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Abstract

Current revisions to the accreditation standards for occupational therapy (OT) education include proposed changes to experiential learning. The AOTA Fieldwork/Experiential Learning Ad Hoc Committee recommends that fieldwork Level I experiences be replaced with a new model of experiential education that includes the use of standardized patients and simulation (AOTA, 2017). The purpose of this article is to present critical perspectives about standardized patient simulation and disability simulation to support informed decision-making about the integration of experiential learning in OT professional education. In standardized patient simulation, actors play the roles of clients and important others in therapeutic scenarios; in disability simulation, students act out impairments in a variety of settings. While these forms of simulation are commonly used within OT education, they are critiqued for failing to present participants with authentic lived experiences of disability. This paper presents alternative approaches that would more fully align the OT curriculum with perspectives and priorities of intersectional disability communities. Recommendations to be considered by educators and educational programs include becoming familiar with relevant literature across fields and communities; developing long-term partnerships with disability organizations and community members; involving people with disabilities in the development, implementation, and evaluation of experiential learning opportunities; and providing experiential learning opportunities that take place outside educational and clinical settings and that attend to multiple intersecting dimensions of people with disabilities' lived experiences. Together, these recommendations can help ensure that students have access to evidence-based educational approaches and best practices that accurately reflect the self-identified needs, concerns, and priorities of intersectional disability communities.

Keywords

Experiential learning, professional education, simulation, people with disabilities, lived experience

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Experiential Learning: Critical Analysis of Standardized Patient and Disability Simulation

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ABSTRACT

Current revisions to the accreditation standards for occupational therapy (OT) education include proposed changes to experiential learning. The AOTA Fieldwork/Experiential Learning Ad Hoc Committee recommends that fieldwork Level I experiences be replaced with a new model of experiential education that includes the use of standardized patients and simulation (AOTA, 2017). The purpose of this article is to present critical perspectives about standardized patient simulation and disability simulation to support informed decision-making about the integration of experiential learning in OT professional education. In standardized patient simulation, actors play the roles of clients and important others in therapeutic scenarios; in disability simulation, students act out impairments in a variety of settings. While these forms of simulation are commonly used within OT education, they are critiqued for failing to present participants with authentic lived experiences of disability. This paper presents alternative approaches that would more fully align the OT curriculum with perspectives and priorities of intersectional disability communities. Recommendations to be considered by educators and educational programs include becoming familiar with relevant literature across fields and communities; developing long-term partnerships with disability organizations and community members; involving people with disabilities in the development, implementation, and evaluation of experiential learning opportunities; and providing experiential learning opportunities that take place outside educational and clinical settings and that attend to multiple intersecting dimensions of people with disabilities' lived experiences. Together, these recommendations can help ensure that students have access to evidence-based educational approaches and best practices that accurately reflect the self-identified needs, concerns, and priorities of intersectional disability communities.

INTRODUCTION

Occupational therapy entry-level educational pathways are undergoing critical analysis within the profession. The Accreditation Council for Occupational Therapy Education (ACOTE) has upheld its mandate that the entry-level occupational therapy (OT) degree move to the doctoral level (ACOTE, 2017b), and ACOTE Standards are under review with academic program compliance with the new Standards expected by July 1, 2020 (ACOTE, 2017a). Further, in response to challenges the profession is facing in regard to integrating fieldwork and experiential components into OT and occupational therapy assistant (OTA) professional education, the American Occupational Therapy Association (AOTA) has created a Fieldwork/Experiential Learning Ad Hoc Committee and charged it with exploring “alternative models that would best ensure future entry-level practitioners are prepared to meet the occupational needs of society” (AOTA, 2017, p. 2). The Committee has recommended that several alternative models replace current fieldwork Level I requirements to meet the “initial experiential learning requirement” (AOTA, 2017, p. 1). As a result, in Draft II of the ACOTE Standards, experiential learning has replaced Level I fieldwork requirements across all levels of OT and OTA education (ACOTE, 2017c). Experiential learning is defined in Draft II of the Standards as “a method of educating through first-hand experience...acquired outside of the traditional academic classroom setting” (ACOTE, 2017c, p. 53). Among the proposed alternatives are standardized patients and simulation, both of which fall under the umbrella of medical simulation.

Medical simulation is an increasingly popular educational method in healthcare professions, including OT (Alinier, 2007; Bethea, Castillo, & Harvison, 2014). Medical simulation is an umbrella term that includes techniques, devices or activities that aim to authentically recreate or imitate clinical situations or procedures. They can allow for practice of clinical skills through the use of software, virtual reality, or computerized mannequins that represent patients. Although there are both strengths and limitations to these forms of medical simulation that warrant further dialogue, this paper focuses on two other types of medical simulation that include prominent use of humans: standardized patient simulation (SPS) and disability simulation (DS).

The potential of medical simulation to develop practice competencies is well supported in the literature (DeLeon et al., 2015; Rutledge, Garzon, Scott, & Karlowicz, 2004). However, SPS and DS have also garnered significant critique that collectively challenges the supposed beneficence of these exercises (Brew-Parrish, 2004; Duggan, Bradshaw, Carroll, & Rattigan, 2009; Kafer, 2013; Minihan et al., 2004; Nario-Redmond, Gospodinov, & Cobb, 2017). As such, there are grounds for the profession to consider these critiques in order to make informed decisions regarding student experiential learning.

The purpose of this article is to present critical perspectives about SPS and DS to support informed decision-making about the inclusion of simulation in OT professional education. This article can be used to support critical reflexivity and consideration of current knowledge about SPS and DS from disability experts outside our profession. Doing so would help ensure that experiential learning requirements are more fully

“based on best practices from the literature across professions” (AOTA, 2017, para. 1), fields, and communities.

THEORETICAL FRAMEWORK

The disability studies scholar Tobin Siebers's (2008) theory of complex embodiment has been used to frame this discussion. The theory of complex embodiment, which incorporates both social and medical model components, highlights the reciprocal relationship between disabling environments and individual impairments. According to this theory, a person's embodiment is not considered defective or abnormal if it includes disabling factors such as pain or fatigue. Rather, embodiment is viewed as a natural form of human variation—both across individuals and within an individual's lifespan. Further, the theory of complex embodiment considers how intersecting identities, whether dominant or marginalized, impact a person's lived experiences. In other words, how a person experiences disability is multidimensional and is influenced by both social and corporeal factors (Siebers, 2008). For example, environmental barriers and structures of power like racism, homophobia, classism, and ableism combine with a person's categories of difference like race, sexuality, class, and disability to impact the way in which they experience the world.

This paper will examine SPS and DS through a critical lens, using the theory of complex embodiment to critique these approaches and consider alternative experiential learning strategies that might guide students in developing more complex and authentic understandings of people with disabilities' lived experiences. As Audre Lorde (2012) has said, "There is no such thing as a single-issue struggle because we do not live single-issue lives" (p. 138). The theory of complex embodiment provides a framework for us to consider how experiential learning techniques can provide opportunities for students to learn about persons with disabilities' (PWD) lives in the complexity in which they are lived.

STANDARDIZED PATIENT SIMULATION (SPS)

During SPS, trained actors play the roles of patients, family members, and others, allowing students to apply treatment knowledge in safe, structured environments. In a national study of entry-level OT and OTA programs, SPS was the most commonly used form of medical simulation (Bethea et al., 2014). SPS is used to standardize students' clinical exposure and assessment and provide them with safe opportunities to practice and gain expertise in clinical skill development (Barrows, 1993; Rutledge et al., 2004). Research shows that the SPS approach improves student clinical skill assessment, communication skills, and clinical performance (Rutledge et al., 2004) and allows faculty to more efficiently and easily maintain a standard assessment to develop a strong baseline for clinical practice (Beullens, Rethans, Goedhuys, & Buntinx, 1997). Students report that SPS increases self-confidence and cultural competence (Rutledge et al., 2004) and provides a holistic exposure allowing clinicians to look comprehensively at contextual issues that might affect clients' health (Bahreman & Swoboda, 2016).

Increasing innovative use of SPS will no doubt be part of the early phases of clinical education based on the many reported benefits from within OT as well as other clinical professions. However, by reflecting on the critiques of SPS from disability communities, OT can further align with holistic approaches to problem-based learning that address participation barriers described by those with lived experience. These critiques emphasize that the current practice of using non-disabled actors in SPS encourages students to focus on impairment or medical conditions in isolation (Minihan et al., 2004). Many disability communities believe this limited view compromises access to and receipt of quality health care and reinforces stigmas and negative images of disability (Brew-Parrish, 1997). This reinforcement occurs because traditional SPS often conflates disability and ill-health, fails to acknowledge that PWD are experts in their own condition and in navigating healthcare and social service systems, and falls short in incorporating authentic everyday experiences of disability as one of a person's many intersecting identities (Duggan et al., 2009). Faculty describe 'disability' training, time investment, and high costs as drawbacks to using non-disabled actors to play the role of a PWD (Keptner, 2017). Critiques from faculty acknowledge that SPS provides only a narrow scope of useable skills and neglects clients' lived experiences in various social contexts and environments (Barrows, 1993).

DISABILITY SIMULATION (DS)

Disability simulation (DS) has long been used as an experiential learning tool for health science students (Jackle, 1974; Kilbane, 2000; Nario-Redmond et al., 2017). These activities typically consist of students role-playing to experience an impairment directly. While DS activities have little empirical evidence in the OT literature, they continue to be included in OT curricula, such as having students utilize assistive technology devices during their daily routines (Smallfield & Anderson, 2012); wearing gloves to simulate peripheral sensory deficits (Short, Best, Scott, & Bright, 2016); and simulating mobility and visual impairments in various environments (DeLeon, et al., 2015). As part of their design, these activities intend to allow students to practice and integrate clinical skills, such as learning about proper equipment use, assessment execution, and physical environmental barriers (DeLeon et al., 2015; Short et al., 2016; Smallfield & Anderson, 2012). In addition to clinical skill-related outcomes, other intended outcomes include changing perceptions about disability, challenging negative attitudes about disability, evoking empathy for PWD, increasing awareness of barriers to participation, and creating opportunities for reflection (Lalvani & Broderick, 2013; Leo & Goodwin, 2014; Singer, 2016).

While commonly used as an experiential and active learning strategy, the effectiveness of DS in educating future professionals is inconsistent, often with unintended negative consequences. Research suggests that DS can provide a false sense of "true insight" into disability and evoke sympathy rather than empathy (Nario-Redmond et al., 2017; Silverman, Gwinn, & Van Boven, 2015). Both participants and organizers question the role of DS in educational curricula, recognizing inaccuracies in attempted representations of disability experiences and calling into question their game-like rather than academic exercise execution (Colwell, 2012; Lalvani & Broderick, 2013; Silverman et al., 2015). In addition, critiques by disability communities see DS as not just ineffective but

philosophically problematic. These simulations are typically designed by non-disabled people for non-disabled participants and often elicit feelings of pity that perpetuate the stigma that disability is a 'bad and sad' experience (Brew-Parrish, 2004; Shakespeare & Kleine, 2013). While DS intends to provide students with opportunities to engage with disability, the methods often artificially construct lived experiences of disability without highlighting the complexity of challenges to full community and social participation. They also typically ignore the adaptive strategies, positive disability identity, and sense of community PWD develop throughout their lives (Brew-Parrish, 2004; French, 1992). Further, analysis after disability simulation is often focused on temporarily experienced impairments and physical barriers while ignoring more complex phenomena such as discrimination, marginalization, and internalized oppression, thus reinforcing a medicalized view of disability that leaves out culture, economics, politics, rights, and justice (Kafer, 2013; Lalvani & Broderick, 2013; Leo & Goodwin, 2014).

ALTERNATIVES TO USING SPS AND DS IN PRACTICE

There are several alternatives to 'traditional' SPS and DS approaches that would achieve similar aims while also avoiding the aspects that disability communities oppose.

SPS Alternatives

Recent research demonstrates the positive responses of students when academic programs creatively explore viable alternatives to traditional experiential education (Nielsen, Jedlicka, Hanson, Fox, & Graves, 2017). As an alternative to traditional SPS, OT professional education programs can hire PWD trained in providing standardized encounters in the role of standardized patient educators (SPEs). Using SPEs allows students to learn from experts on living with disability while also lending credibility to the simulation experience (Yuker, 1988). This model allows students to have a greater understanding of disability as a natural part of the human condition, "reframe medical problems, question assumptions, and look at patients beyond a disability diagnosis" (Duggan et al., 2009, p. 806). PWD in the role of educators offer a more direct translation of real client conditions that can broaden the scope of student exposure and skill development by treating the person within the social context in which they live. This experience allows an opportunity for narrative feedback to students on behaviors, attitudes, and skills demonstrated during the encounter (Minihan et al., 2004). Paying SPEs for their work also opens the door for employment opportunities for a largely under-employed community and affirms the right of PWD to make informed decisions about how they wish to participate within medical and rehabilitation arenas. In addition to using PWD as SPEs, other alternatives include hiring PWD as guest lecturers to explain their experiences, present accurate images of life with disability, and offer recommendations to students on how to develop more culturally competent interventions (Gill, Mukherjee, & Garland-Thomson, 2016).

DS Alternatives

Cultural competence, cultural humility (Kirschner & Curry, 2009), and disability literacy (Heffron, 2016) trainings fulfill many of the same aims as DS but are more readily accepted by disability communities (Shakespeare & Kleine, 2013). These trainings often focus on expanding audience members' critical self-reflection and understanding of

PWD as members of a cultural minority group with shared experiences of discrimination, pride, and community (Minihan et al., 2004). Ideally, such trainings would be led by or with disability community members and/or disability advocacy organizations (Eddey & Robey, 2005).

Another way to provide students with experiential learning opportunities outside of medical simulation and medical/rehabilitation settings is to establish fieldwork sites in 'nontraditional' settings such as community mental health, disability advocacy, and social service agencies (Nielsen et al., 2017). Doing so could also address critical fieldwork site shortages in ways that are aligned with disability community priorities. This could serve both student and community needs through exposure to and supervised provision of proactive, community-based, in-context support, peer support and mentoring, and opportunities to gain awareness about civil rights and legal counsel to combat disability discrimination.

Students might also benefit from being with and learning from PWD as mentors outside a classroom or clinical setting (Gill et al., 2016). Socially engaging with and learning from mentors with disabilities "on their own turf" in disability community and disability advocacy settings could afford students opportunities to ground their disability education in sociocultural and historical contexts (Lave, 2011). A similar, more short-term alternative could involve student learning about physical and environmental supports and barriers on campus through the completion of usability and accessibility audits led by PWD. Such audits could be completed in place of non-disabled student simulation of disability using wheelchairs or other mobility devices to navigate around campus. Instead, PWD-led audits would provide a more authentic look into what campus life might be like for students, staff, and faculty with disabilities. Further, upon completion of the audits, students could advocate for short-term and long-term changes on campus alongside and/or according to the issues identified as most concerning to the auditors with disabilities.

In lieu of conducting DS, experiential learning opportunities can involve the integration of disability arts and cultural works and events such as memoirs, film screenings, and plays written by playwrights with disabilities and starring actors with disabilities; documentaries about disability rights and culture; and engagement in disability rights activism. A few examples of socially and politically conscious documentaries about disability include "Code of the Freaks" (Code of the Freaks, n.d.), which takes a critical look at portrayals of disability in mainstream cinema, and "Lives Worth Living" (Storyline Motion Pictures, 2011), a documentary about the Disability Rights Movement and ongoing inaccessibility and discrimination experienced by PWD. Disability arts productions can also challenge students to see disability through a non-medicalized lens. For example, "Sins Invalid", a performance project "centralizing artists of color and queer and gender-variant artists as communities who have been historically marginalized" (Sins Invalid, n.d., para. 1) creatively challenges dominant views about normalcy, disability, and sex and could become an invaluable part of an OT curriculum. More resources about disability arts and culture can be found at <http://www.notpd.org/resources/>.

Finally, students can engage in disability rights activism and advocacy events organized by Centers for Independent Living and can participate in service learning opportunities (Gitlow & Flecky, 2005) to apply their knowledge of occupational and social justice in ways that directly benefit local disability communities. Additionally, students can discuss video clips, images, and articles about historic and current disability activism, such as the 504 Sit-Ins (Disability Rights Education & Defense Fund, 2010; Shoot, 2017), the Capitol Crawl (Olin, 1990), vigils and acts of civil disobedience in protest of threats to health insurance coverage (Nichols, 2017), as well as an extensive repertoire of disability activism organized over the past 25 years (National ADAPT, 2017).

DISCUSSION

The educational pathway for entry-level OT is undergoing critical analysis by the profession. ACOTE has upheld its mandate that the entry-level OT degree requirement move to the doctoral level (ACOTE, 2017b). Further, fieldwork site shortages and other issues challenge the profession to adapt in order to meet the early experiential learning needs of students. With experiential learning set to replace current Level I fieldwork requirements at all levels of OTA and OTA education (ACOTE, 2017c), this is a timely issue that will affect all new practitioners. This paper presented critical perspectives about SPS and DS as recommended models for meeting “initial experiential learning requirements” (AOTA, 2017, p. 1). While there is substantial evidence touting the benefits of incorporating SPS and DS in OT curricula, these approaches have garnered considerable criticism from disability communities as key stakeholders in the implementation of these approaches.

This paper critically examined SPS and DS using the theory of complex embodiment (Siebers, 2008) and offered alternatives that OT educators might consider to extend student consciousness of intersecting identities and systems of power (e.g., racism, sexism, homophobia, and disability oppression) that impact a person’s lived experiences. Occupational therapy’s tenets are based on a holistic and client-centered appreciation of fundamental elements of daily living that promote meaningful occupational engagement (Hammell, 2009). Medical simulation, including SPS and DS, are embraced by other allied health professions as a means to hone evaluation and intervention skill development that targets the essence of their professional specialization. However, in OT/OTA education, attention to complex embodiment is critical for understanding the multifaceted aspects of living with disability (Siebers, 2017) inherent in OT philosophical underpinnings. Complex embodiment cannot be taught through inauthentic representations of disability by non-disabled actors. Exposing students to approaches that reduce people to the diagnoses assigned to them establishes early on a status quo of perceiving clients as primarily their diagnoses. In the process, this serves to erode OT’s unique occupation-based focus. Using the theoretical framework of complex embodiment can allow educators to extend discussions about meaningful occupation to include social locations of disability, as well as how clients’ multiple intersecting identities are influenced by the contexts and systems of power within which their occupations occur.

At a time when our profession is re-evaluating its best practices for preparing future clinicians, we have the opportunity to simultaneously re-evaluate what is considered 'best practice'. Vision 2025 highlights the importance of "facilitat[ing] participation in everyday living" (AOTA, 2016, para. 1), therefore moving our profession beyond an emphasis on body structure and function to more thoroughly address social, cultural, and economic barriers that PWD are experiencing. The Vision's core tenets highlight the importance of being culturally responsive, which includes responding to disability communities' concerns and priorities. Responding to disability communities' critiques of our educational approaches as outlined in this article requires us to go deeper than simply reflecting on educational design. In order to truly consider what is at the heart of these critiques, we need to rethink how we as a profession perceive life with disability and how our preconceptions about disability and other intersecting identities might affect our practice, and more importantly, our clients and broader disability communities (Shaw, 2010).

When choosing alternatives to SPS and DS, it is important to be critically reflective throughout the development and implementation processes. Being critically reflective can include asking questions such as: Why do I want to do disability simulations? How could these simulations be harmful to PWD? How can I better share power with PWD who would like to be involved with educating students? Do our actions show that we value the contributions of PWD? Are we making contributions to disability communities in return? Engaging in ongoing discussions and developing long-term, mutually beneficial relationships with disability communities is needed to work together on issues of shared concern. Being open and responsive to critiques from disability communities can support continued dialogue with PWD about the systemic issues that matter most to them.

These questions and concerns provide infinite opportunities to inform future research and directions in curriculum design. As the profession pushes beyond traditional clinical settings to advance our stronghold on promoting occupational participation, it will be insufficient to focus on normalizing ideologies in clinical education and intervention. Incorporating the expertise of PWD and their embodied knowledge into student experiential learning might facilitate clinical and research questions to address the many contributing barriers to occupational deprivation, marginalization, and social injustice.

Implications for Occupational Therapy Education

Critically evaluating the limitations of traditional medical simulation and considering alternative solutions can be valuable exercises in professional reflexivity. However, in order to effect meaningful change within the profession, critical reflection must be paired with action (Freire, 2000). As OT educators, we can use our power to amplify the voices of intersectional disability communities during decision-making processes that impact them, such as the use of medical simulation within OT and OTA educational programs. In order to do this, educators can:

- Review relevant literature and media from across professions, fields, and communities, including critical and creative works by PWD. Require these works

in the entry-level curriculum and refer to them when developing educational innovations in experiential learning strategies and approaches.

- Partner with disability advocacy organizations and disability communities and learn from them about their self-identified concerns and priorities related to medical simulation and how they think OT practitioners can better meet their needs. Consider these conversations when developing and implementing experiential learning opportunities for students.
- Involve PWD in all aspects of experiential learning, including development, implementation, and evaluation processes. Invite critique and respond to recommendations for modification and improvement, and compensate partners with disabilities for their time and expertise.
- Consider experiential learning opportunities in community-based, non-clinical settings where OT and OTA students can socially engage with PWD and learn from them as mentors about issues that concern them.
- When implementing experiential learning approaches, ensure that medicalized aspects of PWD's experiences (e.g., pain, impairment, functional limitation) are neither overemphasized nor presented in isolation. Rather, ensure consideration of multiple intersecting dimensions of people's lived experiences, such as how their categories of difference might combine with environmental barriers and structures of power to impact their experiences. Attend to intersectionality (Crenshaw, 1993) when considering how OT practitioners can intervene to improve participation in meaningful activities.

Engaging in critical reflection and action can ensure that students have access to evidence-based educational approaches and best practices during the experiential learning components of their professional education. This will allow OT and OTA educational programs to graduate more socially responsive practitioners, meet clients' broader participation-based needs and goals, and move toward fulfilling AOTA's Vision 2025.

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