How to choose between an actor (or simulated patient) and an expert by experience

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Teaching staff who train health and social care professionals often bring a guest into the classroom so that students get the benefit of engaging with a different person. One guest may have personally lived through the health condition and treatment under consideration (often called an expert by experience) while another may be a role player who acts the role of such a patient[1] (sometimes called a simulated patient). This *How To* guide will help teaching staff decide which of these guests to invite into the classroom.

Contents

Glossary

Actor	A person who has probably not lived through the situation they portray but brings skill in playing the role[2].
Expert by experience	A person who has lived with the health condition and experienced the healthcare that is the focus of the learning. This may include a relative or friend of the person who has been an informal carer.
Formative learning and assessment	Learning experiences that helps the student develop their knowledge and understanding by offering information, emotional experiences, feedback and opportunities to reflect.
High fidelity manikin	A manikin (see below) that includes electronics and robotic aspects so that it can replicate human physical responses[3] – see [here](#)
Lecture	A teaching session where students listen, take notes and perhaps engage in discussion in small groups or plenary.
Manikin	A doll or artificial model of a body part that is made for students to practice on, such as [Resusci-Anne](#) or [Choking Charlie](#).
Mystery shopper	A member of the public who makes an unannounced visit to a real-world healthcare setting to evaluate it. For example, they might check how a GP receptionist responds to a request for help.
Physical Exam Patient (PEP)	A PEP teaches physical examination[4] to medical students. They allow the student to practice on the PEPs own body and then give feedback. Specialist roles include Gynaecological Teaching Associates and Urological Teaching Associates (men who do this are sometimes referred to as Male Urological Teaching Associates) while PEPs can be known as Physical Exam Teaching Associates.
Role play	One or more students act out a medical consultation or treatment intervention with the guest (expert by experience, manikin or actor) playing the part of the patient. Sometimes other students watch and learn too[5].
Simulated patient	An actor is provided with information about the role and the situation and then makes up or is provided with a back story of invented details. A core script may be provided as the basis for improvisation. When repeated with other students, the resulting exchange may be a little different each time.

Simulated ward	A mock-up of a real ward is created for educational purposes[6], staffed by people who take on a variety of roles and where news updates and incidents may happen to help learners practice what to do.
Standardised patient	An actor learns a fixed script and sticks to it. Several standardised patients will be equally able to play and replay the part and repeat the same response to each student. Dr Howard Barrows trained the first standardized patient in 1963 in the University of Southern California. See the example here from Pittsburgh.
Summative assessment	A test which checks the performance level of a student, awards marks and makes pass/fail decisions.
Technology-enhanced learning	Using high-fidelity manikins and other equipment to aid the development of clinical skills

Aspects of the learning process

It can be helpful to decide exactly what the guest is being asked to do in the learning environment[7]. This might be one or more of the twelve options below:

1. Play a well-defined role opposite a student who engages in the role-play session. The guest sticks as closely as possible to a given script and the role play is part of formative learning for students.

2. Play a well-defined role opposite a student who is subject to a standardised examination of ability. The summative assessment is carried out by a separate observer. Repeat this multiple times with successive students.

3. Tell an autobiographical story in your own words. The students are simply listening and taking notes, rather than engaging in a role play. The story is distinctive in that it is autobiographical, first-hand testimony from the individual who lived through it.

4. Use your own body to 'show and tell' learners who may perform specified physical examinations that include undressing parts of the body and touch.

5. Perform a predefined biography or fictional character designed to match syllabus requirements or use one's own autobiography in an unstructured or structured way.

6. Design a role play or a lesson for students

7. Allow another teacher to interrupt the role play and discuss how the student is performing before resuming, perhaps at a slightly earlier point. After playing a role, give feedback out of role, facilitated by someone else[8].

8. Give feedback in role to help students learn[9].

9. Facilitate a discussion in a small group of students to help them learn.

10. Mark the work of students in an examination context, perhaps through observing how they perform in a standardised role-play.

11. Connect the role or personal story to wider aspects of the syllabus and teach that material, such as policy, research, ethics or modes of therapeutic intervention.

12. Host the class.

With such a plethora of options, the educator needing to decide what kind of learning experience will be most productive and therefore who to invite into the classroom and what to ask them to do.

This guide introduces some considerations that should be borne in mind when making these decisions, but it is no more than a brief introduction[10]. Before moving into the detailed comparison, the following points should be borne in mind:

- Comparison between these two schools seems to be hampered by the reluctance of others in the field to consider what they might learn for their own approach from a respectful dialogue with the alternative[11].

- One might easily add a further level of analysis, as the group of people here referred to as 'actors' may be split into two groups – the lay person and the professional actor. Some programmes are passionate about engaging lay members of the public and training them to act the part, while others engage professional actors[12]. This means that a more fine-grained version of this *How To* guide might offer a comparison of the three categories – expert by experience, citizen and actor. However, in this *How To* guide, citizen and professional actors are grouped together and contrasted with experts by experience.

- Reflections and observations which have been grouped into the headings and subheadings below are not so neat and tidy in real life. An item which is listed as a benefit of engaging an actor, for example, may also apply in a slightly different way to experts by experience. Rather than attempt an exhaustive and repetitious analysis, this *How To* guide simply captures each theme, places it in a convenient category and invites readers to take it forward into their own reflective practice.

- Some of those who advocate involvement by experts by experience are on a mission to coproduce the whole educational experience, transform healthcare delivery and democratise society. They invite people with lived experience to share the process of curriculum design, select theories and practices that foreground patient interpretations and involve experts by experience in student selection, teaching, marking and regulation of the profession. These values are gradually infusing the simulation world too, but, in general, simulation is largely designed by professional educators and clinicians and is only a very limited exercise in power-sharing.

- Where two options are available, such as experts by experience or actors, it can be helpful to consider the strengths and weaknesses of each before selecting which one to take forward. Then arrangements can be made to compensate for the weaknesses of the chosen option and to build in additional components drawn from the strengths of the alternative that has been discarded[13].

Considerations in choosing an Expert by Experience

There are several ways in which a person with first-hand, lived experience of the health condition can add value to the teaching process, such as the following.

Advantages held by the Expert by Experience

Spontaneity. A person with a lifetime's experience of living with a condition and navigating healthcare settings and public attitudes will be able to draw on this resource to respond to unplanned moments in a more convincing way than the professional actor who has been given a script. Where the real world of unpredictable responses and genuine humanity are essential components of the learning, the person with lived experience may bring those constructive challenges.

Authority. The expert by experience may have undeniable physical differences that go with the condition but would be difficult for an actor to simulate. Sometimes an expert by experience is selected because they speak a particular language, live with disability or difference, or occupy a particular age group. A true story that actually happened is indisputable[14]. The expert by experience may be able to bring alternative perspectives into the classroom that challenge the dominant worldview of clinicians or academics[15].

Embodiment. Any move away from authentic experience towards simulators or actors trains the student to establish professional distance and treat the patient as a case or a bundle of symptoms rather than as a whole person. In contrast, engaging with an expert by experience can push the student beyond their textbook knowledge into a human encounter. This is particularly the case when the expert by experience is using their own body to teach. Whilst the Physical Exam Patient is perhaps more resilient to the faltering prods and pokes of inexperienced students, there is an undeniable authenticity that cannot be simulated by an actor.

Other factors to reflect on when engaging an Expert by Experience

Support. The expert by experience may require a greater level of support, encouragement and coaching than an actor. The teaching programme may be interrupted if the expert by experience is unwell or absent[16]. This should be seen as requiring entirely reasonable adjustments to accommodate the person. However, the expert by experience who begins

motivated by the educational goal of creating a good learning experience for students may divert the session towards meeting their own needs for therapy, advice or even support with a complaint.

Retrospection. True accounts tend to be retrospective, while role-playing can focus on responding in the present and planning for the future. Indeed, the expert by experience may be describing the service as it was many years ago, rather than contemporary provision.

Confidentiality. Students acquire true information about a real person's life and so both the expert by experience and the students must manage the confidentiality issues that come with the disclosure. Such matters are amplified if the life story triggers adverse emotions such as disgust or shame, hatred or pity. In contrast, the actor is presenting generalised, anonymous or fictional information so there is no prospect of them disclosing confidential information about anyone's real life. This is, therefore, fruitful ground for paternalists, who note that once told, a personal story can never be unsaid and the consequences can never be entirely foreseen, so maintaining anonymity is less hazardous. These risk-averse discourses rarely consider the potential benefits of disclosure, or perhaps assume that they are trivial in contrast to the terrible harm that may ensue if things go wrong.

Harm. The expert by experience may be harmed by sharing their story multiple times – it may cause emotional blunting and unhelpfully distance the person from their own experiences. It may result in the expert by experience compensating for the blunting by creating contrived, artificial or overblown emotional responses that reduce authenticity and lead to students feeling disengaged from the whole experience. There is the potential for the student, after graduation, to be employed in the therapeutic team that cares for the expert by experience. In this scenario, the student may be especially motivated to do well rather than store up embarrassing memories for the future. In contrast, if the scenario that is described in the learning session puts the student in a poor light (such as when role playing a clinician who must take responsibility for a botched procedure), then this may be less helpful to any future therapeutic relationship with the expert by experience. However, estimates of risk should be taken with care, as it is easy to make assumptions based on a stereotype of vulnerability.

Stowaways. This term is used here to point to the fact that, in addition to the intended messages that are conveyed when engaging with a person with lived experience, there may be additional, unintended messages that slip in unnoticed and may help or harm the learning process. This point is drawn from an associated but distinct teaching process in which the student is called upon to role-play a disabled person. Spending a day in a wheelchair or wearing vision-impairing spectacles has been found to achieve its intended goal of increasing positive emotions of empathy towards the disabled person, but the experience also strengthens students' beliefs that the disabled person is incompetent and dependent, as one day is not long enough to learn the psychological and practical coping strategies that the expert by experience has gained over time[17]. On a more positive note, experts by experience often slip an unscripted message into their presentation that pleads

with students to become the best practitioners that they can be, and this reminds students of their motivation for entering the profession. Some fear that experts by experience will become unduly concerned with the wellbeing of the student and attempt to rescue them from a learning situation in which they are failing - although they may be less likely to fall into this trap than academics or clinicians[18].

Considerations in choosing an Actor

As with the discussion above about experts by experience, each item here has several facets. For example, the actor may be able to play the part of a patient who is profoundly traumatised, but this always carries the risk that learners treat the show like a film and miss the raw humanity of the situation being portrayed. So, as mentioned above, none of these headings and subheadings can be treated as rigid and exclusive categories.

Advantages held by the Actor

Consistency. Where exact repetition or large numbers are required, every student can get the same experience delivered in the same way by a team of actors who are all trained to deliver identical role plays. This is helpful when precise technical and clinical skills are being taught that leave little room for error, and when awarding marks and ultimately deciding whether a student passes or fails. Theatre training gives actors the ability to hold true to the given role[19] while responding in a range of pre-set ways to specific triggers from the student or spontaneously improvising multiple alternative scenarios. Indeed, the actor may be more biddable where the goal is a crafted or generalised description rather than one that is dominated by the unique details of the expert's own experience. There may be concerns that the expert by experience will be selected for the emotional impact of their story rather than its contribution to the learning process, or because they are malleable expert and will align with the people in charge rather than challenge their agenda or perspectives.

Stamina. They may tolerate more students or more repetitions than an expert by experience. Where the expert by experience is unable to travel or present their situation in an articulate manner, perhaps due to the severity of their disability, an actor may be able to accomplish the task. The person with back pain may be reluctant to permit a whole procession of students to touch the affected area, as doing so might exacerbate a 'fear-avoidance' response and increase impairment[20]. If the content is particularly distressing, such as loss of a child, the actor can engage in the intensity of that experience without lasting emotional cost. In contrast, asking a person who has survived such a trauma to relive the experience even once may cause them harm or distress.

Versatility. The actor can take on a wider variety of roles, so, for example, they can recreate a crisis and teach students how to respond in the moment to trauma or to a patient who is extremely distressed. They can also take the role of a doctor or physiotherapist and so work on the student's communication skills with the medical team as well as their communication

with the patient. On the other hand, the actor may be extrovert in character and so find it much harder to role play introverted, withdrawn and uncommunicative patients. It is possible to run a 'time-lapse' process. For example, the roleplay can be interrupted with some new information, or 'rewound' and replayed with the actor picking up the story from the cue that has just been given.

Safety. Space and time in which to thoughtfully prepare the intended vignette can reduce the tendency of scriptwriters, spontaneous speakers and audiences to focus on dramatic moments in the story at the expense of mundane but essential truths. When focusing on teaching a clinical skill, the actor and educator can work together to create psychological safety for students in which it is acceptable to show incompetence[21] without being humiliated or reprimanded. An example here might be in teaching medical students how to give bad news. This is a complicated area, however, and it is worth noting that the task of creating psychological safety does not mean creating anodyne experiences and some students and actors may experience strong emotions during or after the session[22].

Other factors to reflect on when engaging an Actor

Melodrama. An actor may favour dramatic moments, entertaining or telling a more coherent story than the fragmentary accounts given by ordinary people. A well-told but inaccurate representation of the experience might lodge in the mind of learners and cause misunderstandings in the future. On the other hand, their training may have made them more alert to these factors and so less likely to get carried away by them in contrast to an expert by experience.

Familiarity. Multiple repetitions of the experience may give the actor technical knowledge which interferes with the outcome. For example, when assessing a healthcare student's ability to explain a proposed treatment clearly to a novice patient, the actor will quickly learn what is entailed in the intervention, and so will be progressively less likely to notice poor communication. However, learners can experiment with different ways of communicating without fear of causing offence. Where the topic is delicate or evokes feelings of modesty, repetition may help the actor overcome natural inhibitions or shame and so become comfortable with undressing before a group or permitting a stranger to examine a part of their body in public[23].

Harm. Whilst actors often read a great deal about a health condition and can be given a brilliant script, it is inevitable that there will be a limited extent to which they can inhabit the role, especially where the experience is ambiguous or complex, such as living with schizophrenia or disfigurement. Where risks are high it is better to work with an actor rather than an expert by experience. As Barrows put it, "It is far better that students make their mistakes in working with a dying patient, a comatose patient or a sexually abused patient in a simulated setting rather than in the real setting."[24] If the actor is then expected to remain in role and move into spontaneous responses to unexpected questions, there is a substantial risk that they will find themselves beyond their capability. An actor who

thoroughly engages with the part may find it difficult when they meet a disinterested, apathetic or incompetent student in the session, and hard to shake off the role after the simulation is over, making it especially important to provide effective preparation and debriefing[25].

Plaksin and colleagues considered the benefits and risks of harm of participation on the simulated patient and the expert by experience themselves. The team sum up their findings this way:

> *'The benefits for those portraying simulated patient roles include improved health knowledge and attitudes, relationships with their health care professionals, and changed health behaviours. Negative effects of being a simulated patient include anxiety, exhaustion/fatigue, and physical discomfort immediately following a simulation, but the literature to date appears to indicate that there are no long-lasting effects. These findings are consistent across age groups and the type of role being simulated. They are also supported by studies of real patients who are involved in medical education.'* [26]

Expense. Actors may be accessible via their talent managers while experts by experience are harder to source. However, the actor's fees may be higher[27]. There may be a limited number of experts by experience available or willing to take on the role. Additional support and reasonable adjustments are less frequently needed by actors in comparison to experts by experience.

Blending the approaches

Many professional actors will have relevant lived experience, while some experts by experience have acting skills, so this binary analysis breaks down in the real world. For example, Snow writes about training experts by experience to be simulated patients[28] and Rutala and colleagues showed that their evaluation of student performance correlated with the evaluation generated by traditional methods[29]. Muckler has commented that the most effective simulations appear to be those that are based on real life events, making it easy for learners to immerse themselves in the situation as if it were real[30]. Other practitioners reject any candidate for the role of simulated patient who has personal experience of the condition being portrayed, due to their concerns about the negative elements listed above.

One advocacy organisation (SEA) has been involved in student assessment where experts by experience coached actors to help them portray a role convincingly, then watched the actors work with students and evaluated the student's response[31]. One might break the process down into decisions about the intended message, scriptwriting and performing. In the example above, SEA was involved in shaping the way in which the message was conveyed and evaluating the performance.

Insights from the film industry

On occasion, an expert by experience hands over their personal story to an actor and asks them to portray it to the audience. Some actors work within the 'method acting' tradition[32] in which they draw on and replay emotional experiences from their own lives that parallel those of the character they wish to play. At its best, acting can stimulate praise such as given by Stephen Hawking:

> *'Eddie Redmayne portrayed me very well in The Theory of Everything movie. He spent time with ALS[33] sufferers so he could be authentic. At times, I thought he was me. Seeing the film has given me the opportunity to reflect on my life.'*

It also risks that the person will lose control and have their story edited, reinterpreted or changed without their permission. At worst, the person may find it distressing to see matters that they had previously laid to rest being portrayed in their raw, unresolved form, or simply that their character is misrepresented. Such an outcome might again be illustrated from the world of film by the story of the 1998 film *Patch Adams* which Adams heavily criticised, saying it neglected to represent his beliefs and ignored all his activism, portraying him merely as a funny doctor to increase takings at the box office.

While parallels with the film industry are in the spotlight, it may also be worth noting the example of Frank Abagnale, whose story was the subject of the 2002 film *Catch me if you can*. The veracity of his own account of his life is disputed, the film embellished it, and Abagnale himself appeared in a cameo role in the film and delighted in the publicity it brought him.

Another blended approach is taken when film and theatre performances intentionally address mental health or disability issues in their storyline and sometimes do so with the deliberate intention of changing public attitudes[34].

Learning to act

Pate and Ricardo[35] describe a process by which members of the public were recruited as volunteers and then taught how to act as a simulated patient. One of their key observations was the need to help volunteers get into role. Volunteers began by saying that they wanted to help the students learn to be better health professionals – a legitimate goal when out of role. Part of being in role was to recognise that they needed to focus on understanding the meaning of their medical test results or deciding whether to accept treatment – to become the patient, rather than the volunteer. Other aspects of learning to act are relevant too, as discussed by Taylor (2014)[36] and Cowperthwait et al (2014)[37]

Support Groups for the public

In the UK, a [Simulated Patient Programme](#) has been run at the School of Medicine, University of Nottingham and there has been a group of patient simulators based at [DREEAM](#) in the Emergency Department at QMC. Bryn Baxendale leads the [Trent Simulation and Clinical Skills Centre](#). Jonathan Wright at the Involvement Centre of Nottinghamshire Healthcare NHS Trust is involved in a project that blends actors and experts by experience to deliver teaching for medical students[38].

Research and publications

A considerable amount of published material is available on simulation, although some of it is about technology-enhanced learning rather than patient simulators or actors[39]. Simulation has been used in training doctors[40], nurses[41], and social workers[42], radiographers[43] and perhaps others too. The journals [Simulation in Healthcare](#), [Advances in Simulation](#) and [Clinical Simulation in Nursing](#) provide platforms for peer-reviewed papers on the subject, although there is a large number of papers in other journals too[44].

There is evidence[45] that experts by experience can help students learn the values inherent in mental health nursing and emerging evidence regarding the impact of patient stories on mental health recovery[46].

National, international and regional networks

The UK East Midlands has a Simulation Strategy 2010-2015 ([here](#)) and Simulation Network ([here](#)). The international Association for Simulated Practice in Healthcare ([ASPiH](#)) runs conferences and their Standards are set out [here](#)[47] along with a lengthy bibliography. ASPiH note that there is substantial variation in arrangements amongst simulated patient groups, both in how to engage with lived experience and in respect of payment for simulated patients. Some strenuously avoid professional actors; some offer no remuneration, while others take opposing views[48]. The Standards of Best Practice helpfully list factors that create psychological safety[49], and which could equally well be applied to experts by experience as to simulated patients, as follows:

Creating psychological safety – adapted from the Standards of Best Practice as defined by the Association for Simulated Practice in Healthcare
Assure safe working conditions in the design of the activity
Anticipate and recognize potential occupational hazards, including threats to the person's safety in the environment
Screen the person to ensure that they are appropriate for the role

Allow the person to opt out of any given activity if they feel it is not appropriate for them to participate.
Brief the person so they are clear about the guidelines and parameters of the activity.
Provide the person with strategies to mitigate potential adverse effects of disclosure/portrayal and prevent physical injury or fatigue.
Inform the person about the criteria and processes for terminating the session if they deem it harmful.
Structure time and create a process for debriefing
Understand the principles of confidentiality that apply to all aspects of each event.
Protect the privacy of the personal information of all stakeholders including that which may be revealed within the session.
Respect the person's self-identified boundaries.
Provide the person with adequate information so that they can make informed decisions about participation in work assignments.
Ensure that the person understands if and how they are being compensated before accepting work.

Further advice on engaging experts by experience as lecturers can be found in *How to engage the public as lecturers*.

Other networks include ASPE, INACSL. SESAM and SSiH, although some of their resources are only accessible to feepaying members, shutting out many experts by experience and simulated patients. The Simulated Patient Network provides free online training.

Status of this document

This is one of a suite of more than 30 *How To* guides that explore practical ways to coproduce healthcare research, delivery, teaching and evaluation. They can all be downloaded from here. Each has been co-authored[50] in public, is available online from the very first draft and each version is amended as soon as anyone suggests an improvement to the text[51]. They are therefore never finished and always open to capturing tacit knowledge and proven expertise from new sources.

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[1] To make this guide easy to understand, medical terminology is often used, such as 'patient', 'health condition' or 'healthcare setting', but the issues apply whether one is teaching medical or social work students, physiotherapists or psychologists. Usage of these terms does not imply adoption of the 'medical model'.

[2] This paper uses the term 'actor' in its lay sense, referring to anyone playing a part. People working in the field of patient simulation use a different definition which tends to ignore the acting

profession and instead uses the term to mean that the person who is playing the part of the patient has been trained and briefed to the extent that a clinician cannot tell them apart from a patient with the condition unless they have access to test results. See Lopreiato, J. O. (Ed.), Downing, D., Gammon, W., Lioce, L., Sittner, B., Slot, V., Spain, A. E. (Associate Eds.), and the Terminology & Concepts Working Group. (2016) *Healthcare Simulation Dictionary*. Retrieved from http://www.ssih.org/dictionary.

[3] Computer controlled whole body manikins can breathe, have audible heart and breath sounds, palpable pulses, can blink and even speak.

[4] See https://www.aspeducators.org/assets/docs/ASPEHistory2014.pdf for a historical perspective on these roles. An authoritative text on medical examination was authored by Barbara Bates and published in 1974 as a *Guide to Physical Examination.* After her death in 2002 others have edited regular updates. See https://batesvisualguide.com/.

[5] Given appropriate support, observing a simulation or role-play can help learners as much as participating in it. See O'Regan S, Molloy E, Watterson L & Nestel D (2016) Observer roles that optimise learning in healthcare simulation education: a systematic review *Advances in Simulation,* 1:4 https://doi.org/10.1186/s41077-015-0004-8.

[6] Mollo EA, Reinke CE, Nelson C, Holena DN, Kann B, Williams N, Bleier J, Kelz RR. (2012) The simulated ward: ideal for training clinical clerks in an era of patient safety. *Journal of Surgical Research.* Sep;177(1): e1-6. DOI: 10.1016/j.jss.2012.03.050. Epub 2012 Apr 12. Available at https://www.ncbi.nlm.nih.gov/pubmed/22524978.

[7] Much of the material in this section came from Thistlethwaite J and Ridgway G (2008) *Making it Real: A Practical Guide to Experiential Learning of Communication Skills, Part 2*, Radcliffe Publishing. See https://books.google.co.uk/books?id=OJoo9Hx0pU0C&pg=PA7&lpg=PA7&dq=simulated+patients&redir_esc=y&hl=en#v=onepage&q=simulated%20patients&f=false

[8] The PEARLS debriefing framework can help in setting the tone and structuring this stage of learning. Eppich W, Cheng A (2015) Promoting excellence and reflective learning in simulation (PEARLS): Development and rationale for a blended approach to health care simulation debriefing *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare:* April 2015 - Volume 10 - Issue 2 - p 106–115. Doi: 10.1097/SIH.0000000000000072. Available at https://debrief2learn.org/pearls-debriefing-tool/.

[9] Sometimes it is important for the guest to answer the question that has been asked, rather than the one that should have been asked. Both experts by experience and simulated patients may benefit from coaching in how to give constructive feedback.

[10] The field is further complicated by idiosyncratic use of further specialist terms, including patient simulator, human patient simulator, role player, expert simulated patient, lay clinical educator, simulated participant and standardised patient. In contrast, people called patients or experts by experience are sometimes called 'real' patients.

[11] So far, a paper has not been found that explores the topic covered in this guide. Inquiries with the SP-Trainer online community have, so far, been unsuccessful in finding anyone who wishes to recognise the merits of the alternative approach or engage in such a dialogue. Indeed, one respondent suggested that Experts by Experience were doing no more than 'forming a rogue community who are making up a whole new brand of SP educational methodology'. Personal communication, December 2019. A further inquiry was sent 24/4/20.

[12] Jack D, Gerolamo AM, Frederick D, Szajna A & Muccitelli J (2014) Using a trained actor to model mental health nursing care *Clinical Simulation in Nursing* (October) Volume 10, Issue 10, Pages 515–520. DOI: https://doi.org/10.1016/j.ecns.2014.06.003

[13] Johnson, B. (1992). *Polarity management: Identifying and managing unsolvable problems*. Amherst, MA: HRD Press.

[14] We might declare that the authentic report from an expert by experience is indisputable, but this will not stop some students questioning the veracity of the account. In order for students to benefit, they must suspend their disbelief and immerse themselves in the experience. This has been explored for simulations and the findings are perhaps applicable to experts by experience. See Muckler VC (2017) Exploring suspension of disbelief during simulation-based learning *Clinical Simulation in Nursing,* Volume 13, Issue 1, 3 - 9

[15] One thinks of the ways in which voice-hearing strategies might challenge medical definitions of schizophrenia, hospital wards that look out on green space might unseat traditional models of recovery after surgery and volunteering might disturb pharmacological explanations of pain. Experts by experience may bring such perspectives into the classroom and challenge conventional scientific notions of what constitutes evidence as well as asking awkward questions about the appropriate remit of health professionals.

[16] Miles Rinaldi found that employees with mental health issues who were in the right job role and receiving the right support (i.e. Individual Placement and Support or IPS) were absent from work less than their nondisabled counterparts (personal communication), so it is important to avoid stereotypes that suggest that experts by experience are less reliable than others. Whilst there are many randomised controlled trials that compare IPS with matched unemployed persons, I have been unable to locate a study that matches IPS-placed employees with their regular work colleagues and then tracks their sickness absence rate in order to make a valid comparison (advice sought from Tom Ayers, Marion Blake, Bob Drake, Helen Lockett, John Marsden, Adam Whitworth). Despite the lack of evidence, the point stands that stereotypes which categorise mentally ill or disabled persons as unreliable should be rejected.

[17] Silverman, A. M. (2015). The perils of playing blind: Problems with blindness simulation, and a better way to teach about blindness *Journal of Blindness Innovation and Research,* 5(2). https://nfb.org/images/nfb/publications/jbir/jbir15/jbir050201.html. DOI: http://dx.doi.org/10.5241/5-81. Also, Nario-Redmond, M. R., Gospodinov, D., & Cobb, A. (2017). Crip for a day: The unintended negative consequences of disability simulations. *Rehabilitation psychology*, 62, 324 –333. http://dx.doi.org/10.1037/rep0000127. Also, Ladau, E. (2014, March 11). I won't pretend that disability simulation works. *Huffington Post Online*. Retrieved from https://www.huffingtonpost.com/emily-ladau/i-wont-disability-simulation_b_4936801.html.

[18] There is a considerable literature on 'failing to fail'. For a perspective on this by experts by experience, see Malihi-Shoja L et al (2013) We aren't all winners: A discussion piece on 'failure to fail' from a service user and carer perspective *Journal of Practice Teaching & Learning* 11(3), pp.8-16. DOI: 10.1921/1902110302.

[19] In the VOICE study, Conversation Analysis was carried out on videos of real interactions between patients and healthcare professionals. The outputs of this analysis then provided the core of the script that was devised to teach communication skills. The VOICE team called the actors 'simulated patients', although they were professional actors, engaged because they were most likely to be able to stay true to the script, which specified details such as inflection as well as the words to be used. See https://www.nottingham.ac.uk/sociology/documents/news-events/voice-skills-training.pdf

[20] Self-efficacy, resilience and working towards overarching life goals help people escape the fear-avoidance cycle and move towards recovery, so it is not as simple as just denying people with pain opportunities to participate. See Meulders, A. (2019). From fear of movement-related pain and avoidance to chronic pain disability: a state-of-the-art review. *Current Opinion in Behavioral Sciences*, *26*, 130-136. https://doi.org/10.1016/j.cobeha.2018.12.007. Also Slepian PM, Ankawi B, France CR (2020) Longitudinal analysis supports a Fear-Avoidance model that incorporates pain resilience alongside pain catastrophizing *Annals of Behavioral Medicine,* Volume 54, Issue 5, May, Pages 335–345, https://doi.org/10.1093/abm/kaz051.

[21] Pollock, Christine et al (2016) Discovering the lived experience of students learning in immersive simulation *Clinical Simulation in Nursing,* Volume 12, Issue 8 (August), 313 – 319. For a review of the concept of psychological safety as applied to teams where sharing is vital to task achievement, see Edmondson AC, Lei Z (2014) Psychological safety: The history, renaissance, and future of an interpersonal construct.*Annual Review of Organizational Psychology and Organizational Behavior*. *1(23-43)*

[22] Janzen, Katherine J. et al. (2016) Handling strong emotions before, during, and after simulated clinical experiences *Clinical Simulation in Nursing,* Volume 12, Issue 2 (February), 37 – 43. Diaz-Agea and colleagues observed students responding to experts by experience with applause, tears and hugs – see Díaz-Agea, José L. et al. (2017) Patient-oriented debriefing: Impact of real patients' participation during debriefing *Clinical Simulation in Nursing,* Volume 13, Issue 9, 405 – 413.

[23] Repetition does not necessarily overcome the gendered power imbalances inherent in these situations. See Kearney GP, Gormley GJ, Wilson D, Johnston JL. (2018) Blurred boundaries: sexuality and power in standardised patients' negotiations of the physical examination. *Advances in Simulation.* Jun 26; 3. 11. https://doi.org/10.1186/s41077-018-0069-2.

[24] Barrows HS (1993) An overview of the uses of standardised patients for teaching and evaluating clinical skills *Academic Medicine* Vol 68, No 6, p443-451.

[25] Jarosinski JM and Webster DA (2016) Acting with a purpose: The lived experience of actors in the role of Standardized Patients portraying mental illness *Clinical Simulation in Nursing* December 2016, Volume 12, Issue 12, Pages 539–545. DOI: https://doi.org/10.1016/j.ecns.2016.08.005.

[26] Plaksin J, Nicholson J, Kundrod S, Zabar S, Kalet A & Altshuler L (2016) The benefits and risks of being a Standardized Patient: A narrative review of the literature *The Patient - Patient-Centered Outcomes Research* February 2016, Volume 9, Issue 1, pp 15–25.

[27] ASPiH note that most sessions last 3-4 hours and recommend remuneration, as they expect people to be regarded as part of the faculty and trained. Despite this, they note that there is substantial variation in payment arrangements, ranging from volunteers who receive nothing to £30 per session up to £200 or more. Where payment is offered, the rate can vary according to the demands of the role or the experience of the actor. (Personal communication, Carrie Hamilton June 2018).

[28] Snow R (2014) Real patient participation in simulations Chapter 14 in Nestel D & Bearman M (eds) (2014) *Simulated Patient Methodology Theory, Evidence and Practice* Wiley Blackwell.

[29] Rutala PJ, Stillman PL & Sabers DL (1981) Housestaff evaluation using Patient Instructors: A report of clinical competence *Evaluation & the Health Professions* Volume: 4 issue: 4, page(s): 419-432. December 1. https://doi.org/10.1177/016327878100400405.

[30] Personal communication 24 June 2019. See also Muckler 2017 op cit.

[31] Sandra Hutton has been experimenting with these approaches. It would be great to describe this work in more detail.

32 Konstantin Stanislavsky (1863-1938) founded the Moscow Art Theatre and championed this approach. However, advocates of simulation fear that adopting this approach will result in the actor overidentifying with the role and prevent them from being able to quickly take 'time out' from the role and promptly return to it when directed to resume 'time in'. See Chapter 16 of the *Review manual for the Certified Healthcare Simulation Educator (CHSE) exam.* New York: Springer Publishing.

33 Amyotrophic lateral sclerosis (ALS) is also known as motor neurone disease.

34 An example is the play called "The Possibility of Colour" written by Pete Carruthers and produced by tree fish productions. A local tour of this play has been evaluated in a report setting out the learning outcomes for health professionals and student nurses.

35 Pate G and Ricardo L (2016) Playing sick: Training actors for high fidelity Simulated Patient encounters *The Journal of American Drama and Theatre* Volume 28, Number 2 (Spring). ISNN 2376-4236. Available here.

36 Taylor N (2014) We're play-acting: Simulation and dramaturgical sociology *Clinical Simulation in Nursing* (November) Volume 10, Issue 11, Pages 554–558. DOI: https://doi.org/10.1016/j.ecns.2014.08.004.

37 Cowperthwait A, Saylor J, Schell K (2014) Healthcare theatre: A unique simulation partnership *Clinical Simulation in Nursing* (2014) (January) Volume 10, Issue 1, Pages e41–e46. DOI: https://doi.org/10.1016/j.ecns.2013.05.012.

38 Personal communication, 22 Jan 2018. It would be useful to have reference details for this work and a description of it.

39 Berragan L (2011) Simulation: an effective pedagogical approach for nursing? *Nurse Education Today.* 31, 7, 660-663. Also Hope A, Garside, J, Prescott S (2011) Rethinking theory and practice: pre-registration student nurses' experiences of simulation teaching and learning in the acquisition of clinical skills in preparation for practice. *Nurse Education Today*. 31, 7, 711-715. Also, Murray C, Grant M, Howarth M (2008) The use of simulation as a teaching and learning approach to support practice learning *Nurse Education in Practice.* 8, 1, 5-8. Also, Nazarjuk, A., Bernal, C. & Southgate, A. (2013). Involving service users in student education. *Learning Disability Practice,* 16(5), 14-19. Also, Webster BJ, Goodhand K, Haith M, Unwin R. The development of service users in the provision of verbal feedback to student nurses in a clinical simulation environment. *Nurse Education Today* 2012;32(2):133-138. Also Kneebone R, Weldon SM & Bello F (2016) Engaging patients and clinicians through simulation: rebalancing the dynamics of care *Advances in Simulation* **1**:19. Available at https://doi.org/10.1186/s41077-016-0019-9. Also, MacLean S, Kelly M, Geddes F, Della P (2017) Use of simulated patients to develop communication skills *Nurse Education Today* Jan;48:90-98. doi: 10.1016/j.nedt.2016.09.018.

40 A survey of medical student training in America received responses from 90 medical schools and 64 teaching hospitals that were all using simulation in some form. See AAMC (2011) *Medical simulation in medical education: Results of an AAMC survey* Washington DC: Association of American Medical Colleges.

41 Sideras S, McKenzie G, Noone J, Markle D, Frazier M & Sullivan M (2013) Making simulation come alive: standardised patients in undergraduate nursing education *Nursing Education Perspectives* 34, no 6, 421-25.

42 Forgey MA, Badger L, Gilbert T and Hansen J (2013) Using standardised clients to train social workers in intimate partner violence assessment *Journal of Social Work Education* 49:292-306.

[43] Shiner N (2018) Is there a role for simulation based education within conventional diagnostic radiography? A literature review *Radiography* Available online 7 February 2018. https://doi.org/10.1016/j.radi.2018.01.006.

[44] Walsh C1, Lydon S, Byrne D, Madden C, Fox S, O'Connor P (2018) The 100 most cited articles on healthcare simulation: A bibliometric review. *Simulation in Healthcare*. 2018 Jun;13(3):211-220. doi: 10.1097/SIH.0000000000000293.

[45] Happell B et al (2018) Changing attitudes: The impact of Expert by Experience involvement in mental health nursing education: An international survey study *International journal of mental health nursing.* DOI: 10.1111/inm.12551.

[46] Rennick-Egglestone S, Morgan K, Llewellyn-Beardsley J, Ramsay A, McGranahan R, Gillard S, Hui A, Ng F, Schneider J, Booth S, Pinfold V, Davidson L, Franklin D, Bradstreet S, Arbour S, Slade M Mental health recovery narratives and their impact on recipients: systematic review and narrative synthesis, *Canadian Journal of Psychiatry*, in press.

[47] There are also standards produced by ASPE and INACSL as well as further information from SSiH.

[48] Carrie Hamilton, personal communication 7 June 2018.

[49] Lewis KL, Bohnert CA, Gammon WL, Hölzer H, Lyman L, Smith C, Thompson TM, Wallace A, Gliva-McConvey G. (2017) The Association of Standardized Patient Educators (ASPE) Standards of Best Practice (SOBP) *Advances in Simulation* 2:10 https://advancesinsimulation.biomedcentral.com/articles/10.1186/s41077-017-0043-4

[50] Requests for help and comment sent to Mary Aiello, ASPE, Rebecca Baines, Zoe Bendelow, Dana Brittan, Laura Byrne, Xander Carey, Connie Coralli, Ralph Della Ratta, Charlotte Denniston, Barbara Eulenberg, Valerie Fulmer, Gail Furman, Suzanne Gough, Gerry Gormley, Bridget Hamilton, Dena Higbee, Barbara Hildebrand, Brian Hodges, Mark Holmes, Nick Hutchinson, INACSL, Involving Australia, Judith Jarosinski, Debasish Kar, Bob Kiser, Chelsea Knutson, Kathy Kyle, Gloria Lagou, Carine Layat Burn, Jeff McQueen, Joe Miller, Carla Mosley, Paul Murphy, Debra Nestel, Tamara Owens, Christine Park, David Patterson, Roni Porfert, Iris Price, Jan-Joost Rethans, Karen Reynolds, Annette Roebuck, SESAM, SSiH, Sydney Smee, Paula Stillman, Diana Tabak, Natalie Teal, Tanya Tierney, Danielle Vogt, Amber Hansel Walton, Sarah Wilding, Iain Wilkinson, Jonathan Wright, Aileen Zanoni. **The following people** have kindly responded to an inquiry with comments and challenges to this discussion: José L. Díaz-Agea, Carrie Hamilton, Nicole Harder, Sarah Goldberg, Elizabeth Kachur, Amy Lorion, Nancy McNaughton, Chris Muckler, Cate Nicholas, Lisa Roder, Naomi Shiner, Kris Slawinski, Sydney Smee, Cathy Smith, Jennie Struijk, Natasha Taylor and Rachel Yudkowsky.

[51] Most of the documents we read are finished pieces of work, carefully crafted and edited in private before being shared with anyone else. This is a different kind of paper – it was shared online from the first day, when the initial handful of ideas were incomplete, poorly phrased and tactless. The work has been edited many times, and, on each occasion, a revised version has replaced the earlier material online. This process is still under way, and so this paper may still be lacking crucial concepts, evidence, structure and grammar. As readers continue to provide feedback, further insights will be used to update it, so please contact peter.bates@ndti.org.uk with your contributions. This way of writing is risky, as it opens opportunities to those who may misunderstand, mistake the stopping points on the journey for the destination, and misuse or distort the material. This way of writing requires courage, as an early version can damage the reputation of the author or any of its contributors. Or rather, it can harm those who insist on showing only their 'best side' to the camera, who want others to believe that their insights appear fully formed, complete and beautiful in their simplicity. It can harm those who are gagged by their employer or the workplace culture, silenced

lest they say something in a discussion that is not the agreed party line. It can harm those who want to profit from their writing, either financially or by having their material accepted by academic journals. In contrast, this way of writing can engage people who are not chosen to attend the meeting or asked for their view until the power holders have agreed on the 'right message'. It can draw in unexpected perspectives, harvest tacit knowledge, stimulate debate and crowdsource wisdom. It can provide free, leading edge resources.