillness
Widening the eyes
Furrowing the brow
Breathing heavily

LYING

Looking around the room before answering
Hesitating before speaking
After initial hesitation, speaking very quickly and confidently

RELUCTANCE TO DIVULGE INFORMATION

Looking around the room before answering
Hesitating before speaking
Maintaining hesitation throughout a difficult topic of conversation

3. PATIENT

Think about your ilness.

What are the highlights of my clinical history?

Can I locate it in space and time?

What are my symptoms?

Do I take any medication?

What are my own choices for this patient? (The "fill in by yourself")

What are my expectations for this encounter?

Do I have questions for the doctor?

9

Fig. 7 Spread

4. PHYSICAL SIGNS

Think about your medical condition.

Are there any physical signs that I need to simulate?

Do I need props to help with my physical condition?

How will I enter the consultation room?

11

Fig. 8 Spread

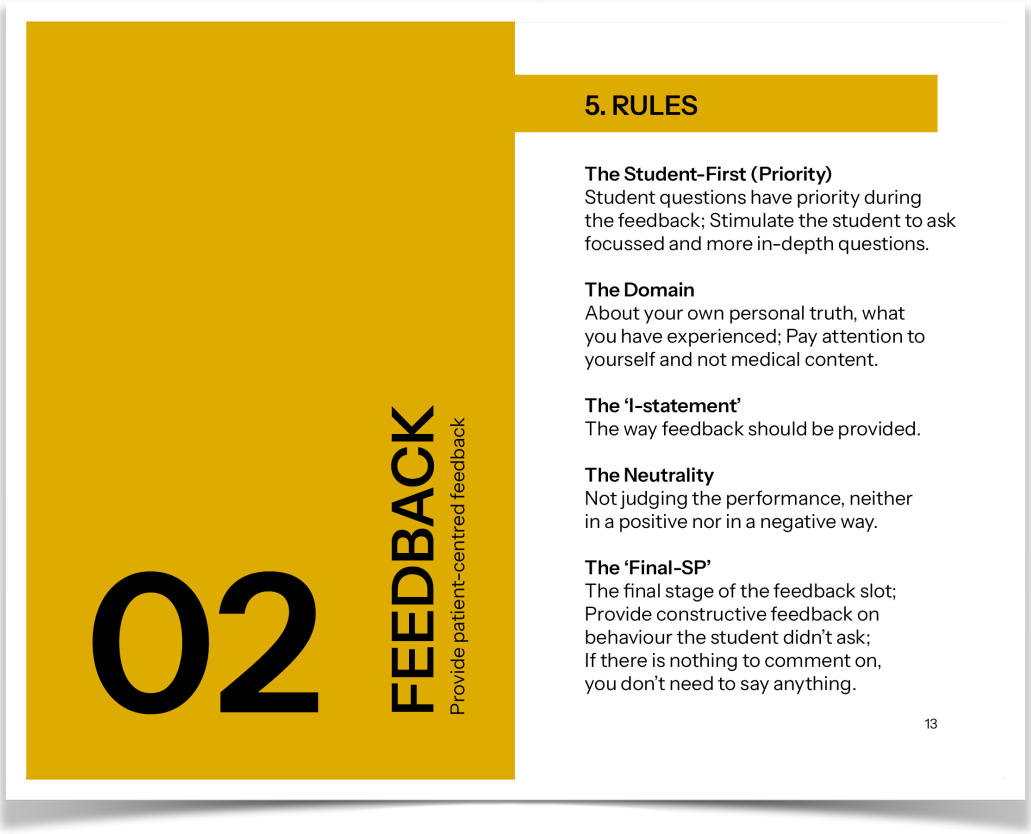


Fig. 9 Spread

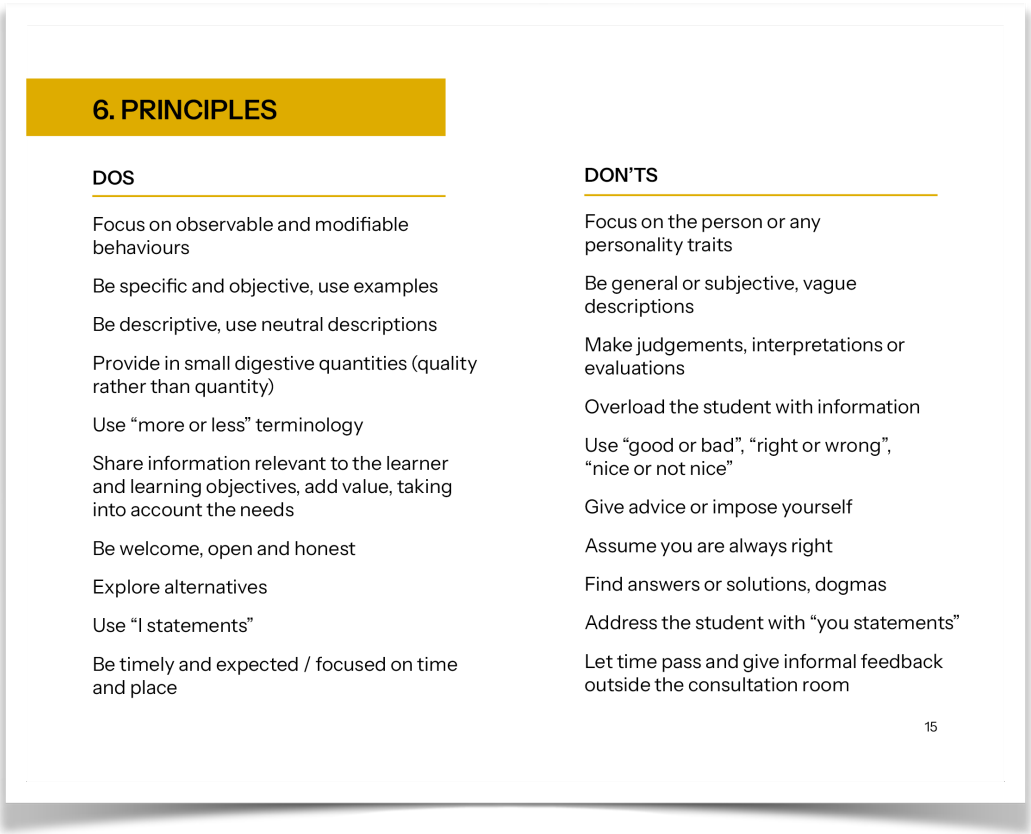


Fig. 10 Spread

7. DESCRIBING FEELINGS

POSITIVE

Acknowledged
Appreciated
At ease
Calm(ed)
Cared for
Cheered
Comfortable
Comforted
Confident
Connected
Cooperative
Considered
Delighted
Encouraged
Engaged
Engrossed
Enthusiastic
Excited
Friendly
Glad
Grateful
Guided
Happy
Heard
Helped
Helpful
Hopeful
Included
Inspired
Intrigued
Listened to
Nutured
Open
Optimistic
Pleased
Reassured
Received
Relaxed
Relieved
Respected
Satisfied
Sensitive
Supported
Surprised
Sympathetic
Touched
Trusting
Understood
Warm

NEGATIVE

Afraid
Agitated
Alienated
Angry
Annoyed
Anxious
Apathetic
Apprehensive
Belittled
Bitter
Concerned
Confused
Cut off
Dehumanised
Dejected
Demeaned
Depressed
Desperate
Disappointed
Discouraged
Dismayed
Distant
Disqualified
Disrespected
Edgy
Embarrassed
Exasperated
Frustrated
Helpless
hostile
Indifferent
Ignored
Impatient
Infuriated
Interrupted
Irate
Irritated
Judged
Lectured to
Livid
Nervous
Oppressed
Outraged
Overruled
Overwhelmed
Patronised
Passive
Peeved
Provoked
Put down
Puzzled
Rushed
Skeptical
Shamed
Talked down to
Tentaive
Terrified
Torn
Troubled
Uncomfortable
Uneasy
Unheard
Unimportant
Unsure
Withdrawn
Worried

17

Fig.11 Spread

8. RECALL THE SPC

After leaving the consulation.

How am I feeling?

How did I feel throughout the encounter?

What did the learner do that led to my satisfaction?

What did the learner do that led to me feeling dissatisfied?

Did I feel listened to?

Did I get the chance to share my ideas?

Was I able to share my concerns?

Was I given a chance to ask questions?

Did I feel comfortable enough to ask questions?

Was I given the opportunity to make specific requirements?

Were my feelings acknowledged?

Did I feel respected?

Was I treated as an individual?

Did I seem important or valued?

Would I see this doctor again?

What would I tell my family/friends about this consultation?

19

Fig. 12 Spread

9. THE 'FINAL-SP'

Examples of additional feedback.
Did the student...?

Commencing the encounter

Greet you? And ask for your name?
State their full name?
Clarify their role?
Attend to your comfort?
Ask for your consent?
State the purpose of the interaction?
Mention note taking?
Clarify the time available?
Assess your ability to communicate?
Demonstrate interest and respect?
Empowered you to ask questions/ seek clarification for anything that was unclear?

Gathering information

Identify your ideas, concerns and expectations?
Survey for other problems?
Set an agenda?
Make interim summaries?

Giving information

Give specific rather than general advice?
Highlight key points?
Check your understanding?

Closing the encounter

Provide an end summary?
Discuss an action plan?
Ask if you had any other worries or concerns?

Relationship-building skills

Use verbal active listening? (e.g. staying with patient's topic; using patient's words; reflection)
Use non-verbal active listening? (e.g. eye contact; nodding)
Use other non-verbal behaviours? (e.g. body posture; gestures; facial expressions)
Probe sensitively?
Make empathic statements?
Show warmth?

21

Fig. 13 Spread

10. LOGISTICS

During feedback phase.

Re-enter the room and sit down in a different position.

Invite the observer to join you at the table.

Start the feedback slot by asking "What would you like to know?"

If you do not know the answer to a question, say that you don't know/ didn't notice.

Repeat the questions the student asks you (and avoid wrong answers).

If it is not clear, ask again "What do you mean?"

Do not hesitate to say what you really experienced.

Before the next SPC.

Why and how am I going to see this doctor?

Let go of what you experienced in the previous encounter.

23

Fig. 14 Spread

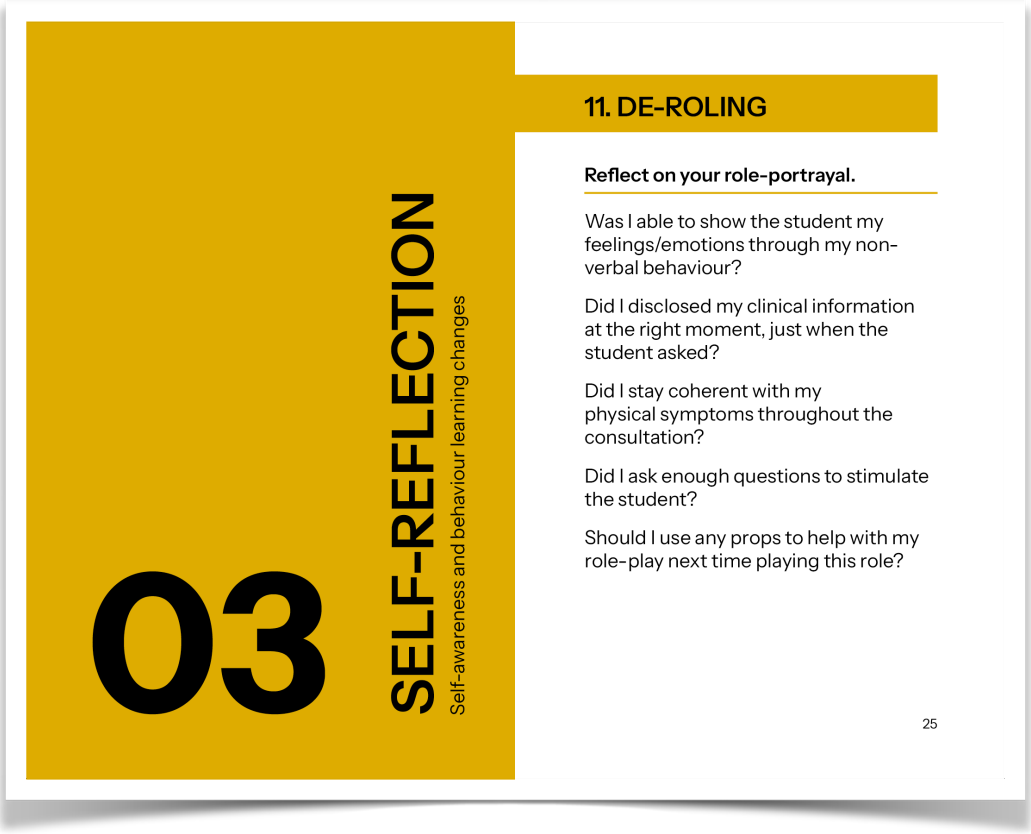


Fig. 15 Spread

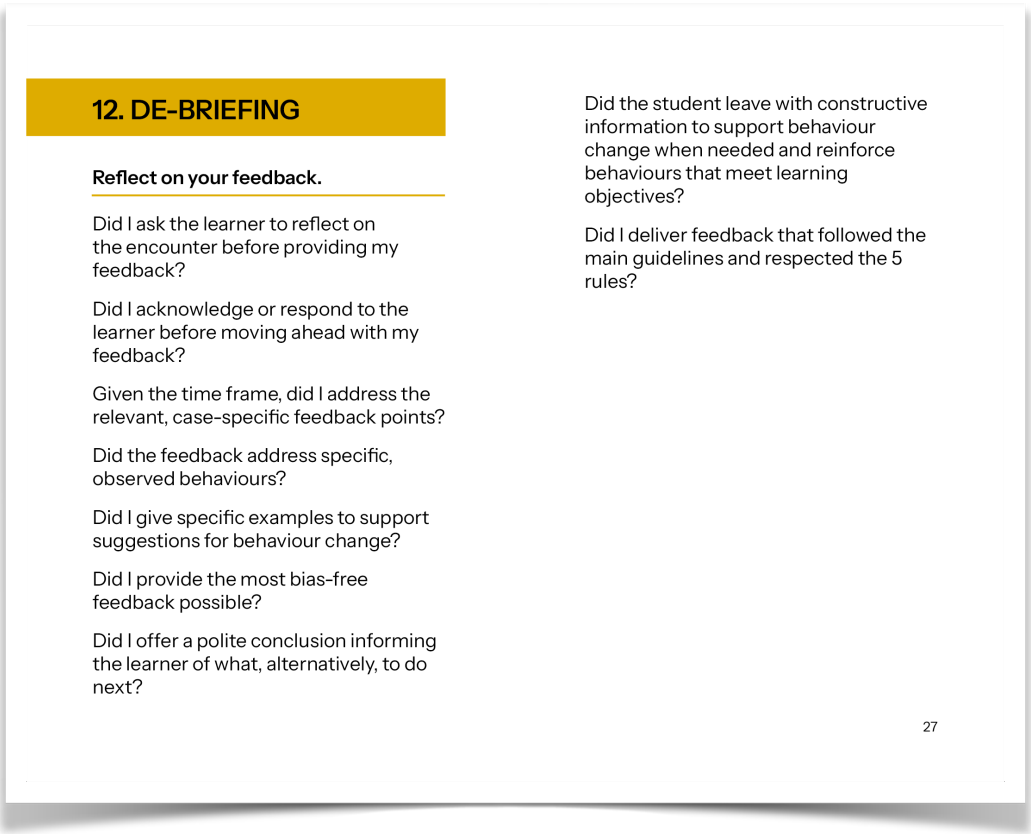


Fig. 16 Spread

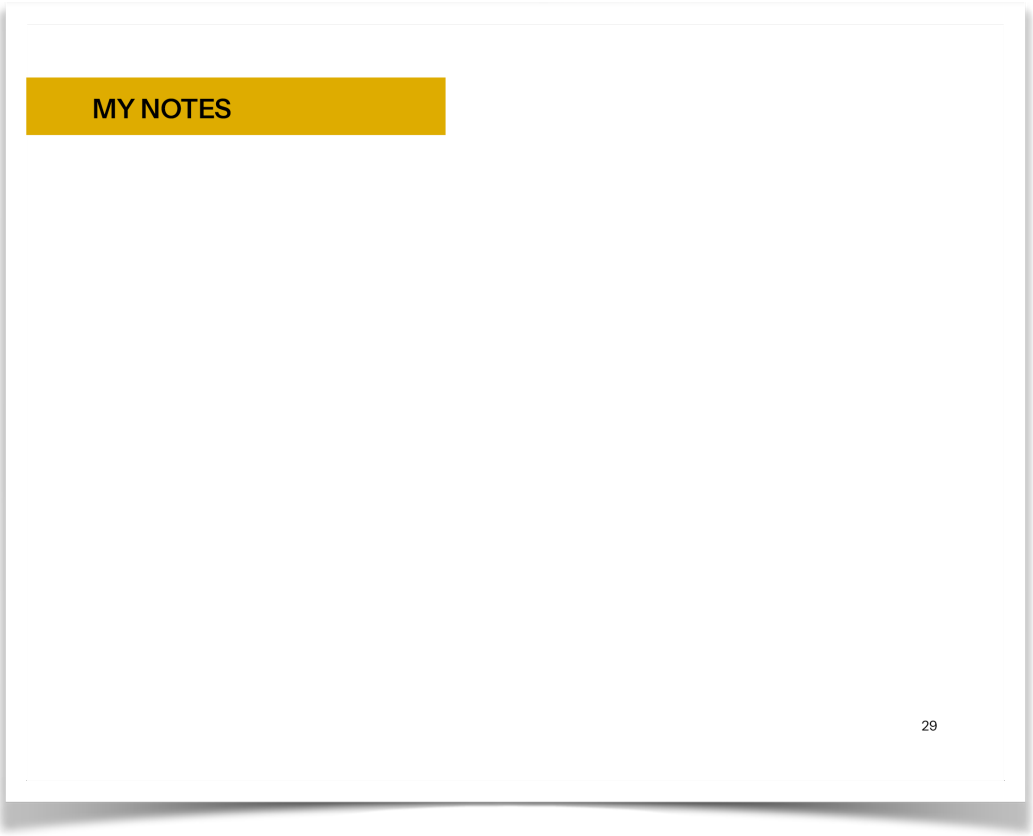


Fig. 17 Spread

Fig. 18 Spread

Fig.19 Back book cover

In terms of prototyping, the main goal was to test the different book covers and get a sense of how it would look like in real life. As such, the following mockup images designed in Adobe Photoshop showcase my development towards the final book cover:

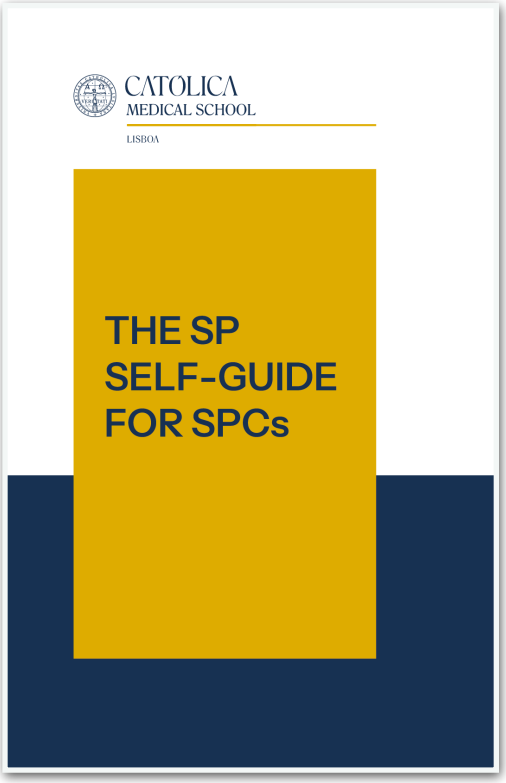


Fig. 20 Cover 1

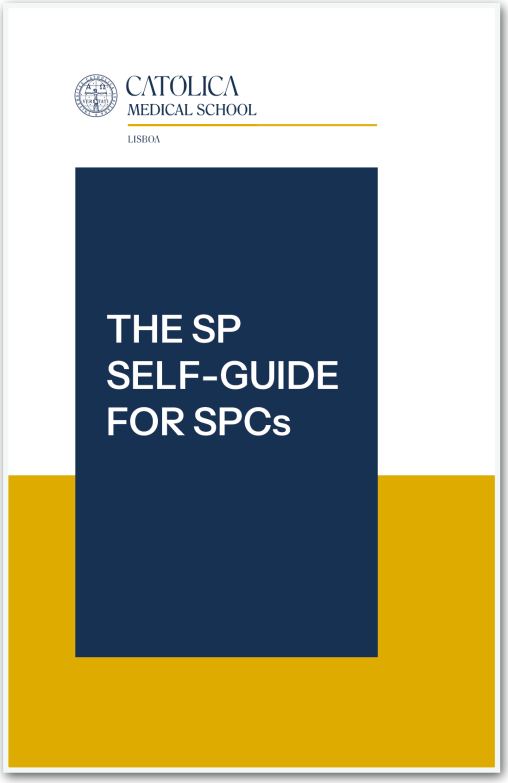


Fig. 21 Cover 2

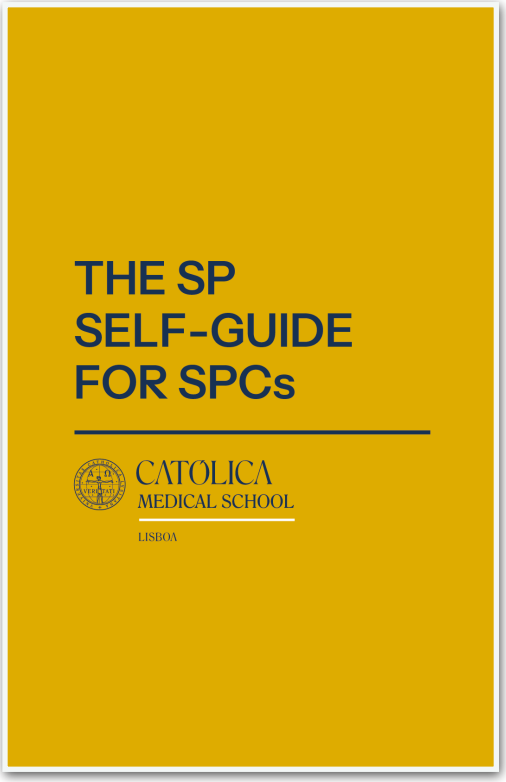


Fig. 22 Cover 3

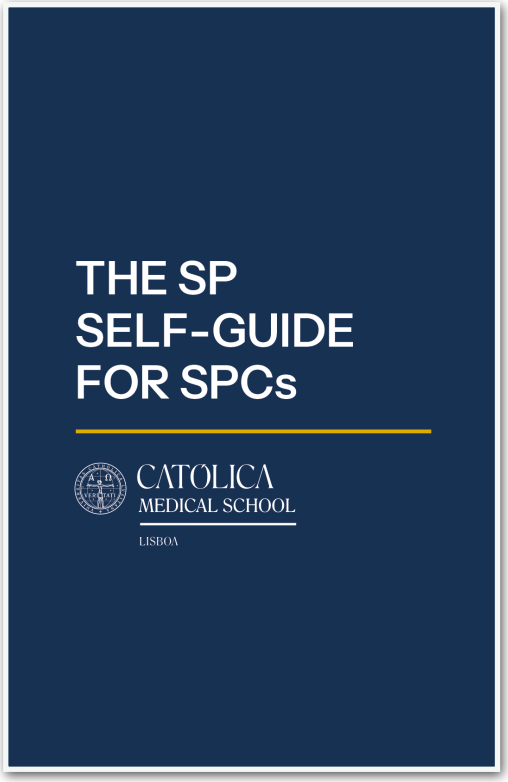


Fig. 23 Cover 4

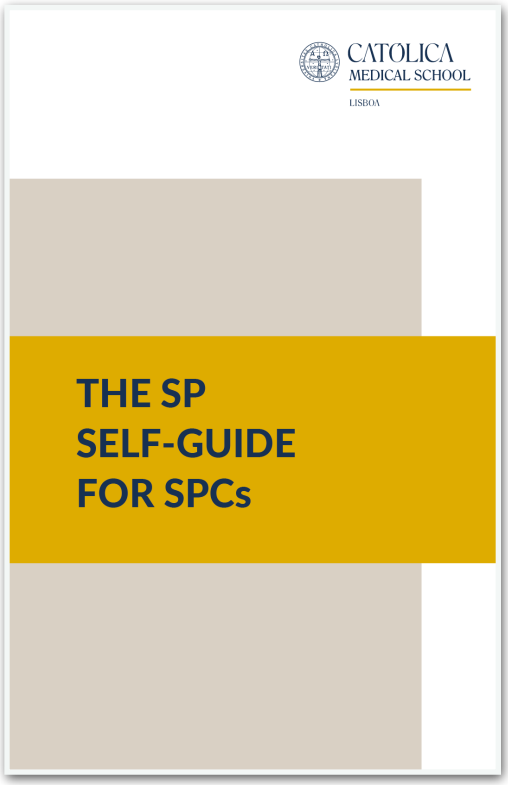


Fig. 24 Cover 5

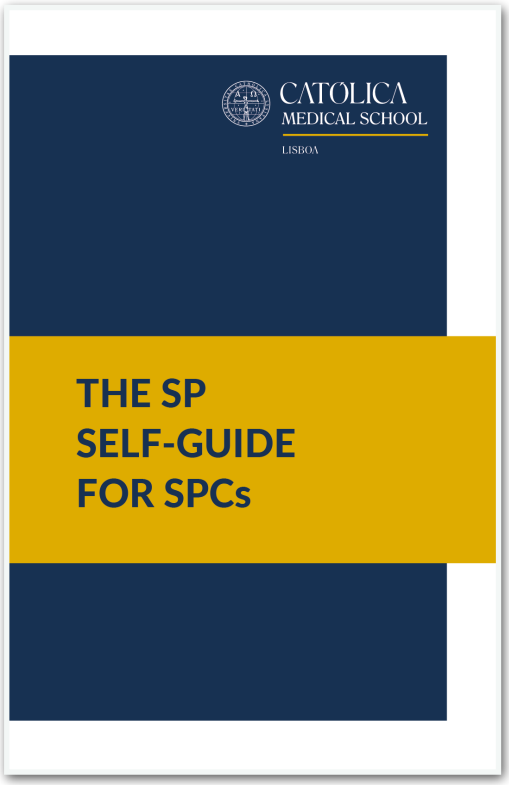


Fig. 25 Cover 6

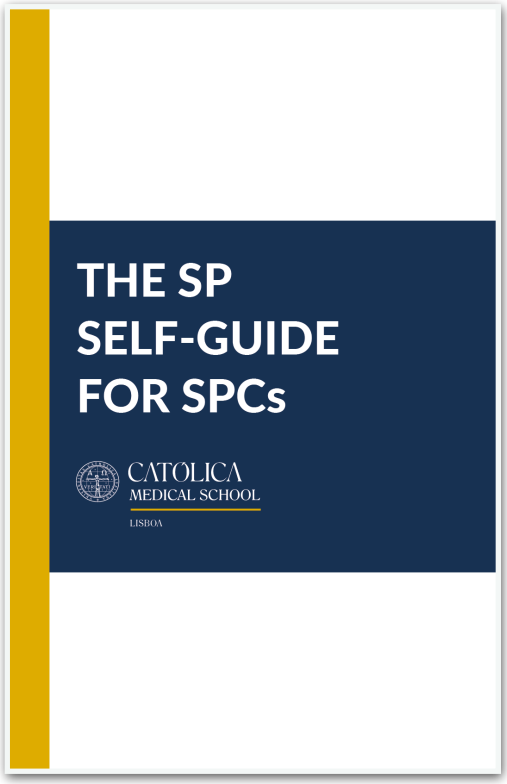


Fig. 26 Cover 7

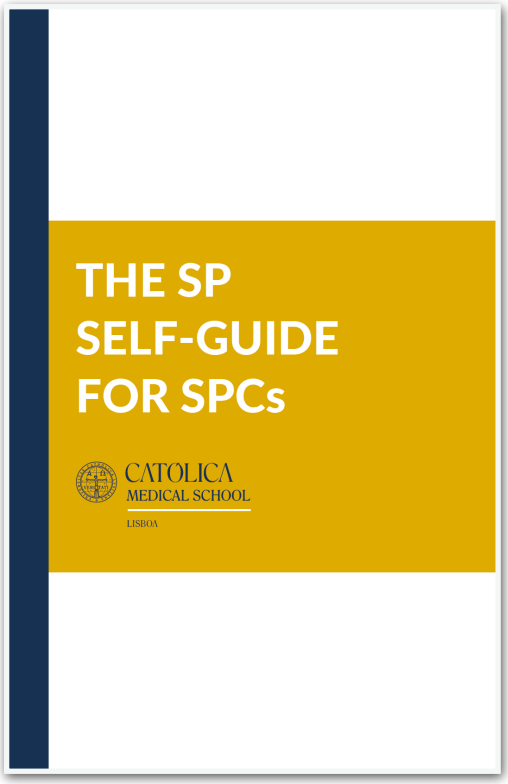


Fig. 27 Cover 8

Fig. 28 Final book cover

4. Implementation and Evaluation

The project is planned to be implemented in September 2024 with the beginning of the new academic year 2024/2025. As such, the evaluation phase will take place in July 2025, after 1 year of utilisation. The main goal will be to analyse the quality and utility of the book and understand if it needs to be further adapted and tailored to the SP's specific needs. Therefore, the evaluation methods will be divided into 3 phases. At first, I will conduct an online quantitative survey where SPs can evaluate the utility of each element presented in the book. The main objective is to understand the level of importance they give to each subject and take notes on how these could be further developed or even excluded. The second phase will benefit from qualitative feedback, when different focus groups of the portuguese SP team will reflect together on their personal experience using the book before, during and after SPCs. The last phase of the evaluation process will be conducted individually, what we call the reflection phase. The goal is to analyse all data

collected during the previous phases and discuss what makes sense to keep and to adapt. Therefore, in a few months, I am planning on redesigning the book and make the necessary changes. A proper evaluation of the project will be based on the experience of 30 SPs using the book throughout the whole academic year, which includes a total amount of 760 SPCs. If my colleagues at Maastricht decide to use this SP self-guide as well, this research study will also benefit from the feedback of 70 SPs from the Netherlands, which includes a total amount of 3500 SPCs. This feedback will be important and unique to collect helpful insights for the implementation of the new SP self-guide for SPCs for the following academic year.

Conclusion

This project is an attempt to find a practical and innovative solution on how to effectively train Simulated Patients (SPs) and at the same time ensuring the quality of their work in undergraduate medical education curriculums. During Simulated Patient Consultations (SPCs), SPs have three main responsibilities: perform a role portrayal of the given scenario, assess the students while performing, and provide feedback at the end of the encounter (Gliva-McConvey et al., 2020a), based on their experience as a patient. These are complex tasks that require a lot of training time with the Simulated Patient Educator (SPE). However, trainings can sometimes be overwhelming for new SPs or, on the other hand, can be not challenging enough for the most experienced ones. As such, this project aims to fill that gap. It is a "pocketbook" containing helpful guidelines for SPs' self-reflection on role portrayal, offering feedback and a guide for self-evaluation. The Simulated Patient Educator (SPE) can conduct multiple trainings and prepare SPs for the SPCs but fostering their individual preparatory training can be a game changer and elevate the quality of the work delivered.

Entitled "The SP self-guide for SPCs", the project follows a design thinking strategy, a human-centred approach to problem solving (Brown, 2019), to better serve SPs during SPCs. It represents an additional instrument to the work of the SPE, grounded on the principle that SP's can achieve higher performances and deliver more consistent feedback if encouraged to self-reflect, and therefore, to become self-aware of their work. This research study seeks to implement an innovative and helpful solution for any organisation that benefits from the contribution of SPs in their medical curriculum, especially Católica's Medical School. The development of the book benefited from various qualitative research methods, which include a review of the literature, document analysis, and participatory observation, aligned with three years of professional experience in the field. Being the final work of a Master's in Communication, this project could not be created without careful design choices. After all, it is a piece of communication in itself that needs to be presented in a thoughtful and organised way.

This Master's project is set on the premise that communication is a core skill in medicine (Deveugele et al., 2005). If effective doctor-patient communication produces better health outcomes, better compliance and elevates the levels of satisfaction for both doctors and patients (Deveugele et al., 2005), it becomes evident that doctors need to develop a range of communication skills. Simultaneously, the introduction of human simulation in medical education not only revolutionised the way medicine is taught (Bleakley & Bligh, 2008) , but it also contributed for the education of these communication skills. Therefore, this project is fundamentally based on a theoretical framework that explores, at first, the importance of communication and simulation in healthcare, touching on key aspects related to the dramatic arts that so importantly inform the SP practice. By cross-referencing all these separate elements it culminates in what we call the SP methodology, used for training communication in medical studies through the use of SPs (Ker et al., 2005). Overall, a well established SP program needs to consider its staff, SPs' recruitment and selection procedures, a choice and maintenance of databases, deal with costs and payments, consider the development of scenarios/cases, security issues, but also the development of a joint SP philosophy (Adamo, 2003; Ker et al., 2005; Nestel et al., 2015c; Tierney et al., 2015). For the success of the SPCs, the development of effective training methods and quality assurance frameworks by the SPE is crucial (Smith et al., 2020a). To ensure reliable results, it is fundamental to consider the logistics and principles for the training processes of SP's role portrayal and offering feedback but also to conduct a regular SP's evaluation and quality control (Smith et al., 2020a). It is important to note that the work of the SPE becomes fundamental during all these stages of the SP program and this project is only useful if these are correctly undertaken. An SP guide serves no one if the SP program does not meet all essential basic requirements.

For further research, I believe it is important to evaluate the success of "The SP self-guide for SPCs". In one year, conducting online surveys and organising focus groups and interviews to discuss the potential gaps is necessary. The Católica's SP bank will provide me feedback on how this book could be adapted and further developed to better serve their needs. It is a project that is far from being completed. Just as the "SP methodology is about learning through the experience of interacting with others" (Bearman et al., 2015, p.149), so does this project. The book needs insights from the experience of SPs interacting with

students, so that it can grow as a tool. At last, I hope this project becomes an essential instrument for SPs, and consequently, helping future doctors to become better professionals. As described by some authors, "there are thousands of healthcare practitioners today who can describe a formative moment in their education, which took place as a consequence of an SP encounter" (Bearman et al., 2015, p.149). This project celebrates this achievement and hopes to contribute for the development of the SP methodology.

On a final note, I agree that "leading SP practitioners will continue to extend the boundaries of SP expertise and practice" (Bearman et al., 2015, p.148). The SP methodology holds an enormous potential as SPs, apart from always having a role in the development of student's basic communication and consultation skills, can also be extended to increasingly advanced practices (Bearman et al., 2015). In a future that is mainly focused on interdisciplinary care along with technological advances, SPs can bring valuable insights from a patient's perspective, which becomes even more important under these circumstances. It is the SPE's job to productively and effectively engage SPs in their work, as they are the ones providing students with exciting opportunities for a richer learning experience (Smith et al., 2020b).

Bibliography

Adamo, G. (2003). Simulated and standardized patients in OSCEs: achievements and challenges 1992-2003. *Medical Teacher*, *25*(3), 262–270. https://doi.org/10.1080/0142159031000100300

Aiello, M. T., Struijk, J. S., Szauter, K., & Nicholas, C. F. (2020). Professional Development of the SP Educator. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 203–219). essay, Springer.

Association of Standardized Patient Educators. (n.d.). *About ASPE*. ASPE Educators. https://www.aspeducators.org/about-aspe

Baerheim, A., & Malterud, K. (1995). Simulated patients for the practical examination of medical students: intentions, procedures and experiences. *Medical Education*, *29*(6), 410–413. https://doi.org/10.1111/j.1365-2923.1995.tb02863.x

Barrows, H. S. (1987). *Simulated (standardized) Patients and Other Human Simulations*. Health Services Consortium.

Barrows, H. S. (1993). An overview of the uses of standardized patients for teaching and evaluating clinical skills. AAMC. *Academic Medicine*, *68*(6), 443–451. https://doi.org/10.1097/00001888-199306000-00002

Barrows, H. S. (1999). *Training Standardized Patients to Have Physical Findings*. Southern Illinois University School of Medicine.

Barrows, H. S., & Abrahamson, S. (1964). THE PROGRAMMED PATIENT: A TECHNIQUE FOR APPRAISING STUDENT PERFORMANCE IN CLINICAL NEUROLOGY. *Journal of Medical Education*, *39*(8), 802–805.

Batenburg, V., & Gerritsma, J. G. (1983). Medical interviewing: initial student problems. *Medical Education*, *17*(4), 235–239. https://doi.org/10.1111/j.1365-2923.1983.tb01456.x

Bearman, M., & Nestel, D. (2015). The future of simulated patient methodology. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 147–149). essay, Wiley Blackwell.

Bleakley, A., & Bligh, J. (2008). Students Learning from Patients: Let's Get Realin Medical Education. *Advances in Health Sciences Education*, *13*(1), 89–107. https://doi.org/10.1007/s10459-006-9028-0

Bokken, L. (2009). *Innovative use of simulated patients for educational purposes*. [Doctoral Thesis, Maastricht University]. Datawyse / Universitaire Pers Maastricht. https://doi.org/10.26481/dis.20090304lb

Bokken, L., Linssen, T., Scherpbier, A., van der Vleuten, C., & Rethans, J.-J. (2009). Feedback by simulated patients in undergraduate medical education: a systematic review of the literature. *Medical Education*, *43*(3), 202–210. https://doi.org/10.1111/j.1365-2923.2008.03268.x

Brannick, M. T., Wahi, M. M., Arce, M., Johnson, H.-A., Nazian, S., & Goldin, S. B. (2009). Comparison of trait and ability measures of emotional intelligence in medical students. *Medical Education*, *43*(11), 1062–1068. https://doi.org/10.1111/j.1365-2923.2009.03430.x

Brown, T. (2019). *Change by Design: How Design Thinking Transforms Organizations and Inspires Innovation*. HarperBusiness, an imprint of HarperCollinsPublishers.

Case, G. A., & Brauner, D. J. (2010). Perspective: The Doctor as Performer: A Proposal for Change Based on a Performance Studies Paradigm. *Academic Medicine*, *85*(1), 159–163. https://doi.org/10.1097/acm.0b013e3181c427eb

Clark, L., Gliva-McConvey, G., & Richards, A. S. (2020). Cultivating Compassionate Communication with Clinical Competence: Utilizing Human Simulation to Provide Constructive Feedback to Learners. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 117–168). essay, Springer.

Cleland, J. A., Abe, K., & Rethans, J.-J. (2009). The use of simulated patients in medical education: AMEE Guide No 42. *Medical Teacher*, *31*(6), 477–486. https://doi.org/10.1080/01421590903002821

Cohen-Tigor, D., & Gliva-McConvey, G. (2020). How a Revolution Took Hold - The Standardized Patient Methodology. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 13–23). essay, Springer.

Collins, J. P., & Harden, R. M. (1998). AMEE Medical Education Guide No. 13: real patients, simulated patients and simulators in clinical examinations. *Medical Teacher*, *20*(6), 508–521. https://doi.org/10.1080/01421599880210

Cranton, P. (2010). Adult Learning and Instruction: Transformative Learning Perspectives. In P. Peterson, E. Baker, & B. McGaw (Eds.), *International Encyclopaedia of Education* (3rd ed., Vol. 1, pp. 18–24). essay, Elsevier.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Sage Publications, Inc.

Creswell, J. W., & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory Into Practice*, *39*(3), 124–130. https://doi.org/10.1207/s15430421tip3903_2

David, L. (2015, June 20). *Constructivism*. Learning Theories. https://learning-theories.com/constructivism.html

Denzin, N. K., Lincoln, Y. S., Giardina, M. D., & Cannella, G. S. (2024). Introduction: The Discipline and Practice of Qualitative Research. In N. K. Denzin, Y. S. Lincoln, M. D. Giardina, & N. K. Denzin (Eds.), *The SAGE Handbook of Qualitative Research* (6th ed., pp. 1–27). introduction, SAGE Publications, Inc.

Deveugele, M., Derese, A., Maesschalck, S. D., Willems, S., Driel, M. V., & Maeseneer, J. D. (2005). Teaching communication skills to medical students, a challenge in the curriculum? *Patient Education and Counseling*, *58*(3), 265–270. https://doi.org/10.1016/j.pec.2005.06.004

Diaz-Navarro, C., Armstrong, R., Charnetski, M., Freeman, K. J., Koh, S., Reedy, G., Smitten, J., Ingrassia, P. L., Matos, F. M., & Issenberg, B. (2024). Global consensus statement on simulation-based practice in healthcare. *Advances in Simulation*, *9*(1), 1–8. https://doi.org/10.1186/s41077-024-00288-1

Dudley, F. (2019). *The Simulated Patient Handbook: A comprehensive guide for facilitators and simulated patients*. CRC Press, Taylor & Francis Group.

Ende, J. (1983). Feedback in Clinical Medical Education. *JAMA: The Journal of the American Medical Association*, *250*(6), 777–781. https://doi.org/10.1001/jama.250.6.777

Fanning, R. M., & Gaba, D. M. (2007). The Role of Debriefing in Simulation-Based Learning. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, *2*(2), 115–125. https://doi.org/10.1097/sih.0b013e3180315539

Furman, G. E., Smee, S., & Wilson, C. (2010). Quality Assurance Best Practices for Simulation-Based Examinations. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, *5*(4), 226–231. https://doi.org/10.1097/sih.0b013e3181da5c93

Gaba, D. M. (2007). The Future Vision of Simulation in Healthcare. *Simulation in Healthcare, 2,* 126–135. https://doi.org/10.1097/01.sih.0000258411.38212.32

Gliva-McConvey, G., & Furman, G. E. (2020a). How to Train SPs in 10 Steps. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 105–116). essay, Springer.

Gliva-McConvey, G., Shannon, G. M., Pitt, J., & Clark, L. (2020b). The Human Simulation Continuum: Integration and Application. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 31–50). essay, Springer.

Haist, S. A., Griffith, C. H., Hoellein, A. R., Talente, G., Montgomery, T., & Wilson, J. F. (2004). Improving students' sexual history inquiry and HIV counseling with an interactive workshop using standardized patients. *Journal of General Internal Medicine*, *19*, 549–553. https://doi.org/10.1111/j.1525-1497.2004.30204.x

Haist, S. A., Wilson, J. F., Pursley, H. G., Jessup, M. L., Gibson, J. S., Kwolek, D. G., Stratton, T. D., & Griffith, C. H. (2003). Domestic violence: increasing knowledge and improving skills with a four-hour workshop using standardized patients. *Academic Medicine*, *78*(10 Supplement), S24–S26. https://doi.org/10.1097/00001888-200310001-00008

Halbach, J. L., & Sullivan, L. L. (2005). Teaching Medical Students About Medical Errors and Patient Safety: Evaluation of a Required Curriculum. *Academic Medicine*, *80*(6), 600–606. https://doi.org/10.1097/00001888-200506000-00016

Harik, P., Clauser, B. E., Grabovsky, I., Nungester, R. J., Swanson, D., & Nandakumar, R. (2009). An Examination of Rater Drift Within a Generalizability Theory Framework. *Journal of Educational Measurement*, *46*(1), 43–58. https://doi.org/10.1111/j.1745-3984.2009.01068.x

Higham, H., & Baxendale, B. (2017). To err is human: use of simulation to enhance training and patient safety in anaesthesia. *BJA: British Journal of Anaesthesia*, *119*(suppl_1), i106–i114. https://doi.org/10.1093/bja/aex302

Howley, Lisa D. (2013). Standardized Patients. In A. I. Levine, S. DeMaria, A. D. Schwartz, & A. J. Sim (Eds.), *The Comprehensive Textbook of Healthcare Simulation* (pp. 173–190). essay, Springer.

Howley, L. D., & Martindale, J. (2004). The Efficacy of Standardized Patient Feedback in Clinical Teaching: A Mixed Methods Analysis. *Medical Education Online*, *9*(1), 4356. https://doi.org/10.3402/meo.v9i.4356

The International Training and Education Center for Health (I-TECH) . (2006). *Training Toolkit - Evaluation - Forms and Questionnaires*. I-TECH Training Toolkit. https://www.go2itech.org/HTML/TT06/toolkit/evaluation/forms.html

Johnson, D. R. (2015). Emotional intelligence as a crucial component to medical education. *International Journal of Medical Education*, *6*, 179–183. https://doi.org/10.5116/ijme.5654.3044

Kachur, E. K., Zabar, S., Hanley, K., Kalet, A., Bruno, J. H., & Gillespie, C. C. (2013). Organizing OSCEs (and Other SP Exercises) in Ten Steps. In S. Zabar, E. K. Kachur, A. Kalet, & K. Hanley (Eds.), *Objective Structured Clinical Examinations: 10 Steps to Planning and Implementing OSCEs and Other Standardized Patient Exercises* (pp. 7–34). essay, Springer.

Ker, J. S., Dowie, A., Dowell, J., Dewar, G., Dent, J. A., Ramsay, J., Benvie, S., Bracher, L., & Jackson, C. (2005). Twelve tips for developing and maintaining a simulated patient bank. *Medical Teacher*, *27*(1), 4–9. https://doi.org/10.1080/01421590400004882

Kolb, D. A. (2015). *Experiential Learning: Experience As The Source Of Learning And Development* (2nd ed.). Pearson Education Inc.

Kurtz, S., Silverman, J., & Draper, J. (2004). *Teaching and Learning Communication Skills in Medicine* (2nd ed.). CRC Press.

Lehner, G. P. J. (1975). *Aids for Giving and Receiving Feedback*. University Associates Publishers, Inc. https://srs-slp.healthsci.mcmaster.ca/wp-content/uploads/2022/08/aids-for-giving-receiving-feedback.pdf

Levenkron, J. C., Greenland, P., & Bowley, N. (1987). Using patient instructors to teach behavioral counseling skills. *Academic Medicine*, *62*(8), 665–672. https://doi.org/10.1097/00001888-198708000-00007

Lewis, K. L., Bohnert, C. A., Gammon, W. L., Hölzer, H., Lyman, L., Smith, C., Thompson, T. M., Wallace, A., & Gliva-McConvey, G. (2017). The Association of Standardized Patient Educators (ASPE) Standards of Best Practice (SOBP). *Advances in Simulation*, *2*(1). https://doi.org/10.1186/s41077-017-0043-4

Lioce, L. (Ed.). (2020). Healthcare Simulation Dictionary (2nd ed.). Agency for Healthcare Research and Quality . 2024, https://www.ssih.org/Portals/48/v2_1-Final.pdf

Madan, A. K., Caruso, B. A., Lopes, J. E., & Gracely, E. J. (1998). Comparison of simulated patient and didactic methods of teaching HIV risk assessment to medical residents. *American Journal of Preventive Medicine*, *15*(2), 114–119. https://doi.org/10.1016/s0749-3797(98)00026-9

Masters, K. (2013). Edgar Dale's Pyramid of Learning in medical education: A literature review. *Medical Teacher*, *35*(11), e1584–e1593. https://doi.org/10.3109/0142159x.2013.800636

Nestel, D., & Bearman, M. (2015a). Introduction to simulated patient methodology. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 1–4). introduction, Wiley Blackwell.

Nestel, D., Bearman, M., & Fleishman, C. (2015b). Simulated patients as teachers: the role of feedback. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence, and Practice* (1st ed., pp. 71–78). essay, Wiley Blackwell.

Nestel, D., Fleishman, C., & Bearman, M. (2015c). Preparation: developing scenarios and training for Role Portrayal. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 63–70). essay, Wiley Blackwell.

Nestel, D., Morrison, T., & Pritchard, S. (2015d). Scope of contemporary simulated patient methodology. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 7–15). essay, Wiley Blackwell.

Nestel, D., Rethans, J.-J., & Gliva-McConvey, G. A. (2015e). Communities of practice and simulated patient methodology . In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 23–30). essay, Wiley Blackwell.

Nestel, D., & Kneebone, R. (2010). Perspective: Authentic Patient Perspectives in Simulations for Procedural and Surgical Skills. *Academic Medicine*, *85*(5), 889–893. https://doi.org/10.1097/acm.0b013e3181d749ac

Nestel, D., Tierney, T., & Kubacki, A. (2008). Creating authentic simulated patient roles: working with volunteers. *Medical Education*, *42*(11), 1122–1122. https://doi.org/10.1111/j.1365-2923.2008.03196.x

Nicol, D. J., & Macfarlane-Dick, D. (2006). Formative assessment and self-regulated learning: a model and seven principles of good feedback practice. *Studies in Higher Education*, *31*(2), 199–218. https://doi.org/10.1080/03075070600572090

Punch, K. (2005). *Introduction to Social Research: Quantitative and Qualitative Approaches* (2nd ed.). Sage Publications Ltd.

Sanko, J. S., Shekhter, I., Kyle, R. R., Di Benedetto, S., & Birnbach, D. J. (2013). Establishing a Convention for Acting in Healthcare Simulation. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, *8*(4), 215–220. https://doi.org/10.1097/sih.0b013e318293b814

Schweickerdt-Alker, L. (2014). Revitalising the SP through authentication: The authentic portrayal. *Medical Teacher*, *36*(6), 541–543. https://doi.org/10.3109/0142159x.2014.887832

Simpson, M., Buckman, R., Stewart, M., Maguire, P., Lipkin, M., Novack, D., & Till, J. (1991). Doctor-patient communication: the Toronto consensus statement. *BMJ*, *303*(6814), 1385–1387. https://doi.org/10.1136/bmj.303.6814.1385

Smith, C. M., Edlington, T. L., Lawton, R., & Nestel, D. (2015a). The dramatic arts and simulated patient methodology. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 39–45). essay, Wiley Blackwell.

Smith, C. M., O'Byrne, C. C., & Nestel, D. (2015b). Simulated patient methodology and assessment. In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 85–92). essay, Wiley Blackwell.

Smith, C. M., Gliva-McConvey, G., & Chapin, A. (2020a). Training SPs for Authentic Role Portrayal. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 73–104). essay, Springer.

Smith, C. M., & Gliva-McConvey, G. (2020b). Misconceptions and the Evidence. In G. Gliva-McConvey, C. F. Nicholas, & L. Clark (Eds.), *Comprehensive Healthcare Simulation: Implementing Best Practices in Standardized Patient Methodology* (pp. 293–300). essay, Springer.

Stanislavski, C. (1956). *My Life in Art* (J. J. Robbins, Trans.). Meridian Books.

Stillman, P L. (1993). Technical issues: logistics. *Academic Medicine*, *68*(6), 464–468. https://doi.org/10.1097/00001888-199306000-00004

Stillman, P. L., Sabers, D. L., & Redfield, D. L. (1976). The use of paraprofessionals to teach interviewing skills. *Pediatrics*, *57*(5), 769–774. https://doi.org/10.1542/peds.57.5.769

Tamblyn, R. M., Klass, D. K., Schanbl, G. K., & Kopelow, M. L. (1990). Factors associated with the accuracy of standardized patient presentation. *Academic Medicine*, *65*(9), S55–S56. https://doi.org/10.1097/00001888-199009000-00042

Tierney, T., Gill, E. E., & Harvey, P. J. (2015). Simulated patient programme management . In D. Nestel & M. Bearman (Eds.), *Simulated Patient Methodology: Theory, Evidence and Practice* (1st ed., pp. 93–101). essay, Wiley Blackwell.

Van De Ridder, J. M., Stokking, K. M., McGaghie, W. C., & Ten Cate, O. T. (2008). What is feedback in clinical education? *Medical Education*, *42*(2), 189–197. https://doi.org/10.1111/j.1365-2923.2007.02973.x

Wallace, P. (2007). *Coaching Standardized Patients: For Use in the Assessment of Clinical Competence*. Springer Publishing Company.

Whitehouse, C., Morris, P., & Marks, B. (1984). The role of actors in teaching communication. *Medical Education*, *18*(4), 262–268. https://doi.org/10.1111/j.1365-2923.1984.tb01021.x

Wind, L. A., Dalen, J. V., Muijtjens, A. M., & Rethans, J.-J. (2004). Assessing simulated patients in an educational setting: the MaSP (Maastricht Assessment of Simulated Patients). *Medical Education*, *38*(1), 39–44. https://doi.org/10.1111/j.1365-2923.2004.01686.x

Annexe A

A list of mood indicators (Dudley, 2019, p.211-212)

Distress and Sadness

Looking down

Swallowing

Raising and furrowing the brow

Twitching facial muscles, especially around the mouth

Passing hands over face

Wringing hands

Staring at a fixed spot

Crying (this should come as a result of feeling the characters emotions; however, if that is not happening, sometimes trying not to blink can make the eyes water).

Anger

Pressing the lips together

Making eye contact more intense

Bringing the eyebrows together

Becoming less talkative

Making voice more determined

Clenching fists and tensing muscles in body

Speaking more slowly, as if in a controlled way

Exaggerating hand movements

Raising pitch of voice

Raising volume of voice

Lowering volume of voice

Anxiety

Speaking more rapidly

Tense body posture

Furrowing the brow

Raising pitch of voice

Raising volume of voice

Looking around the room, upcast eyes

Clipped speech

Breathing rapidly and shallowly

Fear

Slowing pace

Leaving silences

Lowering pitch of voice

Lowering volume of voice

Looking around the room, downcast eyes

Breathing rapidly and shallowly

Shock

Silence

Stillness

Widening the eyes

Furrowing the brow

Breathing heavily

Lying

Looking around the room before answering

Hesitating before speaking

After initial hesitation, speaking very quickly and confidently.

Reluctance to divulge information

Looking around the room before answering

Hesitating before speaking

Maintaining hesitation throughout a difficult topic of conversation.

Annexe B

Sample list of feelings and emotions (Clark et al., 2020, p.151)

Positive Feelings

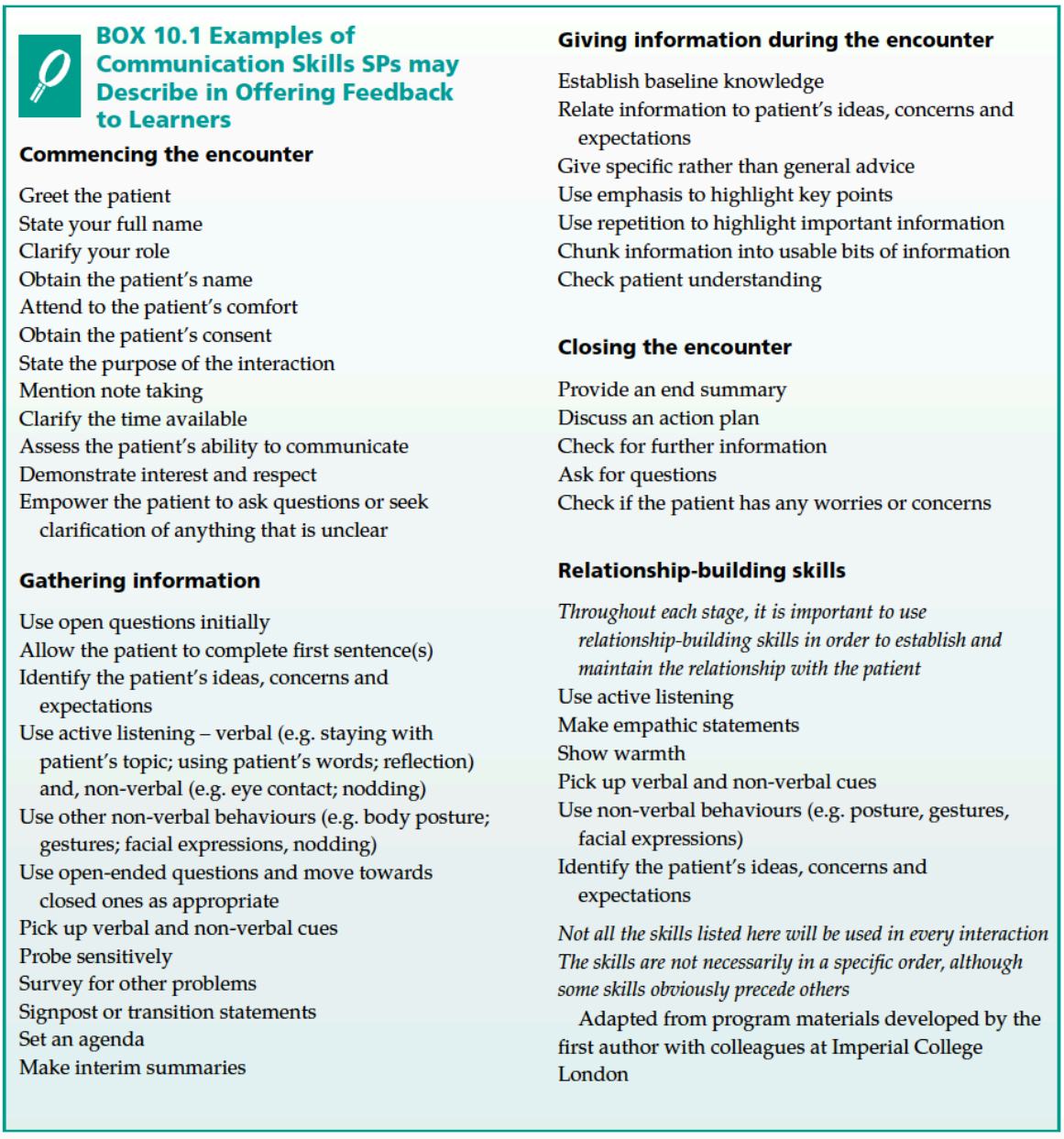
Acknowledged	Appreciated	At Ease
Calm(ed)	Cared for	Cheered
Comfortable	Comforted	Confident
Connected	Delighted	Encouraged
Engaged	Engrossed	Enthusiastic
Excited	Friendly	Glad
Grateful	Guided	Happy
Helped	Helpful	Hopeful
Inspired	Intrigued	Nurtured
Open	Pleased	Reassured
Received	Relaxed	Relieved
Respected	Satisfied	Sensitive
Supported	Surprised	Sympathetic
Touched	Trusting	Understood
Warm		

Negative Feelings

Afraid	Agitated	Alienated
Angry	Annoyed	Anxious
Apathetic	Apprehensive	Belittled
Bitter	Concerned	Confused
Cut off	Dehumanized	Dejected
Demeaned	Desperate	Discouraged
Dismayed	Distant	Disqualified
Disrespected	Edgy	Embarrassed
Exasperated	Frustrated	Helpless hostile
Indifferent	Ignored	Impatient
Infuriated	Interrupted	Irate
Irritated	Judged	Livid
Nervous	Outraged	Overwhelmed
Patronized	Passive	Peeved
Provoked	Put down	Puzzled
Rushed	Skeptical	Shamed
Tentative	Terrified	Torn
Troubled	Uncomfortable	Uneasy
Unsure	Withdrawn	Worried

Annexe C

Examples of communication skills SPs may describe in offering feedback to learners (Nestel et al., 2015b, p.73)



BOX 10.1 Examples of Communication Skills SPs may Describe in Offering Feedback to Learners

Commencing the encounter

Greet the patient
State your full name
Clarify your role
Obtain the patient's name
Attend to the patient's comfort
Obtain the patient's consent
State the purpose of the interaction
Mention note taking
Clarify the time available
Assess the patient's ability to communicate
Demonstrate interest and respect
Empower the patient to ask questions or seek clarification of anything that is unclear

Gathering information

Use open questions initially
Allow the patient to complete first sentence(s)
Identify the patient's ideas, concerns and expectations
Use active listening – verbal (e.g. staying with patient's topic; using patient's words; reflection) and, non-verbal (e.g. eye contact; nodding)
Use other non-verbal behaviours (e.g. body posture; gestures; facial expressions, nodding)
Use open-ended questions and move towards closed ones as appropriate
Pick up verbal and non-verbal cues
Probe sensitively
Survey for other problems
Signpost or transition statements
Set an agenda
Make interim summaries

Giving information during the encounter

Establish baseline knowledge
Relate information to patient's ideas, concerns and expectations
Give specific rather than general advice
Use emphasis to highlight key points
Use repetition to highlight important information
Chunk information into usable bits of information
Check patient understanding

Closing the encounter

Provide an end summary
Discuss an action plan
Check for further information
Ask for questions
Check if the patient has any worries or concerns

Relationship-building skills

Throughout each stage, it is important to use relationship-building skills in order to establish and maintain the relationship with the patient
Use active listening
Make empathic statements
Show warmth
Pick up verbal and non-verbal cues
Use non-verbal behaviours (e.g. posture, gestures, facial expressions)
Identify the patient's ideas, concerns and expectations

Not all the skills listed here will be used in every interaction The skills are not necessarily in a specific order, although some skills obviously precede others

Adapted from program materials developed by the first author with colleagues at Imperial College London

Annexe D

Trainer Attributes: Competence Self-Assessment form

Trainer Attributes:
Competencies Self-Assessment

Trainer Attributes "I":	I have strength in this area √	How I will build strength in this area
○ am confident and fully prepared—just nervous enough to keep alert.		
○ know my subject matter—have studied my topic and experienced the events about which I speak.		
○ know my audience—respect and listen to participants, call them by name, whenever possible.		
○ am neutral and non-judgmental—validate everyone's experiences and their right to their own perspectives; respect differences of opinion and lifestyle.		
○ am culturally sensitive—aware that my own views and beliefs are shaped by my cultural background just as participants' cultures shape their perspectives.		
○ am self-aware—recognize my own biases and "hot-buttons" and act in a professional manner when they are pushed.		
○ am inclusive—encourage all participants to share their experiences and contribute to the group learning process.		
○ am lively, enthusiastic, and original. I use humor, contrasts, metaphors, and suspense; I keep my listeners interested and challenge their thinking.		
○ use a variety of vocal qualities. —vary my pitch, speaking rate, and volume; avoid talking in a monotone.		
○ am aware of my body when presenting—body posture, gestures, and facial expressions are natural and meaningful, reinforcing my subject matter.		
○ make my remarks clear and easy to remember—present one idea at a time and show relationships between ideas; summarize when necessary.		

○ enhance my delivery with illustrations—examples, charts, visuals, and audio aids.		
○ understand group dynamics—the stages all groups go through; am comfortable with conflict resolution.		
○ am flexible—read and interpret my participants' responses (verbal and nonverbal) and adapt my plans to meet their needs; am in charge without being overly controlling.		
○ am open to new ideas and perspectives—am aware that I don't know all the answers; recognize that I learn from participants as well as offer them new knowledge or perspectives.		
○ am compassionate—understand that much of the material may have an emotional impact on participants; am empathetic and understanding when participants' experience emotional reactions to training.		
○ am interested in evaluating my work—encourage co-trainers and participants to give me feedback.		

Adapted from Trainers Guide to Cancer Education, National Cancer Institute

Annexe E

Trainer's Skills: Competencies Checklist

I-TECH
INTERNATIONAL TRAINING & EDUCATION CENTER ON HIV

Trainer's Skills: Competencies Checklist

Trainer/Speaker: _____ Facilitator: _____ Date: _____

Evaluator: _____ Topic: _____

Please summarize trainer's demonstrated knowledge/skills using the rating system below:

1. Trainer shows strength in this area
2. Trainer demonstrates some ability in this area
3. Trainer needs additional support in this area

Delivery — the trainer:	**Rating**	**Body Language** — the trainer:	**Rating**
○ greeted the audience warmly.		○ maintained good eye contact with the audience.	
○ used a voice loud and clear enough to hear easily.		○ was friendly and smiled.	
○ delivered a talk designed in a logical way from beginning to middle and end,		○ used body language to help communicate ideas visually	
○ clearly described what to expect from the presentation.		**Audience Participation** — the trainer:	
○ used effective examples and illustrations.		○ involved the audience.	
○ defined unfamiliar technical terms.		○ handled questions and comments with calm courtesy.	
○ summarized the main points before finishing.		○ broke up lectures/discussion at appropriate points.	
Visual Aids — the trainer:		○ provided clear instructions for all activities.	
○ used visual aids.		○ clarified or rephrased questions to elicit audience participation.	
○ made sure materials could be read easily from where I was sitting.		**Technical Competency** — the trainer:	
○ got the point across in a clear and simple way.		○ taught technically accurate content.	
○ did not block the screen or flipchart.		○ answered technical questions from the audience.	
○ talked to the audience rather than to the screen or flipchart.		○ gauged audience level of technical knowledge and adjusted the presentation accordingly.	
○ used key words rather than sentences		○ accurately broke down technical/complex concepts in a way participants could understand.	

Please use the space below to specify:
Specific topics where the trainer lacks technical knowledge/expertise:
Ways the trainer might connect better with and engage the audience; be more inclusive:
Use materials more efficiently:
Use a clearer, more organized approach:
Use visual aids that better educate his or audience: