Wigs, brown sauce and theatrical dames: clinical simulation as play

Walking into the store cupboard, just off the A&E ward, I see a pile of arms in a box. Two luxuriant scalps lay across a closed hospital laptop. Flaccid faces peak out of a drawer. Some brown liquid with a couple of blood-red specks is splattered across the base of a stainless-steel kidney dish.

That store cupboard is where a London hospital's simulation centre keeps its theatrical apparel (see Figure 1). This is brought out whenever there is a simulation-based medical education course, together with the toiletry bags of make-up and sacks of costumes. The doctors and nurses who work in the simulation centre dress up the mannequin to appear as a young man who has just had a motorbike accident; or an elderly lady unsteady on her feet; or a young woman with acute pain in her belly – the appearance of each character, as in countless episodes of *ER* or *Holby City*, provoking the summary telling of a backstory, the unfolding of a storyline structured around bodily trauma, and narrative crisis resolved in the saving of a life. The doctors and nurses also wear costumes, to enact the parts of the anxious relative, the elated drunk, or the cocksure orthopedic surgeon.

[insert Figure 1: simulation centre store cupboard]

The enactment of critical, clinical situations has become integral to medical education. The argument for this is that healthcare workers can learn to practice safely away from real patients. In much of the clinical literature, simulation-based education is evoked in terms of skills training, and is the very opposite of play. Issenberg et al (2005, p.23), for example, conclude their systematic review of medical simulation by defining it as an "opportunity for learners to engage in focused, repetitive practice where the intent is skill improvement, *not idle play*" [our italics].

One doesn't need to be a Freudian to interpret this negation as pointing to a denied presence: there is indeed play going on in simulation centres. Take a look at Figure 2. It shows a manikin dressed up for a scenario based around the simulation of an ectopic pregnancy. Note how the signifier for 'female body' consists of a large,

colourful bra. The theatricality of the big, bright breasts ensure that junior doctors immediately ascertain the sex of their simulated patient, a crucial step in their differential diagnosis. The bra operates like a theatrical prop: it sets a scene; it provides a clue to the essential meaning of events. In our experience, it tells participants on a professional development course about emergency medicine that the mannequin is a patient whose condition pertains to gynecological intervention.

[insert Figure 2: manikin with pink bra]

There is nothing idle about this play - contra Issenberg et al. It is precisely what makes simulation possible. Participating in a simulation-based course requires cooperative pretending, recognition of the narrative conventions by which scenarios unfold, and the display of traits and emotions appropriate to a fictional scene, but not necessarily outwith this. This is active, creative, and also ideological work which goes far beyond the passive ‘suspension of disbelief’ called for in clinical accounts of

simulation-based teaching (e.g. Gaba et al, 2001).

Such work can be made sense of on the basis of literature that takes play seriously. The anthropologist of play, Brian Sutton-Smith (1997), describes different rhetorics by which play is understood in academic research. One of these – the rhetoric of the imaginary, summarised below - is particularly helpful for making sense of what happens in hospital simulation centres:

> We are eternally making over the world in our minds, and much of it is fantasy. The difference is that while children have toys, adults usually have images, words, music and daydreams, which perform the same function as toys. *Our fantasies are the microworlds of inner life that all of us manipulate in our own way to come to terms with feelings, conflicts, realities, and aspirations as they enter into our lives.* Children and adults may not really be so different in their use of fantasy play...*Play is not based primarily on a representation of everyday real events - as many prior investigators have supposed - so much as it is based on a fantasy of emotional events.* (p. 156 – our italics)

Within this rhetoric, play is understood to be motivated by feelings, rather than unmediated images of reality. It appears as an emotionally vivid experience, which allows the limits imposed by normal or non-play reality to be transcended; mocked as much as mimicked. Rather than representing the world, play deconstructs it, taking it apart in order to suit players' emotional responses to events.

If we draw on this rhetoric to examine field data generated in an ethnographic study

of London-based simulation centers (Pelletier and Kneebone 2015, 2016a, 2016b), we see phenomena that are rarely commented upon in the literature on medical simulation. These include the relish with which parts were played and the pleasure taken in acting ‘out of character’ at work. For instance:

> In the control room, John answers the phone, playing the role of a consultant. In a strong Scottish accent he says: ‘Hamish McTaggart by name...’ The other educators in the control room laugh loudly. John then enters the simulated theatre. Lindsey, the trainee, says to him ‘Hi John’. He responds in a heavy Australian accent: ‘I’m Shane’. [Field notes]

The parody of accents and professional traits was mirrored in the exaggeration of symptoms. Educators explained this in terms of the importance of teaching trainees how to manage clinical situations: it was imperative, then, that trainees recognise a situation as pertinent to clinical knowledge. A scenario was deemed a failure if a trainee did not identify the clinical condition, or if the scenario did not make it sufficiently visible. For example, the following field note was made during one scenario in which a trainee had failed to identify symptoms manifested by the mannequin:

> John asks the technician to increase the settings on the manikin, so that the heart rate falls even more quickly. He then turns to me and says: “well, you have got to make it obvious what is going on, otherwise they just don't know”. [Field notes]

Symptoms and conditions therefore appeared heightened and exaggerated. The urgency, excitement and anxiety this generated contrast with how trainees represented

their everyday work in discussions:

> During the coffee break, Susan, a trainee, says to another trainee standing next to her: 'In my hospital, there isn't a cannula on the whole ward. None of the equipment works. The seniors aren't at all interested in your situation. But I guess there would be no point in simulating this, as *what we want* to learn is the clinical stuff. [Field notes]

The italics here highlight the expression of desire - "what we want to learn is the clinical stuff" – which illustrates Sutton-Smith's point that play is performed "to come to terms with feelings, conflicts, realities, and aspirations as they enter into our lives". The purpose of a course, and the principle according to which aspects of reality were treated as 'simulatable', was – in Susan's words here – the expression of a wish: of learning 'clinical stuff'; of doing meaningful, satisfying, effective and exciting work. It follows that what was not simulated were the dissatisfying, intractable, limiting aspects of life in hospital. This is one way of understanding why paperwork, administration and record-keeping – which take up significant amounts of a junior doctor's time, in 'real life' – were absent from simulation-based practice.

When clinical simulation is treated as a form of play, which is meaningful *because* of its emotional vividness, its educational rationale is affected. It need no longer be accountable solely in terms of developing skills, and apologetic about its simplification of medical work. Rather, there is scope then to explore how it can sustain the deconstruction and analysis of medicine as an emotional practice. These contrasting rationales are not mutually exclusive. However, treating

simulation as an imaginative exercise is one response to “simulation deniers” (Turkle, 2009) who state that it can never be like real life; that it is trapped within its own magic circle, inherently separated from the real world (Caillois, 1967; Juul, 2005). This stance on medical simulation characterises the clinical literature, including the arguments of those who advocate its use: Gaba (2004), for example, justifies simulation in medical education in terms of one day achieving something akin to Star Trek’s holodeck, a claim which celebrates the achievements of current technologies whilst simultaneously deferring their full benefits to some point in the future. Others argue that simulation cannot replace work-based learning, but only supplement it (e.g. Issenberg et al, 2005; Ziv et al 2003). Both of these qualifications treat simulation as a form of illusion: a fake/unreal/inauthentic version of reality.

It is this distinction – ‘*skill improvement, not idle play’* - that upholds a view of play as trivial. But if we follow Sutton-Smith in defining play as the exercise of imagination, it becomes possible to see how the boundaries between reality and non-reality are anything but firm, but rather negotiated and shifting. Simulating professional practice is then not simply a question of learning skills for subsequent transfer to ‘real life’. It is also an exploration of, and an experimentation with, what makes those skills meaningful; worth exercising. Rather than simulation acting only as an ante room to the workplace, it can then be imagined as a space in which the emotional experience of work is manipulable, and thus transformable in ways that go beyond the transfer of skills, to touch on the meaning of those skills for the experience and quality of work. Simulation becomes then a resource with which to explore and manipulate the pains and pleasures of work, its failures and frustrations; and an occasion on which to work

through them to develop better responses to its tribulations.

One incident during fieldwork illustrates our point. It happened as part of a course intended to address a high rate of 'failure to rescue[i]' incidents on one ward. The course involved all staff on that ward. On the day Caroline – one of the authors of this chapter - observed, several of the ward's nurses interrupted the introductory lecture on communication skills to interject that 'failure to rescue' incidents were not caused by a dearth of such skills, but rather by management's irresponsible cost-cutting exercises:

> So what are you going to do if you come round to my ward and I have seven patients to look after, two post-ops, and no HCA[ii] . What are you going to say or do? [Field notes]

The presence of 'management', in the form of the deputy director of nursing, meant that this version of reality was counterposed by another: that the hospital's funding was being cut, with little prospect of future increases. The debate that followed set versions of the reality of work against each other. Nurses pointed to the fictional status of work systems designed to identify deteriorating patients; 'management' disclaimed the power to resolve this. The exchanges shaped what was treated as the object of the simulation: a scenario was not seen as indicative of an individual's capacity to respond to an emergency, but rather of working conditions; and, most importantly, of the different ways in which these were being made sense of in the hospital.

The discussion was heated, which was indicative of what was at stake: how the hospital's failure to rescue patients should be interpreted. The skill exercised by the educators however ensured it did not degenerate into a shouting match: by

repeatedly asking both nurses and ‘management’ to respond to each other’s accounts, to acknowledge their lived and felt reality, the educators enabled the course to become an occasion on which to re-think how clinical work was done, and how the division of labour could be altered to achieve different outcomes. Agreement was not reached on the day Caroline visited the hospital. However, a principle of ongoing collective review appeared to have gained support among both staff and ‘management’.

The course illustrates Sutton-Smith’s account of the benefits of imaginary play: it sustained explorations of versions of reality. This suggests how training-oriented simulations can give rise to aesthetic reconfigurations that make the world appear alterable; and in this sense, make it playful, in the most profoundly serious and non-trivial sense of the word. This has implications for imagining the ethics of professional simulation: simulation may be ethical not because it is safe, but precisely because it is dangerous. It puts versions of reality at stake. It opens up reality to critical transformation. It is on this basis that it might be understood as a central pedagogic resource in professional and higher education.

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[i] Failure to rescue' is a category with the health service's taxonomy of errors, and refers to a failure to identify a rapidly deteriorating patient, who then goes on to die.

[ii] HCA stands for healthcare assistant.