Chapter 9
The Role of Patients in Surgical Education

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9.1 Introduction

The key ideas in this chapter have historical precedence, since the centrality of patients in education has long been recognised. Osler wrote at the beginning of last century, "For the junior student in medicine and surgery it is a safe rule to have no teaching without a patient for the text, and the best teaching is that taught by the patient himself" (Bliss 1999). We use the term *patient* to describe individuals who are in or have recently completed an episode of treatment. *Simulated patients* (SPs) are individuals trained to portray real patients. The term, *standardised patient* is widely used in Canada and the United States (US) probably reflecting the prevalence of SPs in high-stakes assessments of clinicians where there is a need for repetitions of 'standardised' performance (Wallace 2007). However, we adopt the term 'simulated patient' reflecting the more generic role. Here *trainee* refers to medical students, surgical residents or trainees. *Medical education* includes all under- and post-graduate training while *surgical education* refers to teaching and learning on surgical rotations (undergraduate or residency) or in specialist surgical training. We do not draw a distinction between education and training. Surgical examples are provided where they exist; otherwise we draw on illustrations from other areas of clinical practice. We frequently take a United Kingdom (UK) perspective, as below.

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9.2 The Role of Patients in Healthcare Services

Since its inception over 60 years ago, the UK National Health Service (NHS) has undergone significant changes. Current policy documents place the patient at centre stage in the NHS (Darzi 2008). Patients may be involved as informant, consultant or partner in drafting strategic healthcare service policy, in service development and at the level of individual care (NHS Modernisation Agency 2005). There is a legal responsibility for NHS Trusts, Primary Care Trusts and Strategic Health Authorities to involve and consult patients and the public in proposals for change. There has also been a shift away from simply seeking the views of patients (as expert advisor) to maintaining their involvement across the life of projects (as partners; NHS Modernisation Agency 2005; Coulter 1999).

Professional medical standards have come under scrutiny with high-profile cases of poorly performing and unethical clinical practice of doctors. The Kennedy Report on high mortality rates in a paediatric surgical unit makes several recommendations for embedding patient and public involvement in the NHS. Healthcare service organisations must make efforts to systematically obtain feedback from patients and professional organisations and must involve the public in their decision-making processes about education and training (Kennedy 2001).

Professional associations and licensing bodies increasingly promote active roles for patients and the public. The specialist Medical Royal Colleges acknowledge the importance of patient involvement in education and professional issues via 'patient liaison representatives'. These are lay members of Patient Liaison Groups (PLGs) who bring patients' perspectives to college issues. Lay members of the PLG at the Royal College of Surgeons England (RCSE) are volunteers, most are either patients or carers, are not medically qualified, do not represent any organisation and their views are their own as individuals, independent of the college. Terms of reference outline their scope of practice and a maximum term of office.

Broader societal changes have also influenced the role of patients in education. This includes changes in which healthcare is viewed as a commodity with patients as consumers. The NHS Plan (2000) describes a service that is organised around the needs and concerns of patients and not around the convenience of providers (Department of Health 2000). Patients' charters have been published since the early 1990s and set out patients' responsibilities. However, those we examined do not mention involvement in education. In contrast to the early writings on the NHS, patient involvement is no longer assumed but invited with many schemes supporting active patient involvement.

9.3 Changes in Medical and Surgical Training

Influential reports on medical education over the last century reveal a shift in perspective away from passive and relatively powerless patient involvement that reflected strong hierarchical structures in clinical settings (Calman 2007). Educational

policy documents have also adopted comparable language about patient (and public) involvement to those in service policy documents. Despite contemporary examples of patient involvement in education, much can still be done to increase contributions and ensure their perspectives are routinely considered.

The landscape in which surgical training occurs is constantly changing (see Chap. 1). Increased clinical throughput, specialisation and the number of seriously ill patients all influence the capacity for training (Kneebone and Nestel 2010). Concerns have been expressed about insufficient exposure to patients for trainees. Restricted working hours are having powerful effects on traditional patterns of learning (Reznick and MacRae 2006; Aggarwal 2006). Long but relatively unstructured apprenticeships are no longer feasible. In response, new surgical curricula have been introduced. New educational methods have permeated all levels of training, such as workplace-based assessments and simulation although the latter is limited by accessibility (see also Chap. 3). The focus of healthcare delivery is shifting away from individual clinicians towards clinical teams, and workforce structure and functions (Williams et al. 2007). This team-based but potentially fragmentary approach to care may profoundly impact patients' experiences. Clinicians may not always be aware of this effect as they grapple with the implications for their own role. More than ever, effective communication with patients, their relatives and colleagues is essential for safe clinical practice. This is an opportunity for genuine engagement of patients in all phases of education from planning to evaluation.

In the UK and Ireland, the Joint Committee on Surgical Training (www.jcst.org) has collaborated with the four Surgical Royal Colleges, the specialist associations and the nine Specialty Advisory Committees to produce the Intercollegiate Surgical Curriculum Programme (www.iscp.ac.uk) for post-graduate surgical education and training. The curriculum defines stages in the development of competent surgical practice to consultant level with each stage underpinned by explicit outcome standards. Common and specialty-specific surgical skills are described together with generic professional skills. The curriculum is mapped to the Good Medical Practice Framework of the General Medical Council of the UK and draws strongly upon the CanMEDS roles (Frank 2005). Skills and behaviours associated with the role of surgeon as 'communicator' are specified in Table 9.1.

9.4 Patients' Experiences of Healthcare Services

Capturing patient perspectives on healthcare experiences can provide a deep understanding of what constitutes quality care. This includes individual interactions with surgeons and the ways these encounters fit within the patients' overall experiences of healthcare. Patients are the only source of information regarding some aspects of service reporting on their experiences through formal and informal channels (Ware et al. 1995).

Table 9.1 Surgeons as communicators: communication with patients and their relatives (https://www.iscp.ac.uk/Syllabus/Overview.aspx?spec-GEN)

Skills
Elicits information regarding the beliefs, concerns and expectations of patients with regard to their presenting conditions
Evaluates factors such as the patient's age, gender, ethnic, cultural, socio-economic and spiritual values and the impact that these may have on the management of that patient and condition
Delivers information to the patient and family humanely and in a way that is understandable
Provides the information the patient needs or wants to make a decision by using systematic approach that is empathetic, non-coercive
Works with patients who present significant communication challenges such as anger or confusion, or an ethno-cultural background different from the doctor's own
Supervises the co-ordination of care for hospital patients with terminal illness
Counsels patients effectively
Recognises a situation where a potential complaint is developing and taking the appropriate steps to defuse the situation where possible
Behaviours
Shows empathy
Adapts style and approach to each individual patient's needs
Avoids using technical medical jargon
Gives opportunities for the patient to ask questions, encourages discussion and promotes the patient's participation in decision making to the level appropriate for the situation
Checks patient's and/or relative's understanding throughout the consultation before moving on
Encourages patients who have knowledge about their condition to use this when they are making decisions about their care
Responds to patient's concerns, anxieties or doubts as they arise
Recognises when the limits or his/her competence has been reached and refers to a more senior practitioner

As quality assurance measures, patient satisfaction surveys provide valuable feedback. Patients rate elements of the healthcare experience (Ware et al. 1995) on variables patients are thought to be most concerned about (e.g. making appointments, waiting times, politeness of staff, comfort of facilities). However, they may also include specific judgements on the encounter with the doctor such as interpersonal and professional skills (e.g. listening, explaining, showing interest, friendliness, respect and reassurance) (NHS Modernisation Agency 2005; Thorne et al. 2002; Richards and Coulter 2007).

Aggregate survey data has educational value identifying strengths and areas for development. Surveys may offer insight into a surgical team's performance prompting remedial action and maintenance of valued practice. This type of data also highlights the notion of a patient 'journey' or 'pathway' with events impinging on each other. The encounter with the surgeon is just one interaction in the patient's overall journey. A US-based survey and telephone study of patient satisfaction with surgeons' communication skills suggested effective communication before and during hospitalisation. However, patients were less satisfied after discharge when new questions arose. The authors proposed teaching strategies to improve surgeon communication for the longer-term support of patients (D'Angelica et al. 1998).

Survey data has limitations such as the structure and content of questions, their level of detail, timing and method of distribution. Patients may also find it hard to comment on treatment during their care for fear of reprisals, lack of confidence, pain or low energy.

Patients' experiences of healthcare providers are also evidenced in verbal or written expressions of gratitude or complaints. Although gratitude is often non-specific, complaints vary in specificity. Timing also varies with verbal feedback most often provided at the point of care while written feedback is commonly delayed. Expressions of gratitude are more likely to be offered to clinicians, with complaints sent to a senior and/or administrative officer. Post-discharge complaints make it more difficult for feedback to be acted on in part because of a highly mobile workforce, especially for trainees. The responsibility for dealing with complaints is often removed from the source resulting in little direct action. The severity of the complaint (and its consequences) may influence the extent to which feedback returns to the individuals. Encouraging trainees to reflect on gratitude and complaints is important. The non-specific nature of gratitude makes it harder for trainees to identify attitudes and behaviours that were appreciated. Learning from complaints may be easier since they are more likely to refer to specific events. Again, reflecting on the event, its circumstances and outcome may promote learning and improve quality.

Patients have been asked to keep diaries revealing a longitudinal experience of care (Kielmann et al. 2009). From diaries, it is apparent that patients experience health care differently to those who deliver it, that is, patients have their own perspectives that can be difficult for health professionals to recognise from their position of expertise. Although potentially valuable, it is probably not feasible for trainees to make direct use of patients' diaries. Observing a patient support group may provide frank and immediate insight to the breadth of patients' responses to healthcare services.

9.5 Patient Involvement in Medical and Surgical Education

Patient involvement in medical and surgical education varies widely. We outline examples in and outside clinical settings while acknowledging there are many others. First, we outline relevant theoretical perspectives. Bleakley and Bligh argue for raising the profile of patients as educators (Bleakley and Bligh 2008). Using similar language to Osler, they suggest that patients are 'texts' that can be read to co-produce knowledge to support the development of clinical reasoning. That is, the trainee–patient relationship is not only a starting point but also potentially a continuous source of learning. A critical role for the clinician is in facilitating and valuing trainee–patient learning. Of course, there is value in the trainee–clinician relationship but it has dominated 'knowledge production' and minimises potential and critical learning from patients. Bleakley and Bligh also identify the paradox that patient-centredness is usually not learned from patients but from clinicians and educators.

Table 9.2 Potential content for trainees' learning *with* and *from* real and/or simulated patients in surgical education

Stage	Content
Pre-operative	Patient's ideas (e.g. about symptoms, illness, disease)
	Patient's concerns (e.g. most worrying, other concerns and the reasons why)
	Patients' expectations (e.g. of the consultation, of the surgery, of the eventual outcome of their problem)
	Patient assessment skills (e.g. history-taking, physical examination)
	Information giving skills (e.g. explaining procedures, interventions and operations; obtaining informed consent; explaining risk; giving bad news)
	Negotiation skills
	Investigative and procedural skills (e.g. patient experience)
Intra-operative	Surgical technique (e.g. patient experience)
Post-operative	Patient's ideas (e.g. about their symptoms, illness, disease)
	Patient's concerns (e.g. most worrying, other concerns and the reasons why)
	Patients' expectations (e.g. of the consultation, of the eventual outcome of their problem)
	Patient assessment skills
	Negotiation skills
	Information giving (e.g. explaining post-operative and discharge care; giving bad news; disclosing error)
Overarching	Professionalism
	Patient safety
	Quality
	Clinical reasoning

Constructivist learning theories describe the ways in which individuals create new knowledge by engaging with others through talk, activity and problem solving. Social environments are critical for learning. Wenger locates or situates learning in 'communities of practice' (Wenger 1998; see also Chap. 2 for more on learning theories). Although patients appear in the 'community', they have largely been marginalised in the 'practice', that is in co-construction of clinical knowledge. Patients as full members of the 'community of practice' may enrich and improve the quality of clinical learning.

A systematic review of real patient involvement in medical education identified 47 research papers (Jha et al. 2009). Most studies focused on the role of patients as teachers, with fewer studies reporting roles in assessment and course development. Most studies were set in undergraduate medical education. Authors argued for patient involvement as a means of bringing patient perspectives into education. Patients mainly contributed to teaching of clinical and communication skills. Few studies implemented robust evaluation strategies making it difficult to draw conclusions about educational impact.

Learning from patients may occur in any stage of their surgical pathway – pre-, intra- or post-operatively (Table 9.2). Involvement in education may occur during the routine delivery of care or form part of a formal teaching session. Trainees may be observed interacting with the patient or may observe or assist

others. Audiovisual recordings can facilitate later review of performance. A US study exploring empathic communication of surgical trainees in their first visit for oncology consultations used videotapes for analysis of communication behaviours and identified trainees' inattentiveness to patients' expressed emotions providing a clear target for improved behaviour (Easter and Beach 2004).

Patients may participate as experts in their illness/condition in teaching sessions to share their experiences from the perspective of a patient (Nestel et al. 2008d). Although there are many examples for patients with chronic illness and in undergraduate medical education, we could not locate any in surgical education. Negative and high-impact experiences may motivate some patients to contribute to education (Bideau et al. 2006; Blasco et al. 2005). Sensitively facilitated, sharing of these experiences are likely to be rich learning opportunities for trainees, surgical educators and patients.

Clinical skills assessments are often performed with patients such as the Objective Structured Clinical Examination (see also Chap. 5). However, there is a shift to working with SPs in such assessments to achieve standardisation of assessments (Adamo 2003). The patients may be asked to be themselves or adopt a given history. They may also be asked to make a judgement on trainee performance.

Multi-source feedback (see also Chap. 5) offers another way in which patients can contribute to surgical education. Currently, multi-source feedback provides summary assessment data to individual trainees on many facets of professional practice collected from their colleagues. This could be extended to patients who can make judgements on trainee performance from their own perspective.

There are several excellent patient-focused resources in websites, films and books. Audiovisual accounts of patients' illness and healthcare experiences are recorded and made available online. These are often designed for patients but may have relevance for health professionals. The DiPEX resources are a high-quality database of patients' experiences of illness from diagnosis through recovery (Ziebland and McPherson 2006). Videorecorded accounts of patients' experiences have advantages and disadvantages for patients and trainees when compared with in person discussions. The former offers a resource to be accessed at the trainees' convenience and the patient only needs to revisit the experience once. Disadvantages include no opportunity for patient-trainee interaction to seek clarification or further detail.

9.6 The Advantages and Disadvantages of Patient Involvement for Different Groups

9.6.1 Outcomes for Patients

Active involvement of patients in education has diverse outcomes. Although we can ascribe positive or negative value to outcomes, it is really the patient who makes this judgement. The literature reports positive outcomes such as higher

levels of engagement in self-care, feeling valued, improved levels of health related knowledge, specific therapeutic benefits and extra attention (Haq et al. 2006; Blasco et al. 2005; Vail et al. 1996; Lehmann et al. 1997; Cowles et al. 2001; Stacy and Spencer 1999). Negative outcomes include the psychological impact of revisiting stressful experiences, feeling burdened by the 'responsibility', distress associated with a lack of insight into their condition and/or deficits in trainees' communication skills, reinforcement of the 'sick role' and time pressures (Walters et al. 2003; Coleman and Murray 2002). Patients may be compromised in consenting to participate and providing honest feedback to trainees whilst receiving care. Ways to ensure that patients can comfortably decline involvement need to be practised. Timing of contribution is also an important issue. At different phases during treatment, remission or recovery the impact on patients may vary. Although emotionally expressive interactions can be powerful they must not cause harm to the patient. Patients may also feel uncomfortable using their experience to improve the care of others questioning their validity in improving quality for others.

9.6.2 Outcomes for Trainees

Positive outcomes for trainees of learning from real patients include making sense of theory, providing a meaningful and memorable context for knowledge (Bell et al. 2009). Pattern recognition, communication and physical examination skills develop (Gaver et al. 2005; Klein et al. 2000; Smith et al. 2000). Trainees have also reported improved understanding of social and psychological factors in illness, disease and response to treatment and a temporal dimension often absent from readings about clinical medicine (Bell et al. 2009; Thistlethwaite and Cockayne 2004; Stacy and Spencer 1999). Additionally, trainees have reported an appreciation of the complexity of patients' experiences and clinical practice (Bell et al. 2009; Bideau et al. 2006; Smith et al. 2000; Gaver et al. 2005). Negative outcomes include the inability of trainees to locate patients with conditions about which they must learn. Some trainees lack confidence or skills to seek active patient involvement. Learning from real patients has also left some trainees feeling uncomfortable and incompetent (Bell et al. 2009; Barnes et al. 1980).

9.6.3 Outcomes for Clinicians/Educators

Positive outcomes may include greater knowledge, greater personal satisfaction, improved relationships with patients, development of attitudes commensurate with patient-centred care and improved interpersonal skills. In response to specific patient involvement there may be acquisition of new and important information to assist diagnosis and management. Trainees may also value the professionalism of consultants who are willing to teach and learn with and from patients. Negative

outcomes for clinicians may include balancing and slowing the delivery of care with education, compromising relationships with patients who may ask for favours for participating in teaching, managing relationships with patients whom trainees may have upset or created difficulties.

9.7 Simulated Patient Involvement in Medical and Surgical Education

SPs involvement in medical education was first were reported in 1963, at the University of Southern California. Barrows trained an SP to simulate the history and examination findings of a patient with multiple sclerosis and paraplegia (Barrows 1968). Using a checklist, the SP assessed the performance of the trainee. SPs now make a substantial contribution to medical education. Initially, SP involvement was ancillary; however, there are several drivers to their expansion and centrality in curricula. These include ethical imperatives for learning in simulation, patient safety initiatives, patient empowerment and increased numbers of medical students with reduced access to patients in clinical settings. Additional drivers include growing acceptance of simulation as an educational method, emerging theoretical underpinning and the maturation of SP programmes.

SPs work as a 'proxy' for real patients coached to portray patients and to provide feedback to trainees. SPs have the potential to raise the profile of patient perspectives, to promote the development of professionalism and effective communication in trainees. Additional benefits of trained SPs include the provision of predetermined scenarios of given levels of challenge that reflect specific goals of training programmes, the opportunity to tailor learning to individual trainee needs, ease of scheduling as required and the provision of standardised scenarios for assessment of trainees in clinical and surgical skills. Unlike real patients, SPs are trained to provide structured feedback to trainees on their performance.

In undergraduate medical education, SPs usually play the role of a patient in supporting the development of a range of interpersonal and professional skills. Guidelines for roles are provided by clinicians and educators or designed with participants at the time of the session. SPs also play 'standardised' roles in high-stakes assessments in which they may be asked to make judgements on trainee performance. *Unannounced* or *incognito SPs* enter clinical practices with the purpose of assessing the actual practice of individual clinicians. Interventions usually take place in primary care and often go undetected by the clinician. Several excellent papers outlining the breadth of work undertaken by SPs have been published (Barrows 1968; Vu et al. 1992; Ker et al. 2005; Petrusa 2002; Adamo 2003; May et al. 2009; Rethans et al. 2007; Wallace 2007).

The scope of SP methodology is rapidly expanding. For example, SPs have worked in diverse and complex educational activities. In Chap. 3, Kneebone describes the concept of patient-focused simulations (PFS), where SPs are linked with simulators (benchtop models such as suture pads) in simulated clinical settings

to support the development of procedural skills. Trainees are expected to integrate psychomotor, dexterity, patient-centred and professional skills essential for safe clinical practice as they perform 'procedures'. No longer are trainees expected to learn discrete skills separately and removed from the settings in which they will be practiced. Rather, trainees can rehearse the entire set of skills and receive feedback from expert clinical and patient perspectives. The approach has been applied with undergraduate medical students, junior doctors, surgical trainees and new roles practitioners (Kneebone et al. 2006a; Nestel et al. 2010b; LeBlanc et al. 2009; Moulton et al. 2009).

In the developments described above, SPs work directly with real patients to write and perform authentic roles (Nestel et al. 2008c). Actors (SPs) play the roles of healthcare professionals in team simulations in the operating theatre, the interventional suite and at handover (Black et al. 2006; Nestel et al. 2005, 2008b; Kassab et al. 2010). Handheld computers and other technologies have been introduced for SPs to provide feedback to trainees (Nestel et al. 2008a; Kneebone et al. 2008). SPs lead some aspects of teaching sessions such as briefing and debriefing students, training them in managing emotions and performance anxiety, and orientating them to role-play. SPs are often called to work in scenarios that are sensitive, highly charged and for which high-stakes judgements are made.

In surgical education, SPs support trainees in learning history-taking, physical examination, procedural skills, operative skills, to give information, to explain risk, to obtain informed consent, clinical decision making, ethics and professionalism (Moulton et al. 2009; LeBlanc et al. 2009). SPs also contribute to training in managing 'difficult' interactions such as those involving patients with strong emotions, cultural differences and communication deficits, and in disclosing error and making apologies when things have gone wrong (Chan et al. 2005; Chipman et al. 2007).

SP-based education is becoming increasingly professionalised with professional associations although no professional licensing exists. In order to work in demanding scenarios, SPs require an understanding of education, interpersonal skills theory, patient-centred communication skills and performance. They may be placed in highly emotive scenarios with diverse groups of individuals (SPs, students, tutors, clinicians, researchers). Responding to these complex demands, 'professional' responsibilities for all those involved in SP work have been developed by stakeholders (trainees, tutors, administrators and SPs) in SP-based teaching (Table 9.3). Reciprocal guidelines were also developed for trainees, tutors and administrators, illustrating the partnership and collaborative nature of this work (Nestel et al. 2010a).

9.8 Patient-Focused Simulations (PFS)

PFS in surgical education provide the opportunity for trainees to integrate the skills required for safe clinical practice of procedural (e.g. intravenous cannulation, urinary catheterisation) and operative skills on conscious patients (e.g. lipoma

Table 9.3 Expectations of SPs in professional education

1. Possess a range of qualities such as self-awareness, sensitivity, empathy, vigilance, respect, enthusiasm, curiosity, warmth and a good memory
2. Possess facilitation skills
3. Work in partnership with other SPs and teachers to support trainee learning
4. Show respect to trainees
5. Have knowledge of basic educational principles
6. Have knowledge of principles of patient-centred communication
7. Model behaviours for effectively managing difficult situations
8. Use knowledge and experience to support trainee learning
9. Use acting expertise to portray roles – avoid stereotype or caricature
10. Actively participate in training and teaching sessions
11. Invite feedback on performance (e.g. role-play and feedback)
12. Critique scenarios and SP roles
13. Follow programme guidelines in giving feedback to trainees
14. Participate in session/programme evaluations
15. Keep information about trainees' confidential although incidents or concerns should be reported to the programme director in a timely fashion
16. Be familiar with the prescribed SP roles

excision and wound closure, carotid endarterectomy). The physical, psychological and social fidelity of real work environments is recreated, enabling trainees to integrate the broad sets of skills (e.g. professional, psychomotor, communication) that are often taught separately but all required in real clinical practice. Having a 'patient' at the centre of the scenario creates a sense of reality that is absent in manikins or simulator kit. PFS can be used flexibly to support learning. Trainees are first encouraged to reflect on their prior relevant experiences and to identify their learning needs. Immediately after the scenario, trainees self-assess and receive feedback from clinical assessors and SPs in approximately equal measure (Kneebone and Nestel 2005; Kneebone et al. 2008; Nestel et al. 2008a). Scenarios are videotaped enabling facilitated feedback or trainee-led reflection. Results from several studies suggest that trainees benefit from these experiences and that PFS offers learning opportunities different from traditional approaches to skills teaching (LeBlanc et al. 2009; Moulton et al. 2009). Although studies have shown that trainees found the scenarios and SP roles realistic, convincing and richly complex for learning (Kneebone et al. 2006b, 2007), real patients were not involved at any stage.

9.9 Authenticity in Simulated Patient Methodology

We have stated that SPs can function as proxies for real patients. Given the emphasis of healthcare service and education policy documents of involving patients as partners, they are notably absent from the realm of SP work. In part, this is

for obvious reasons, that is, SPs are working instead of real patients because of their many advantages (e.g. standardisation, repeatable performance, feedback etc). However, we have a responsibility to ensure that SPs' performances are derived from real patient experiences, that the voice of the SP is that of a 'real' patient. Otherwise, SPs may simply serve to recreate clinicians' and educators' perceptions of patients' experiences (Nestel et al. 2008c; Morris 2006).

There is little published literature on the processes adopted for writing SP roles and scenarios. Common practice is that roles are crafted by clinicians and educators often derived from an individual patient's history or an amalgam of several patients' records. There are important reasons for this including the pressure to produce new roles for teaching and assessments, the desire to tailor learning experiences to trainees' individual needs and to align roles with other curriculum activities. But clinician or educator-generated roles may be quite different from the authentic experiences of individuals (Black et al. 2006) that they are interpretations of a patient's history and without direct patient involvement. However, it is challenging for those immersed in teaching and the delivery of healthcare to see through the eyes of someone who is not. The literature reports many examples of clinicians experiences as patients (Klitzman 2007; Jones 2005; O'Brien 2008). Clinicians and patients think differently about many facets of healthcare (Morris 2006; Temple et al. 1998; Lazarus 2007). Because of this gap between clinical and patient perspectives and the implicit assumption that SPs are representing real patients, there is an obligation to explore authenticity in all aspects of SP work.

Here we summarise three SP-based projects in which real patients have been invited to participate. The first project explored the feasibility of immersive simulated-based training for surgical trainees in carotid endarterectomy (Black et al. 2006). During the operation, patients are conscious contributing to progress by maintaining some speech and motor movements in order for the anaesthetist and surgeon to assess cerebral perfusion. In the simulation, a carotid model was aligned with an SP lying on the operating table in a simulated theatre with a full operating team. The trainee was required to perform the operation. Pre-operatively, the trainee obtained an informed consent from the SP (and partner) and made a follow-up visit in the recovery room. Audiovisual recordings were made and used to provide feedback to trainees on all aspects of surgical expertise. In order to base the SP role and scenario in reality, patients who had undergone this operation were interviewed exploring their experiences, concerns and information needs pre-, intra- and post-operatively. Experiences as reported by patients differed from those that the research team had considered, adding a richness and a genuine patient perspective in the crafting of the SP role (Black et al. 2006).

In the second project, patients in the emergency department who had undergone procedural and examination skills (e.g. intravenous cannulation, ECG) were interviewed. SP roles and scenarios were then constructed based on these individual patients' histories and experiences. This information was used to develop SP roles for patient-focused simulations. SPs were asked to rate the realism of these real patient and faculty-generated roles for procedural skills. Although differences in

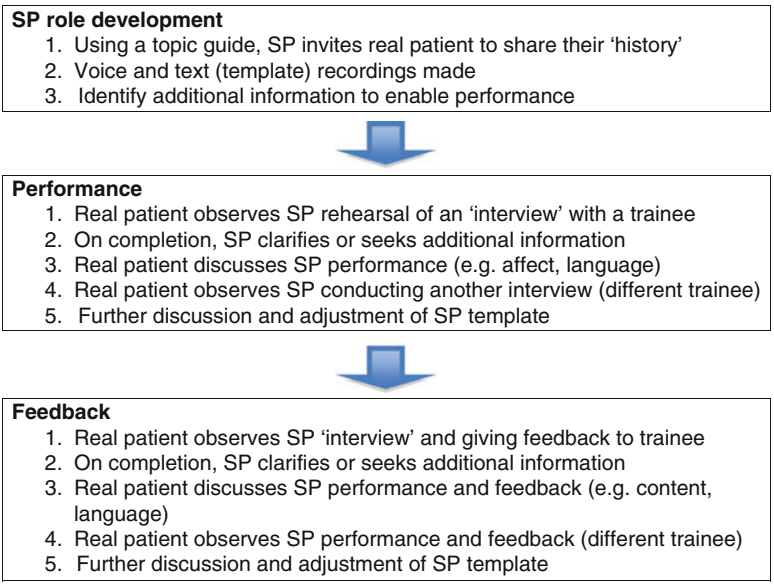

Fig. 9.1 Process for including real patients in SP role development and training

ratings were not statistically significant, analysis of free text comments showed the benefits of providing authentic patient language derived from interviews with real patients (Nestel et al. 2008c).

In the third project, patients with complex histories were recruited to participate in SP training for role performance and feedback. There were three parts to the project (Fig. 9.1). First, crafting the SP role was based on individual patients working with two SPs to obtain the patient's perspective of the "facts" (~60 min). Faculty observed and facilitated where it was thought to be necessary. Although a template was used to record information, the patient's story was first heard in full. Additional information was discussed including the patient's attitudes towards their illness, clinicians and the healthcare service. SPs noted the real patients' use of language, accents and mannerisms. Discussions were also voice-recorded for later reference. Second, the real patient then observed the SPs in consultations with trainees. After the encounters, the real patient coached the SPs on their performance with respect to authentic representation. Several iterations and discussions resulted in what the real patient deemed authentic performance (~60–90 min). Third, SPs were observed by real patients giving feedback to trainees. The SPs were consistently more critical and provided more detailed feedback than the real patients whom they were portraying. SPs also emphasised different points. The SP adopted the language of a professional communications expert (e.g. "There were few open ended questions") compared with the real patient (e.g. "I did not have a chance to really tell you what was happening to me"). The process proved salutary to the SPs involved, reminding them of the realities of the people they represent.

The educational impact of these approaches to involving real patients in SP-based work needs further evaluation, but it was already very clear how easy it was to make inaccurate assumptions about patients' attitudes and experiences.

9.10 Simulated Patient Involvement in High-Stakes Assessments

SPs now regularly participate in high-stakes assessments. SPs have the responsibility of performing consistently according to a prescribed role and of making judgements about trainees. Although checklists are sometimes used, rating scales are reported to have greater reliability and validity. SPs commonly make judgements about interpersonal skills but this may be from a technical perspective (e.g. use of open-ended questions, empathy, transition statements). They are sometimes trained to assess clinical decision making, examination and other professional skills. Despite the statistical reliability and validity, it is important to remember that often these judgements are made from the perspective of the 'professional' SP as proxy for a clinician assessor rather than as proxy for a real patient. We need to be clear about the nature of the assessment the SP is offering. In many instances, it appears that these perspectives become one rather than appreciated and valued for their diversity.

9.11 Concluding Remarks

Real and simulated patients have important contributions to make to medical and surgical education. Many opportunities go untapped. Whether patient surveys on healthcare experience or active involvement of patients in the process of care delivery, patients have much to offer. While healthcare service policy has embraced patient and public involvement, education policy has been slower and less committed.

Following Bleakley and Bligh (2008), we argue for a shift in prominence of the trainee–patient learning dyad, facilitated rather than led by clinicians. Similarly, we argue for real patient–SP dyads facilitated by educators to create authentic SP roles, performance and feedback, which can then be incorporated into patient-focused training programmes. We propose that patients be considered as full (although transient) members of the 'community of practice' promoting learning for clinicians, trainees and patients.

There are benefits and challenges of involving patients at all stages of education. Of course, not all patients will be suited to such work. Ways need to be found to ensure that a breadth of patient perspectives can be represented. The emphasis on educational interventions of patient involvement at the undergraduate level is noteworthy. However, there are very few examples in specialty training, where the

dominant learning sphere seems to be the clinician-trainee with the patient ancillary. Of course, we will need to evaluate the educational impact on trainees of real patient and SP methodologies. There is much to be done to explore the breadth of possibilities for both.

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