ESSAYS

# Authoring and othering: examining bias in scenario design

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https://ijohs.com/article/doi/10.54531/WIDJ3751

## ABSTRACT

Simulation-based education (SBE) is recognized as an interactive educational methodology for producing new knowledge and developing professional skills. Effective engagement of simulation has the potential to shape and shift ideas, beliefs and attitudes about what it means to be a good healthcare professional. As healthcare simulation educators we have a responsibility to ensure that the scenarios created and enacted by our Simulated Participants are educationally sound and clinically representative.

Case development is more than the sum of creating a patient illness landscape for students to navigate. There is a social and ethical responsibility to sensitively and accurately articulate how a patient's medical history dovetails with their unique world view, culture, values and beliefs, without essentializing or moralizing. To prevent reproducing stigmatizing stereotypes, and make visible our taken for granted assumptions, we need to embrace health professions as both a social and clinical undertaking, and understand how the echoes of pedagogical experience can profoundly influence students' professional values and attitudes in clinical practice.

Engaging critical perspectives, this submission will address SBE's potential impact of reproducing healthcare inequities through poor scenario design and outline considerations for distinguishing and ameliorating essentializing and stigmatizing representations.

## Introduction

The following essay sets forth our perspectives as simulation specialists on the influence of simulation-based education (SBE) authoring practices in producing and reproducing cultural stereotypes in health professional training. Our goal is to inspire readers to consider the impact of authors' decision-making on simulation scenario design, simulated patient recruitment, training and practice. This is not a research or quality improvement study. As educators, we are interested in contributing to a conversation that is well underway within the field of simulation regarding the ethical and social considerations embedded in our work.

Healthcare Simulation Education (HSE) is recognized as an interactive educational methodology for producing new knowledge and developing professional skills. Effective engagement of simulation has the potential to shape and shift ideas, beliefs and attitudes about what it means to be a good healthcare professional [1]. As healthcare simulation educators we have a responsibility to ensure that scenarios created and enacted by our Simulated Participants (SPs) are educationally sound and clinically representative.

The term othering in our title refers to the grouping and isolation of people perceived to be different from the norm by virtue of their cultural, ethnic or dispositional characteristics. The other has been described as an individual who seemingly does not belong, who we see as different from us in some fundamental way [2] We hope to raise awareness about the importance of reflexivity when designing simulation learning opportunities. Reflexivity is 'thoughtful, conscious, self-awareness' [3]. It involves examining our own assumptions and reasoning in the production of knowledge, and awareness and reflection on our own taken-for-granted aspects of daily life. Educational design is at the heart of this discussion; to make visible the consequences of authoring formulaic, culturally referenced scenarios.

**SAMUEL JONES/DEERCHILD/KUMAR** (PLEASE CHOOSE ONE SURNAME) is late for his appointment with you today. You notice his left eye is swollen and bruised, he is sweating and seems confused.

**You are concerned that he may be** (CHOOSE ONE)

1. Injured
2. Afraid
3. Under the influence

**You ask him to sit down and notice that he is clutching a:** (CHOOSE ONE)

1. Dreamcatcher
2. Prescription bottle
3. Rosary

Specifically, this essay will explore the links between learning objectives and the cultural and social messages that are represented in scenarios and portrayed by SPs, the burgeoning role of allyship with patient partners to foster authentic simulation portrayals, and the shift from patient-centred to person-centred simulation [4].

The choices above shine a light on how our role as authors can contribute to problematic cultural stereotypes. In healthcare simulation, scenarios act as vehicles for professional identity formation as well as skills and knowledge acquisition. Our perceptions about clinically relevant social and cultural details of a patient's presentation may contribute to and impact a student's approach and response to patients and their illness experience.

## Attribution: assumptions and judgements

When two individuals or groups hold a difference of opinion or perception regarding their causal explanation for events or behaviour, research indicates that, as human beings, we are remarkably inclined to assign responsibility or blame to others based on dispositional characteristics (personality traits) while measuring our own behaviour in terms of task difficulty (situation) [5].

Both our own self-assessment and assessment of others can be biased. We tend to excuse ourselves circumstantially (Traffic was terrible) and blame others based on our perception of their character flaws (They're always late, lazy etc.)

This overestimation of our own (situational) innocence, and underestimation of (dispositional) culpability cultivates a sense that our assessment and insight into others is very accurate.

We all hold implicit biases. Learned at home, at school or indirectly from TV, movies or social media, we begin to imagine what the person with an eating disorder or the survivor of breast cancer looks like, and often assume we know the thoughts and ideas of someone struggling with mental health or homelessness.

Simulation is a powerful methodology to support learners in transformative interactions, with opportunities to experience, reflect and consider their assumptions and judgements through facilitated conversation and feedback with the person sitting in front of them. As an author, a critical responsibility is to act as better allies for marginalized communities.

## Consider the following:

1. _____ is experiencing excessive sweating, shortness of breath and some discomfort in their chest.
2. _____ is having trouble sleeping, feeling really withdrawn, and admits to increased use of drugs and alcohol.
3. _____ is complaining of fever, fatigue, sore throat, weight loss with swollen lymph nodes.

Do we default to preconceptions about who befits these roles?

The stressed middle-aged white male patient is typically the most likely candidate to be featured in a scenario depicting chest discomfort, while the young female patient of any number of diverse cultural and/or ethnic backgrounds may be overlooked for the same symptoms and is therefore often under-represented.

Scenario authors need to be encouraged to look beyond preconceptions and consider options that broaden our view. Thoughtful authoring that addresses the taken-for-granted implications of different representations and common exceptions may serve to deepen students' appreciation for the wide array of people experiencing illness.

## The problem field: objectivity and standardization

Standardizing simulation portrayals is premised on the idea of fairness. Scenarios are standardized to allow students the same opportunity to demonstrate their skill and knowledge, often within a summative assessment and for the purposes of making a judgement. SPs have been part of this very important contribution over the years.

Fairness, however, is limited in this context. Critiques of standardizing practices and Objective Structured Clinical Exams (OSCEs) are recognized within the literature [6–9], pointing to the detrimental effects of reducing patient presentations to checklist items while essentializing patient groups and populations. In the context of a tightly timed examination, patient representation can be over-generalized and simplify the inherent complexity and ambiguity that students will face as practising professionals [7].

Ironically, perhaps, standardization can serve to undermine professional values, attitudes and person-centred approaches promoted in formative simulation learning activities. Rewarding checklist scores aimed at demonstrating clinical knowledge may come at the expense of the communication skills required to explore ambiguous, affective simulated patient presentations.

It is fair to say that many simulation scenarios designed for formative learning do not represent the experiences of ethnicity, ableness, gender, body size etc., despite an author's good intentions. Without consultation or patient collaboration regarding a person's experience of an illness or condition, an author may be imagining and deciding the salient features of a story in isolation.

## Over-generalization

In our experience SPs are often requested to engage in scenarios based on visible ethnicity, and to portray family culture, behaviours and values in order to give learners an experience of communicating with people seemingly different from themselves, effectively reproducing the cultural biases they are trying to redress. In other words, 'othering'. The impetus to have SPs represent other cultures may hold value if clear learning objectives are built into a teaching session that informs the SP portrayal and their feedback.

It can be seductive to insert cultural artefacts (accent, ethnicity), entertaining elements (exotic or funny names) or other cultural symbols (rosary, dreamcatcher), perhaps in the hope that learning will become more memorable and consolidated by the student. These shortcuts serve only to generalize culture in ways that can be reductive and ultimately insulting.

We have an opportunity to engage in a dialogue with scenario authors and educators to explore ways to normalize diversity when diversity is not the focus of the case [10]. Where gender, race, weight, ability, sexual orientation etc. are not integral to the case we can seize this reflexive opportunity to send out a variety of SPs that reflect the diversity of our centres or programmes. This also provides diverse students the chance to see themselves reflected in the patients that are coming in for routine check-ups and not just in simulation scenarios where cultural stereotypes may be exploited to meet programme imperatives.

## Scenario development: considerations

The critical importance of setting clear, relevant learning objectives cannot be overstated as a key element in scenario design and development.

Learning objectives set the stage for a simulation session, the SP portrayal of a patient story, and the rational and experiential goals (what we hope students will understand (content) and experience (practice)). Learning objectives are instrumental in guiding learner success.

Learning objectives can serve our ethical thinking as we consider scenario development and the rationale for details we choose to include or omit. Once determined, learning objectives act as a guide for scenario development and SP engagement. They serve as an effective checkpoint should the author stray into territory that treads on cultural boundaries and assumptive content. Solid learning objectives, when aligned and focused on learner success, lend coherence to scenario design and inform decisions about SP recruitment, training approaches, portrayal and feedback. Scenarios in part act as vehicles for students to learn about a person's illness experience. A central issue for SP educators and authors is a tacit assumption that we can represent a population or disease state when in fact we can only represent one individual's experience with a particular illness and presentation.

Since the 'linguistic turn' at the beginning of the 20th century [11] we have come to appreciate that language does more than 'describe'; it interactively produces truths that then may be acted upon. The ways in which we choose to represent a patient informs our relationship with them. In other words, the labels we use to identify people have histories and cultural meanings that will shape student impressions. For example, whether a person with an illness is described as a 'patient' versus 'a disease' versus their birth or chosen name, a particular relationship is engendered between a healthcare provider and the person who needs care. [11]

Ethical thinking also extends to considering how collaboration between educators and patients or community members can be respectfully translated to a particular individual's lived illness experience through simulation. Patient partners should have autonomy to negotiate how they would like their experience to be represented (demographic details and confidentiality) and how they would like to be included in the process of developing scenarios that authentically represent their experiences [4, 10].

Too often we have experienced scenario shortcuts in which links are made between abuse (substance or domestic), cultural (indigenous) and social demographics (financial, marital, housing details).

For example, creating a scenario that depicts a person as poor, homeless, addicted and uneducated panders to cultural stereotype without opportunity for reflective learning. This representation elides the complexity of the person's lived experience. The homeless person may also be a recent PhD graduate who has just lost their home and their partner to cancer. These exceptions call on student skills and capacity for humane, thoughtful analysis that reach beyond embedded common cultural shorthand.

## Conclusion

> Education is an ethical undertaking and as such requires conversations and multiple perspectives. It is a project of political praxis that recognizes the effects of knowledge production as materially implicated – on real bodies and lives. Such a recognition calls for us to recognize the educational consequences of generosity and compassion in our approach as teachers [12].

Authoring simulation scenarios involves more than creating a patient illness landscape for students to navigate. Including people with lived experience in the scenario development process and the thoughtful, fair recruitment, training and engagement of SPs is increasingly central to a fair and equitable authoring process.

Thoughtful consideration and commitment to the objectives of each scenario and its live portrayal assists in mitigating often careless or assumptive details that can limit or interrupt the student's analysis and approach. SP educators' engagement in scenario development as authors, reviewers or editors requires a nuanced appreciation for unintended educational, social and cultural effects.

> In order to prevent reproducing stigmatizing stereotypes, and in order to make our taken for granted assumptions visible, we need to embrace the health professions as a social undertaking as well as a clinical one ... [13]

Learning objectives that determine whether diversity is a relevant scenario component, normalizing diversity in clinical representations when diversity is not the focus and partnering with community members with lived experience all work hand in hand to ensure we avoid tokenism and recreation of stereotypes [10].

In this way we come to understand how the echoes of pedagogical experience can profoundly influence students' professional values and attitudes in clinical practice.

## Declarations

### Authors' contributions

N/A

### Funding

N/A

### Availability of data and materials

N/A

### Ethics approval and consent to participate

N/A

### Competing interests

N/A

**Received:** 16 April 2021
**Accepted:** 20 August 2021
**Published:** September 2021

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