Culturally and Linguistically Diverse Simulated Patients: Otherness and Intersectional Identity Transformations Revealed Through Narrative

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Abstract

Simulation aims to replicate the important aspects of a situation to aid learning. Simulated patients (SPs) should ideally represent the diversity of patients encountered in clinical practice. Culturally and Linguistically Diverse (CALD) people are underrepresented in simulated patient groups in comparison to population demographics. Little is known about CALD SPs. The research aim was to explore the experience of CALD people who have worked as simulated patients.

The methodology is narrative. In accordance with the intention to reveal values, beliefs and actions embedded in a particular context, participant stories were explored to reveal rich and meaning-making content. This approach offered motivations, rationales and driving emotions rather than outcomes. Participant stories were developed preserving the coherence of their account using a modified version of Emden's (1998b) process. The theoretical framework of intersectionality was used as this supported the complexity of individual identities whilst reflecting contexts and cultures. Using an interpretive scheme of significance, value and intention a thematic analysis was undertaken. This analysis was intensified through intersectional analysis.

Five themes and four intersectional identity groups emerged. The five themes: The SP experience, The SP imperative, Otherness, Learning and Identity emerged. These themes encapsulate the changing selves of the SP through their life journeys and more poignantly their simulated journeys. The four intersectional identity groups: shielding emotion, taming stigma, influencing image and overcoming ignorance represented the dynamic way the SPs identities were represented to themselves as well as to others through simulation. A CALD SP model named "BLOSSOM" was developed that demonstrates the movement of identity through simulation akin to the liminal processes described by van Gennep and modified by Turner (1987). The model is crosscut by intersectionality and the pluralism of otherness. The outcomes of this model have implications for the recruitment, retention and simulation scenario development incorporating CALD SPs and form the basis for the recommendations.

Student Declaration

"I, Karen Livesay, declare that the PhD thesis entitled 'Culturally and Linguistically Diverse Simulated Patients: Otherness and Intersectional Identity Transformations Revealed Through Narrative' is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature:  Date: 15/9/16

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For me, it begins (and ends) with family and the wonderful friends who are like family. I have the great good fortune to have been nurtured for my entire life. Those around me inherently influence what I do and how I do it and who I am, and this is the ideal time to acknowledge and thank them.

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Glossary of terms

CALD	Culturally and Linguistically Diverse
Debriefing	An activity that follows the simulation experience led by a facilitator for the purpose of reflection and feedback (Lopreiato et al., 2016).
Fiction contract	The understanding between learners and facilitators in simulation whereby participants put aside their disbelief during the scenario and accept the events as real. Sometimes called "suspension of disbelief" (Lopreiato et al., 2016).
Fidelity	The degree to which the simulation mimics the real event. Further classified as psychological fidelity and environmental fidelity (Lopreiato et al., 2016).
HPS	Human Patient Simulators that are high technology, full body manikins (Galloway, 2009).
Learner	Any trainee undertaking a simulation activity to learn, whether in an entry to practice or post graduate capacity.
Manikin	A life size full or partial body simulator with varying degrees of physiologic function and fidelity (Lopreiato et al., 2016).
OSCE	Objective Structured Clinical Examination.
Other	The label that separates an individual from the prevailing norm applied to the othered individual (see othering)(Pifer & Baker, 2014).
Othering	A process that marks and names an individual as different from oneself (Canales, 2000; Grove & Zwi, 2006; Johnson et al., 2004).
SBE	Simulation based education.
SBME	Simulation based medical education.
Simulated patients	Lay people who presents the gestalt of a patient; this includes history, body language, emotional, personality and cultural characteristics and who may provide some physical findings and learner feedback (adapted from Barrows, 1987 cited in Cleland, Abe, & Rethans 2009).
Simulation	A technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion (Gaba, 2004).
Simulationist	An individual involved in the design implementation and evaluation of simulation activities (Lopreiato et al., 2016).
SP	Simulated patient.
SPs	Simulated patients

Chapter 1

Introduction to the Research

> He could not fly, but he could walk. "Now I will go and find my mother," he said (Eastman, 1960).

1.1 Introduction

A journey of a thousand miles begins with a single step said the Chinese philosopher Lao Tzu. This journey began as a quest. Much like the little bird searching for his mother in the opening quote, I searched for more effective simulation based education (SBE) techniques. This was an elusive search. Each time I felt an improvement had been made in the way simulation within the School of Nursing (where I worked) was designed, delivered, or documented, another innovation waited to be included. SBE remains a burgeoning field. New developments were constantly reported through health, education and simulation specialty educational sources. Reports of innovations that could be implemented were abundant. Positive evaluations from learners and facilitators provided feedback to SBE designers that the learning was enjoyable and well organized. Feedback from clinical environments that nurses entering practice at the conclusion of their course, were well prepared, reflects well on the plethora of teaching and learning methods employed to develop those students, but improvement and pushing the envelope were always promising something more.

In this chapter I will briefly define simulation and the common terms associated with this pedagogical approach. I outline the context and my personal motivation for the research, introduce the research aim and set out the methodological frameworks that support the research. An overview of thesis chapters and presentation is provided.

1.2 An introduction to simulation based education (SBE)

Simulation is defined as "a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion" (Gaba, 2004, p.i2). Simulation based education includes many different approaches. Technology enhanced

simulation, such as that used in flight simulators, are well recognized as a mechanism for aviation practice and assessment. Comparably, human patient simulators are technologically enhanced manikins that replicate a variety of body functions. Although technology enhanced SBE may be the most commonly known method, simulation can also be delivered using virtual reality and through trainers that replicate a single body part. However, the simulation application relevant to this research is that of simulated patient methodology.

A simulated patient is a layperson who presents the gestalt of a patient; this includes history, body language, emotions, personality and cultural characteristics and who may provide some physical findings and learner feedback (adapted from Barrows, 1987 cited in Cleland, Abe, & Rethans, 2009). Incorporating simulated patients into SBE for nurses was one of the innovations I undertook as simulation coordinator.

Simulation provides a practice environment that enables learners to reflect on their knowledge and skill and test their critical thinking. Often the learner can repeat the experience until they are satisfied with their performance. Students' clinical competence can be assured via simulation prior to them working with real patients (Weller, Nestel, Marshall, Brooks, & Conn, 2012).

Many health disciplines use some SBE to prepare students for clinical practicum, to bridge the gap between theory and practice, or to undertake clinical examinations. My focus and background is nursing. In nursing education SBE has been shown to be effective for the development of clinical psychomotor skills (Shin, Park, & Kim, 2015). More specifically, simulated patients working with nursing students in simulation were shown to be effective in improving knowledge, communication and clinical competence amongst learners (Oh, Jeon, & Koh, 2015). Simulation research broadly has developed from evaluative perspectives associated with educational interventions. More recently other fields of study have developed linking error prevention to simulation practice, interprofessional teamwork, training for high impact, low frequency emergencies and demonstrating the efficacy of simulation education to improved patient outcomes (Acero et al., 2012; Cook & Boggio, 2012; Garbee et al., 2013; Ziv, Wolpe, Small, & Glick, 2003). The benefits of learners working with simulated patients have been documented significantly in the literature. Fairness in exposure to clinical situations that give rise to learning opportunities as well as practicing communication with humanistic responses

that are difficult to reproduce in manikin based simulation are listed amongst the benefits (Gamble, Bearman, & Nestel, 2016).

This introduction to simulation is intended to set the scene of the context that gave rise to this study. The major bodies of theory associated with simulation, teaching cultural competence to health professional students using simulation, simulated patient methodology and research are presented in detail in chapter 2.

1.3 The researcher in context

I am inextricably present in the development, design and enterprise of this research. I begin by situating myself within the context of the research. It is my intention to acknowledge my influence on the aim, methodology and processes that follow including the analysis and understanding of the narratives that eventuate. Owning our subjective influence is a common approach in qualitative research (Caretta, 2015).

I have worked for many years as an emergency nurse and later as a nurse educator in areas of the city with higher than average diversity amongst residents. My patient and student population has been characterized as culturally and linguistically diverse (CALD). I have a connection and responsibility to both my clients and students; I choose to work in culturally diverse environments. I respect the importance of individual experience and discourse to share meaning and understanding. Simulation based learning was a mechanism focused on action and communication that was a natural fit for me. A decade ago when I began working in simulation I believed that simulation was giving students authentic preparatory experiences for genuine practice.

In 2011, I was coordinating simulation education in an undergraduate nursing degree program. The curriculum designers had embraced SBE and each student participated in 76 hours of SBE across the degree, embedded in various subject areas of the program. This was a comparatively large SBE component by national standards at the time. In delivering a large component of simulation, I had used a variety of different approaches and techniques believing this would maintain both student and facilitator interest. The various approaches could be more suited to some learning styles and the teaching team may begin to develop a preference for some approaches over others. Students used simulated body parts known as part task trainers, whole body manikins from basic low technology through to high technology human patient simulators, they experienced

video assisted simulation as well as virtual reality simulations and met and worked with simulated patients. The purposes of SBE in the nursing curriculum were:

- linking theory and practice via experiential learning;
- providing genuine repeated practice opportunities with feedback;
- preparing students for clinical practicum; and
- identifying students at risk of failure.

The practice environment students entered was characterized by cultural diversity. The 2011 Census data provides a snapshot of some of the characteristics of diversity in the wider population.

"At the 2011 Census, the total population of Victoria was 5,354,039 persons:

- 26.2% of Victorians were born overseas in more than 200 countries.
- 46.8% of Victorians were either born overseas or have at least one parent born overseas.
- 23.1% of Victorians spoke a language other than English at home.
- 67.7% of Victorians followed 135 faiths." (Victorian State Government Multicultural Commission, ND).

Whereas the university was situated in a local government area where the diversity described included:

- 39.7% of the total population were born overseas
- 42.8% spoke a language other than English. (Victorian State Government Multicultural Commission, ND).

The university describes itself as one of the most culturally diverse institutions in the fastest growing and most multicultural regions of Australia (Victoria University, 2014).

1.4 The catalyst

The incident that I attribute to the genesis of this research came about as an epiphany of understanding for me. I will briefly outline the circumstances. As noted, I was coordinating the simulation program and believed that simulation experiences delivered were beneficial as preparation for clinical experience and evaluative for identifying students who needed further practice before undertaking clinical practicum.

I had participated in a series of simulation exercises with nursing students. I was playing a simulated role, and was presenting as a family member in an emotionally wrought state. Over a series of sessions I repeated this performance with many students. The aim of the simulation scenario was complex communication. Several days later I was visiting a clinical venue and witnessed a culturally diverse student interacting with a culturally diverse patient. What became evident was that neither understood the other, and both language and cultural expectations were implicated.

I had participated in simulation with this student the week prior to this incident. I reflected on that experience and watched other native English speakers in simulation with culturally diverse students who spoke in accented English and realized that the simulated patient (SP) sometimes compensated for the student's language ability.

The epiphany was that genuine preparation for practice should replicate the important aspects of practice and that these had to include working with simulated patients with CALD backgrounds. The preparation with exclusively non-accented, English speaking SPs was missing a vital aspect of the real world—the impact of cultural and linguistic diversity. The issue was not limited to communication, although this was the initial catalyst. As my understanding expanded the range of health determinants associated with cultural and linguistic diversity also came into focus.

As I recruited and trained CALD people to work as SPs I turned to the literature to inform key decisions. It was immediately apparent that the CALD SP group I was working with was entirely unique. And further, little was known about SPs and next to nothing was documented about CALD SPs.

1.5 The problem in context

Australian society is seen as one of the more ethnically diverse communities amongst English speaking countries (Leong, Weiland, & Dent, 2010). Melbourne, Australia is therefore a multicultural city. Having worked in nursing, in Melbourne, for many years I have noticed the different outlooks toward health, health promotion, chronic illness, pain and suffering, family interrelatedness in healthcare and attitudes to death and dying. Some differences seem generational, others connected to faith, whilst others seem consistent with ethnic origin. Cultural beliefs influence health outcomes and

patients' behaviour (Leong, Weiland, & Dent, 2010). My experience is mirrored by that of Dewhurst (2007). Despite communication skill training with SPs during medical education in the United Kingdom, he reported struggling to develop a rapport with patients and recommended the curriculum include effective use of interpreters when practicing in "cosmopolitan Melbourne". Language barriers have been shown to impact health care understanding, compliance and patient satisfaction (Cooper & Powe, 2004).

A study on the effects of health care comprehension with low English proficiency patients found increased confusion about medication, trouble understanding drug container labels, and difficulty understanding adverse effects of medication (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). It is not surprising in light of these findings that language barriers decrease compliance and adherence to health care recommendations. Patients who use ad hoc interpreters such as family are further disadvantaged with errors of "potential clinical consequence" significantly more likely (Cooper & Powe, 2004), while language concordant health care providers may suffer from false fluency that also results in error (Wilson et al., 2005). Communication adequacy does not lie solely in language proficiency either. Different cultures may have different approaches to communication through aspects such as respect and politeness as well as expectations of "patient-centredness" and reassurance by a doctor controlled care prescription (Skelton, Kai, & Loudon, 2001, p.258).

Diversity does not rest solely in the domain of the patient, and must be considered by the health practitioner as well. As stated by Leong, Weiland and Dent (2010), "… clinicians own cultural beliefs may influence service provision to patients from other cultures" (p. 458). Students from linguistically diverse backgrounds may struggle with communication with both patients who speak a language other than English at home and other staff. Jeong et al. (2011) suggests colloquialism and technical language can pose barriers to linguistically diverse students. In the United States minority populations were said to make up approximately 25% of the overall population whereas minority doctors and nurses less than 10%. Race and language concordance has positive impacts on the health care provider and patient relationship and can help alleviate racial and ethnic health care disparities (Cooper & Powe, 2004). Conversely where the provider is not a native speaker of the majority language important clinical content may be missed (Skelton, Kai, & Loudon, 2001).

Historically, researchers and health administrators focused on biomedical issues specific to ethnic groups such as rickets and thalassemia (Gillam, Jarman, White, & Law, 1989). Despite the biomedical focus of the time it was recognized that, the health needs and expectations of ethnic groups were expected to change substantially over the following generations. Almost 30 years ago, consultation rates for disorders, such as depression and anxiety, were reduced for some ethnic groups and especially women (Gillam et al., 1989). Yet health disparity related to cultural and linguistic diversity was still reported a decade later, with lack of knowledge of the prevalence of illness in ethnic groups as well as overlooking traditional remedies that could cause drug interactions and miscommunication still cited as causes (Brach & Fraserirector, 2000).

More recently the focus for learning about culture and developing care has moved away from the cognitive approach that focuses on knowledge of customs and traditions. The more contemporary approach focuses on social position, education and socioeconomic status to help explain health status (Williamson & Harrison, 2010). Educational strategies that focus on learning cultural attributes assume that culture is static and that everyone in the group embodies those attributes. These approaches ignore other differences such as age, gender, class, education and sexual orientation within linguistic or national backgrounds (Williamson & Harrison, 2010). This observation positions me to consider the term culture to be inclusive of a range of diversities including age, ethnicity, gender, belief system, sexual orientation and disability.

The code of ethics for nurses in Australia (2008) says in part, "The nursing profession recognizes the universal human rights of people and the moral responsibility to safeguard the inherent dignity and equal worth of everyone" (p.1). In order to meet this requirement nurses in Australia need to practice in a culturally competent manner. Cultural competence in healthcare is defined as "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system… and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p.297). The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) describe cultural competence as a developmental process that importantly does not specifically address the needs of Aboriginal and Torres Strait Islanders. Nonetheless, this process goes beyond a focus on knowledge or awareness of difference and instead integrates culture into service provision (2013).

Bates, Hankivsky and Springer (2009), commenting on The World Health Organization's commission on the social determinants of health, highlight the importance of gender as a social determinant of health. Gender equity and its implications for health, they argue, do not only impact women as is sometimes implied. "Normative masculinity" influences some men to deny pain, ignore problems and avoid seeking healthcare (p.1003). Further, the authors argue that individual categories of identity addressed in isolation are limiting and that dynamic intersections of social categories are a more fulsome device for considering inequity, oppression and privilege than simply additive measures (Bates, Havinsky, & Springer, 2009). Napier et al. (2014) espouse a similar view but go further than intersectional identity characteristics related to culture. They note that to relate culture to poor health outcomes alone overlooks the other contributing societal factors that compound poor health such as employment and living conditions. By addressing these societal factors, the intra-group variability becomes more visible. When health care providers consider health determinants related to the intersection of multiple cultural identity characteristics as well as societal factors they can avoid the trap of stereotyping based on learned facts about a given cultural or ethnic group (Betancourt, et al., 2003).

1.6 Motivation for the Study

The impact of culture in health was foregrounded for me alongside a group of dedicated CALD SPs who were now working in simulation with a variety of health professional students. I understood that I was working with a unique group, but was unsure of how that should translate to a research question.

I contemplated a comparative study looking for differences between the CALD group and other SP group samples. I thought about a study of SPs more generally to learn about the people who work as SPs, but that failed to address this area of passion I had working with people who represented the real patient population and all their diversities. Faced with a situation where little knowledge of a topic exists, I felt spoilt for choice as to which aspect of simulated patient methodology I should study. I felt drawn to the idea of ethnography or a field of study that would enable me to explore who these people were; I wanted to study simulated patients. But the CALD group of SPs seemed unlike other SPs I had worked with. Why were most SP groups apparently made up of people from the prevailing or dominant race? I include an extract from my reflective

journal written during this period while undertaking a course work unit in preparation for this study that outlines my uncertainty and how it was overcome.

> During the research methods course work unit I had a real crisis. I had started with an idea of what I wanted to do and over the weeks I felt like I lost the idea and had gotten really confused. I went back to the proposal I had written as part of the application and it didn't grab me anymore. I didn't think I had enough grist to write a thesis and I could no longer clearly articulate what I wanted to do.
> About the three quarter mark of the course work unit I met with the unit coordinator and we charted on a white board what I knew and where I felt the gaps were. I think two things happened that day. First I think the unit coordinator was excited and energized by my project and maybe that gave it some kudos, some capital and second, in working through that process on the whiteboard I got clarity again. I took photos of the whiteboard exercise and have referred to it subsequently as I have needed to get my thoughts in alignment again. At last I felt like I had a topic.

1.7 Research Question

I sought to explore the experience of CALD simulated patients. My perspective that diverse cultures should be represented in simulated patient groups established my area of interest. As there was no previous research dedicated to this group, I sought to begin with an exploration. The questions I addressed were: What experiences influence CALD people to become and continue as simulated patients? What is their experience of the simulated patient role?

1.8 Research aim

The research aim was to explore the experience of CALD people who have worked as simulated patients.

1.9 Justification of the research

Quevedo (2008) identifies therapeutic relationships in an era of increasing diversity as a challenge of contemporary health practice. Health services are the "global villages where, daily, many languages, cultures, and customs intersect, clash, merge, and evolve." (Quevedo, 2008, p.63). Understanding the patients explanatory model of illness will unlock appreciation of their unique beliefs and enable a shared position from which to negotiate care and treatment requirements (Kleinman, 1988). Quevedo (2008) asks "How can we negotiate this uncertain terrain of relationships more effectively? Are there principles to guide us and stories to illustrate the pitfalls? (p.63)"

The literature presented in chapter 2 will demonstrate a scarcity of information about CALD SPs. Even in those programs designed to expose students to concepts of diversity, the most common approach is a single intervention of a diverse characterization (Guiton, Hodgson, May, Elliott, & Wilkerson, 2004; Miller & Green, 2007). While passing reference is made to desire or intention for diversity amongst SPs, outcome measures are rarely reported. In other cases programs report using cultural stage dressing for situations and specifically use manikins or recruit actors, training them intensively about the culture despite their not belonging to the actual cultural group (Aeder et al., 2007; Haas, Seckman, & Rea, 2010). While not actually documented, the inference that CALD SPs are difficult to recruit is suggested.

The significance of this research is achieved through the opportunity to learn from a group of CALD SPs. In exploring their perspectives of experience the opportunity to learn about a group who have not previously been studied, yet are desired in SP groups, is achieved.

Increased understanding of CALD people who are SPs could potentially influence recruitment as well as the inclusion of diversity characteristics in simulation. Tokenistic diversity embedded in simulations only where cultural competency is a desired learning outcome does not reflect authentic simulation. New insight into CALD SPs provided by those SPs could expand the inclusion of diversity in scenarios and SP groups. Additionally, new knowledge associated with SP methodology more generally would be produced.

1.10 Philosophy and theoretical framework

This study sought to understand the experience of CALD SPs from their perspective. Locating the participants as different to those SPs who had previously been studied focused attention on difference. While not intending to decry difference, I wanted to understand experience and felt that a focus on difference predetermined a perspective. Rather I wanted to capture all complexities of participants rather than pre-define them.

The philosophy of social constructionism positioned the participants and me together: developing, interpreting and understanding meaning constructed between us, through shared experience and discourse. Social constructionism first described by Berger and Luckmann (1966) describes the process of assembling or achieving a perspective of shared knowledge through a social interaction. Conversely the constructivist approach favours the process of knowing as developed within ones mind (Emden, 1998a) While the relationship between the two perspectives is patent, it was the social rather than individual focus that was required so that I could share the meaning of contexts and histories of which I had no experience, as Australian born (Andrews, 2012).

The theoretical framework of intersectionality describes the convergence of identity characteristics such as race, gender and class to avoid an either/or proposition and recognize intragroup difference (Crenshaw,2013). Extrapolating the concept beyond sexism and racism an intersectional approach facilitates a richer more detailed ontology that details dynamic relational identity positions and denies efforts to reduce participants to a single category at a time (Phoenix & Pattynama, 2006). Therefore Intersectionality allowed me to understand and portray the myriad of intersecting identity characteristics that impacted each person's life. "Local environmental, social and cultural forces exercise a refractory power over the influences of structure on identity and disadvantage" (Trahan, 2011). The identity characteristics and effects of those are socially specific and fluid and can be captured through a framework such as intersectionality.

Other issues associated with diversity and research with a minority group were acknowledged through the influence of postmodernism and feminism. Postmodernism challenges conventional approaches and power claims of neutrality in considering reality, and rejects essentialized outcomes. In this manner no account has authority and instead authenticity of beliefs is privileged (Traynor, 1996). The focus of

postmodernism on challenging boundaries and ways of viewing circumstances as well as hearing the range of voices was a mechanism to consider the range of cultural backgrounds of the individual participants and their unique perspectives.

Feminist philosophy favours cooperation and collaboration as a relationship or transaction between the researcher and participant and recognizes multiple ways of knowing (Ironside, 2001). While emphasis is placed on gender bias, privilege and oppression it is for the purpose of emancipation, and to overcome hierarchy (Ironside, 2001). Feminism's concern with socially just and inclusive practice gave emphasis to relationships and trust while recognizing the relationship between the participants and me. The various intersectional positions of the participants were associated with oppression and privilege to different degrees. Through feminism a focus on different conditions in different circumstances could be achieved.

Narrative is the set of stories or events that describe development and transition in people's lives that can be interpreted for the purpose of study (Emden, 1998b; Lai, 2010). Narrative methodology provided a means to hear the voices of the participants in context and entirety. Cultural meanings are deeply embedded in stories and therefore decontextualized interpretation could be avoided. Narratives permitted insight for exploration of particular participant's perspectives. I now outline the important aspects of presentation and conclude with a description of thesis organization.

1.11 Presentation of the thesis

I acknowledge the very plain titles of each of my chapters. This is in keeping with the business-like approach I adopt in most endeavours. The scope of this research has, from time to time, felt overwhelming. I am a list writer who finds mind maps annoying. Undertaking a major project such as this research has amounted to many task lists, action statements and outcome measures. All of these strategies have kept me on track. Nevertheless this thesis is a creative endeavour, and therefore I searched for an inspirational introduction (quote) to each chapter.

As I contemplated an individual approach I considered the many and varied influences that had aided my PhD journey. I thought about what I had learned about my study, the process of research and how some of my beliefs had been challenged. Inevitably a

learning experience changes us. Although often it is difficult to recall how we were different before.

I returned to my reflective journal for inspiration. As I skimmed through the early entries I was struck by the juxtaposition of the following entries:

> So much new terminology and the theoretical reading is complex because of this – and dry. Values, and tendency to overlook the familiar, are useful concepts but unsure how checks and balances for this will work or how they will be established or recognized in practice.
>
> Are you my Mother by P.D. Eastman. Why am I thinking about this book?? Is it the association to ethnography and lived experience? Is it the bird's identification of others as different? Is it the stereotype of the Mother depicted in a headscarf (no other animal is wearing culturally significant clothing). Can I use this?

I recall being read *Are you my mother?* (Eastman, 1960) as a child and in turn I read it to my children. It recounts the tale of a baby bird that hatches while his mother is away getting food, and who then leaves the nest to look for her. In his quest he meets a dog, a kitten and a hen and asks each if they are his mother. He is eventually returned to the nest by an industrial digging machine that the little bird calls a "snort" where he is reunited with his mother.

This expose of identity and categorization of species by familiar traits suggests the manner in which we imprint likeness and difference as well as recognition of the familiar from an early age. While it is common to use an inspirational quote to introduce each chapter of a thesis, that literary purview belongs to those far more artistic than me. As a person who values authenticity, using a text that continued to speak to me seemed fitting; I have therefore used the symbolic journey of the unnamed little bird seeking his mother, to introduce the concepts of each chapter.

Other aspects of thesis presentation I would like to distinguish are differentiated by font and form. The main thesis text is Cambria body. Where I include excerpts from my reflective journal or field notes I have used Comic Sans MS.

The narratives of the CALD SPs are presented in Arial. Where I am quoting the participants I use Arial and indent the entry from the left margin.

1.12 Organization of the thesis

In this chapter I have introduced the research topic. I have shown the relevance of the topic to health care and health professional student education and practice. The significance of the research has been demonstrated and the aims of the study stated.

Chapter 2 presents the literature review for the theoretical foundation on which the research is based. The pedagogy of simulation and the historical context of simulated patient methodology through to present day are explored. The seminal work in each simulation area is reviewed and examined. Cultural competency education and the means through which it is taught in simulation are critically analyzed and ideas surrounding the research focus of CALD SPs discussed including identity and otherness.

Chapter 3 outlines the underpinning philosophy for the thesis being social constructionism. The influences of postmodernism, feminism and dialectic theory are described. The theoretical framework of intersectionality is explained and the rationale for its use linked to the research aim and participants. The methodological approach of narrative is justified. Having detailed the aspects of research design the approach is then described in the methods.

Chapter four focuses on the narratives of three of the participants. All of the remaining eight narratives are appended (see Appendix 1:Narratives). The participants' stories are rich and detailed and provide insight into their unique worlds.

Chapter 5 deals with thematic analysis outcomes and provides thick descriptions from all 11 narratives to detail support for the themes that emerged. These themes provide a mechanism for understanding and recognition of the context of the stories and individuals as they portray themselves within the narrative accounts.

Chapter 6 delves into the narratives using the intersectional identity groupings of the participants. The stories of the participants, along with my perspective and my unique interpretation are contrasted with the theoretical perspectives from those authors who

have made contributions to relevant fields of knowledge. Some contributions are in contrast to my findings while others are strikingly congruent. Finally, my theoretical contribution is drawn from the findings, analysis and discussion and the model, BLOSSOM – A model for CALD SPs in simulation, is presented.

Chapter 7, the conclusion chapter, summarizes the findings of this thesis and presents the recommendations that have emerged through the study. The strengths of the study are considered, as are the limitations. Areas for further study are also presented.

1.13 Conclusion

This chapter has established the context of this study. The motivation for the study has been described. Only through insight into the context and motivation can the specific elements of the research be assessed and reflected upon by the reader. The significance signals the potential impact of this study and lays out the potential for advancing knowledge in simulated patient work. Having articulated the plan of this research the following chapter presents the literature review.

Chapter 2

Background and Current Discourse

He did not know what his mother looked like. He went right by her. He did not see her (Eastman, 1960).

2.1 Introduction

To recognize the importance of salient features in an event it is vital that we have grounding. An understanding of the background literature that displays the knowledge in the field is fundamental to the beginning of this journey.

This chapter will systematically address the literature related to my study. The background literature is multifaceted and will be viewed through the lens of health education and culture. I will begin with learning through simulation or simulation based education (SBE). The focus is then sharpened to consider simulated patient methodology—a subset of SBE. Finally, I will explore how the juncture of health, life and culture can be considered through the multiple instances of oppression and privilege by reviewing the framework of intersectionality.

2.2 Simulation as a learning technique in health

Educating health professionals usually involves acquiring conceptual knowledge, developing psychomotor skills and applying that learning to clinical situations. One of the methods of aligning conceptual knowledge utilization with practical skill development is simulation. Simulation is defined as "a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion" (Gaba, 2004, p.i2). Through the intentional replication of real experiences, learners can practice application of knowledge and skill. Guidance in the simulation process enables the learner to receive timely and individualized feedback to encourage improved future performance.

Simulated learning enables control of the complexity of the learning situation to suit the intended learning objectives and capability of the learner. Thus SBE can flexibly provide introductory learning as well as remediation or maintenance of clinical practice currency (McAllister et al., 2013). Learners practice skills, communication and teamwork in contextually complex environments resembling real world practice. Simulation enhances learning by enabling repeated practice until the desired outcome is achieved: be that familiarity, competency or mastery. SBE accepts that errors will occur and in turn they can be rich learning experiences without risking patient safety (Galloway, 2009).

Simulation as a teaching and learning method enables practice without exposing real patients to the hazards posed by service provision from inexperienced students (Hovancsek et al., 2009). Often patients are too unwell to tolerate student learning and the risk of adverse events occurring in health provision provided by novices. The widespread uptake of simulation in the past 15 years marks a movement away from more traditional health care training that has relied primarily on real patients (Issenberg & Scalese, 2008). Ziv, Wolpe, Small and Glick (2003) classify the conflicting needs of optimal patient care and using patients to learn and refine skills as a "fundamental ethical tension" (p.783). They go on to explain that simulation allows learners to achieve higher levels of proficiency prior to real patient encounters.

Along with ethical tensions, the competition for learning placements in clinical settings, shorter hospital stays and patients with higher acuity illnesses have contributed to reduced availability of patients suitable for learning as well as reduced clinician time to teach (Hober, Manry, & Connelly, 2009; Issenberg & Scalese, 2008). The patient safety movement has produced significant research demonstrating the frequency and severity of iatrogenic and preventable patient error associated with systems and team dysfunction (Garbee et al., 2013; Kohn, Corrigan, & Donaldson, 2000; Leape, 2000; Stelfox et al., 2006). Like aviation training, simulation based medical education (SBME) is seen as an important strategy in reducing error (Ziv et al., 2003).

In addition to error minimization, another positive attribute of simulation is the opportunity to provide learners with standardized experiences. Faculty can ensure through simulation that all learners have been exposed to clinical scenarios deemed important for the discipline. In clinical training environments student experiences may be uneven in terms of exposure to those pertinent presentations (Jeffries, 2007). For

example, in critical clinical emergencies learners typically observe without participating. Thus by using simulation they can actively participate and learn. Simulation based education also accords the opportunity to scaffold the learning experience unlike exposure to deteriorating patients in practice where the complexity of the situation evolving may overwhelm the learner (Arthur, Levett-Jones, & Kable, 2013).

A significant proportion of the simulation literature justifies this teaching and learning approach through the detail of its advantages such as those shown here and through the report of evaluations of learner skills acquisition (Chang, Chung, Wong, 2002; Kennedy, Cannon, Warner & Cook, 2014). However the disadvantages are not so evidently discussed. While sometimes couched in terms of barriers to SBE where issues of cost and facilities are addressed, more often the literature is silent regarding disadvantages.

Simulation is not restricted to the level of the individual learner. Arora and Sevdalis (2008) describe three levels of simulation education. Micro-simulation aims to develop individual motor and cognitive skills. Meso-simulation aims to develop crisis management, situational awareness and team skills. Macro-simulation is concerned with system and organizational level outcomes and responses. At each simulation level, the use of audiovisual capture can also enable vicarious learning opportunities (Jeffries, 2007).

The differentiation of simulation by audience or participant between micro-, meso- and macro-simulation is not the only differentiation. Fidelity, which describes the degree to which the simulation mimics the real world, also requires differentiation (Meakim et al., 2013). Fidelity can be thought of in terms of the degree to which the simulation evokes psychological responses of the real world known as psychological fidelity.

Environmental fidelity describes the extent to which the environment, including the equipment, replicates reality (Beaubien & Baker 2004; Meakim et al., 2013). How much fidelity is enough has been a vexing question for simulation facilitators. Dieckmann, Gaba and Rall (2007) recommend fidelity should be related to simulation goals and, with respect, to the target group: “there should be enough realism of the right type for the purpose of the simulation…” (p.191). In view of this recommendation and in line with Gaba’s (2004) definition of simulation addressing real experiences and replicating important aspects of the real world it is surprising that as will be shown, cultural difference is not apparent in routine simulation and neither is this cited as an

impediment. The assumption that the authenticity of a simulation is a critical determinant of transfer of learning from the simulated environment to the clinical environment is challenged by Norman, Dore and Grierson (2012), whose findings showed that comparisons of the outcomes of high fidelity simulations to outcomes of low fidelity simulations are not statistically significant, with only modest gains from increased fidelity.

Indeed, the transfer of learning from simulation to the real patient setting is crucial. Lessons learned in SBE are intended to inform future clinical practice. McGaghie et al. (2011) in their meta-analysis comparing SBME with traditional clinical education showed that SBME with deliberate practice was superior to traditional clinical learning for the purpose of developing clinical skills. Norman, Dore and Grierson (2012) similarly found high fidelity simulation was superior to opportunistic instruction. Convincingly, evidence of applied clinical outcomes, such as survival rates from cardiac arrest in pediatric patients, provides an example of effective SBE. Pediatric cardiac arrest survival increased significantly above the national average in correlation with simulation based, mock cardiac arrest codes in a study reported by Andreatta, Saxton, Thompson and Annich (2011). Simulation can therefore be argued to be an effective method to teach and practice health professional skills. Those of us practicing in the field also have ample anecdotal "evidence" of the changes apparent in learners who have participated in simulation.

However, not all learners and faculty regard SBE positively. Resistance to teach using simulation has been reported amongst faculty (Adamson, 2010; Jansen et al., 2009; Livesay, Lawrence, & Miller, 2015). The standard of best practice for simulation facilitators states that proficient facilitation can be provided by faculty who have undergone "specific simulation education, continuing education and targeted work with an experienced mentor" (Boese et al., 2013). Learners, even those achieving measurable improvement in performance, sometimes state a preference to learn on real people (Chang, Chung, & Wong, 2002). In spite of this, where unannounced SPs are used in real practice the detection rate in the majority of studies is less than 15% with some studies reporting false positive detections (Rethans, Gorter, Bokken, & Morrison, 2007). In addition, Colliver and Williams (1993) quote studies demonstrating house officers clinical behaviours are similar, regardless of working with either SPs or real patients. These observations suggest the standard of many SP performances in primary care environments is convincingly similar to the gestalt of real patients. The preference for

real-life learning is multifactorial although it may be influenced by the environmental fidelity or the simulation approach used. There is no single simulation technique, and different simulation approaches are more effective for different learning outcomes.

2.3 Simulation approaches

Simulation education can be undertaken in multiple ways. The common approaches cross very low to very high fidelity. The most basic, a task trainer replicates an aspect of a procedure such as a cannulation arm, for practice inserting intravenous therapy (Galloway, 2009; Maran & Glavin, 2003). Complex task trainers have haptic software so the user experiences tactile stimuli. Through the trainer the learner would feel the resistance and the sensations felt when performing the real procedure. For example, when undergoing keyhole more properly known as laparoscopic surgery, the trainee surgeon would feel similar sensations to real practice with a haptic laparoscopic unit (Galloway, 2009). High technology full body manikins that demonstrate physiological processes such as breathing, heart and bowel sounds are available in infant, child and adult sizes and are often referred to as human patient simulators (HPS) (Galloway, 2009; Waxman, 2010). The most complex is the simulated environment in which the environment of a team is reproduced such as an operating theatre. The simulated environment can be augmented by any number of manikins, task trainers, haptic systems or simulated patients (Maran & Glavin, 2003). SBE also includes computer based and virtual reality trainers. The final approach to simulation I would like to focus on is that of simulated patients.

2.4 Simulated patient methodology

Simulated patients (SP) are people who have been trained to accurately portray a specific patient (Barrows, 1993). First introduced by Barrows in 1963, the SP has been known by many names that are often confused and used interchangeably in the literature. Simulated patient or standardized patient, are the two terms predominantly in current use. Although many definitions of the terms are provided with variations, the crux of most definition differences is based on the idea of standardization. Wind, Van Dalen, Muijtjens and Rethans (2004) differentiate between the terms by stating that assessment requires consistent role portrayal to create an equal assessment and this role is known as a 'standardized patient'. In situations where the authenticity of the

portrayal is paramount the term 'simulated patient' is more fitting (Wind et al., 2004). Barrow's own definition and naming convention of simulated patients and standardized patients has changed over the course of his work (Barrows, 1993). Given the lack of consensus and adapting from Barrows (1987) as cited in Cleland, Abe and Rethans (2009), I offer the following definition for this thesis. A simulated patient is a layperson who presents the gestalt of a patient; this includes history, body language, emotional, personality and cultural characteristics and who may provide some physical findings and learner feedback. I choose to hold with the argument proposed by Nestel et al. (2010) that the term *simulated* reflects the range of activities across which SPs work and will therefore use this term.

Simulated patients are said to provide value to both students and to teaching.
Some of the benefits of working with SPs are:

- preparing students for clinical practice in a less threatening environment than with real ill people;
- students learn in an environment that safeguards patients where directed and immediate facilitator feedback on performance is available;
- SPs provide feedback from the patient perspective;
- a patient encounter can be interrupted and re-started after instruction, feedback or correction;
- difficult communication skills can be practiced in a controlled setting;
- SPs provide focus, motivation and encourage active learning;
- SPs enable teachers to provide equivalent patient experiences to all students rather than relying on the serendipitous nature of clinical assignments;
- the learning process can be planned and scaffolded with SPs;
- SP learning experiences required as part of the curriculum can be identified and provided;
- the SP is available at times and in settings commensurate with the needs of learners and teachers;
- SP experiences enable standardized and consistent evaluation; and
- the level of complexity of a learning encounter can be directed or manipulated (Barrows, 1993; Bokken, Rethans, Scherpbier, & van der Vleuten, 2008).

In keeping with the postmodern and feminist philosophies of this study this comprehensive list of benefits of simulated patient methodology presents a perspective from an exclusive and limited standpoint. As will be shown, the prevalence of SPs from

minority cultural and linguistic backgrounds to the prevailing culture is minimal at best. If the SP protects the real patient from student learning then the status quo is an example of majority cultures being privileged. If the SP represents the patients voice then only the majority voice is heard and difficult conversations are limited to those that concern biomedical issues or universal problems rather than those of disadvantaged minority groups. This unitary perspective of representation positions the importance of CALD SPs and the insight of their perspective to the body of SP knowledge.

2.5 Historical work with SPs

Wallace (1997) provides an interesting and comprehensive history of the innovation of SPs from their inception in 1963 by Howard Barrows. Wallace (1997) notes that SP simulations provide a "veritable reality" experience suggesting this is as close to a real clinical encounter as one can be without actually being there (p.6). She observes, as does Barrows (1993), that SP simulations were born from a need for more rigorous evaluation of medical students' clinical skills. Most tellingly Wallace (1997) recounts that in the 1970s Barrows developed four so-called "difficult cases", one of which was listed as a patient from another culture (p.10). Remarkably, this reflects that SPs work in cultural contexts, while considered difficult, was recognized early in SP field development. Early work with SPs focused more on teaching the SP to accurately portray physical findings or recruiting people with stable chronic signs and symptoms that could reliably be used. Some SPs were also taught the process of correct physical examination to enable them to provide this teaching and feedback to learners developing their skills. These latter SPs are today known as teaching associates and work in the specialty niche of intimate examination. SP programs continued to develop. By 1989, when Stillman, Regan, Philbin and Haley (1990) undertook their survey of medical schools, they identified eight distinct ways that SPs were integrated into curricula.

In 2009, May, Park and Lee provided a 10-year literature review on the use of SPs. By then, the growth in SP work had been exponential. SP accounts included in the literature review emanated from six countries and included the disciplines of medicine, nursing, dentistry, pharmacy, dietetics and multidisciplinary areas. Importantly, the most common SP work was in teaching communication skills followed by teaching clinical

skills and physical examination. Still other uses, such as medical ethics, teaching skills, cultural competency, and teamwork were also noted (May, Park, & Lee, 2009).

Further growth in SP utilization occurred in 2004 with the introduction of Objective Structured Clinical Examinations (OSCEs) for all medical graduates as part of licensure in the United States of America. Similar requirements occurred in Canada. Entry to practice health disciplines worldwide have instituted SP encounters with their students in preparation for OSCEs. SPs are used in both formative and summative health education (Taylor, 2011).

2.6 SP program development

Early literature related to SPs focused on program development, accounts of recruitment and training with evaluations from several pivotal and leading centres of simulated patient methodology. These accounts provided direction to all those that followed and this tradition continues still as ever more programs emerge to meet the increased demand for SPs (Bosek, Li, & Hicks, 2007; Cantillon et al., 2010; Cleland, Abe, & Rethans, 2009; Ker et al., 2005). When starting a simulated patient bank I found this information to be crucial.

Ker et al. (2005), drawing on the literature and their experience in Dundee, provided a series of tips. These tips informed many of the actions I took in developing a SP bank as well as some of the justification for costs and decisions. Valuable ideas included the recruitment process for screening suitable SPs as well as a framework for training new SPs. The nexus of SP evaluation, feedback reward and recognition also emerged from these tips. These ideas were further enhanced through the work of Bosek, Li and Hicks (2007). Their primer provided information on scenario development with the SP, rehearsal for the role, preparing students and faculty to work with SP simulation and debriefing. Despite the location of the program and nationality of the SPs the body of literature related to SP recruitment, training and program development was universally strong and relevant. The principles developed were applicable across contexts and continue to provide utility.

Debriefing is a familiar concept in all types of SBE. It is the time where learners reflect on performance and integrate knowledge skills and attitudes and is considered critically

important (Chronister & Brown, 2012; Decker et al., 2013; Shinnick, Woo, Horwich, & Steadman 2011). Bosek, Li and Hicks (2007) make the important distinction when discussing working with SPs between debriefing and de-roling. They acknowledge the importance of discharging emotion as part of debriefing whereas de-roling includes detaching from the role portrayed and dealing with any incongruence felt. Successful de-roling assists the SP to cope with the portrayal. This is an important aspect of occupational health and safety for SPs, yet de-roling is given surprisingly scant attention in the literature.

Much of the SP literature reports research of educational interventions with SPs measuring the effectiveness of programs (Cahalin, Markowski, Hickey, & Hayward, 2011; Ramsay, Keith, & Ker, 2008; van der Vleuten & Swanson, 1990). Nestel et al. (2010) produced a 26-point list outlining the responsibilities of SPs for teaching sessions. The requirement for SP feedback to learners is featured in this list. This is an important aspect of SP methodology. As a representative of the patient, it is through feedback that the learner engages with the patient's voice. In their survey of SPs at Imperial College London, Nestel et al. (2010) report that SPs were aware that their critically important feedback needed to be precise and inspiring but also noted this was challenging. Students valued the teaching and immediate feedback with SPs (Bokken et al., 2008).

Feedback from SPs can be either formative or summative. In OSCEs summative feedback from the SP may contribute to the student grade. Feedback can be provided in a variety of ways. Students may receive written or verbal feedback that can be delivered individually or to a group. Nestel et al. (2010) note technology enhanced feedback. SPs can be trained to provide technical skills regarding examination technique, but frequently anchor their feedback in the domain of communication and interpersonal skills. The SP concentrates on how they feel as the patient and relates these feelings and reactions to the learner. In this way the SP is representing the patient. "This is what underlies the uniqueness and strength of feedback given by SPs" (Bokken, Linssen, Scherpbier, van der Vleuten, & Rethans, 2009). Bokken et al. (2009) conclude that no clear guidelines for SP feedback exist. This issue may have been remedied by the outcomes of the Nestel et al. (2010) study that resulted in feedback guidelines for tutors and SPs. In contrast to the emphasis on learners receiving feedback, SPs also desire detailed feedback according to Webster, Goodhand, Haith and Unwin (2012). They found that their SPs felt enormous responsibility to discharge feedback to learners and

thus in turn sought feedback on their own performance. SPs felt a strong sense of empathy with their learners that could impact their ability to provide negative comments to those learners at times. Whereas Wind et al. (2004) found that the quality of feedback increased when the SP played a role that was authentic and said to be "congruent with his or her own lifestyle" (p.40).

2.7 SP authenticity and role development

Nestel and Kneebone (2010) have also addressed authenticity of SP roles. They note there is little research on how roles are constructed. However, they assert that roles may reflect an amalgam of patient histories brought together by the faculty into a single story. This Nestel and Kneebone (2010) claim tints the lens of the simulation to reflect the teacher's perceptions rather than the patient's. Using interviews with real patients and involving real patients in all stages of the "patient focused scenario" they argue places the patient voice at the centre of the learning experience. As an alternative using real life case studies from sources including Coronial reports provides authentic content and has the added benefit of generating emotional reactions from the learners (Mulcock, Rudd & Churchouse, 2008). The alternative Nestel and Kneebone (2010) suggest is scenarios prepared by people who have seldom had the experience of that illness or procedure. This was particularly pertinent to scenario development for me. As a nurse who had witnessed many of the situations in practice that were being portrayed in simulation I was profoundly aware I had a perspective from only one side of the situation. My perspective would always be through the lens of the health care provider. Despite the strength of Nestel and Kneebone's (2010) argument for authenticity and the observation of emotional impact described by Mulcock, Rudd and Churchhouse (2008), or the poignancy of Taylors (2011) description of the aesthetic of simulated suffering, accounts of educator devised scenarios incorporating cultural content that can be interchanged between national groups can still be found (Grossman, Mager, Opheim & Torbjornsen, 2012). Evaluations that fail to meet the standards and criteria recognized as best practice for authenticity, or fail to identify important detail regarding their SPs sample where cultural awareness is a criterion of the simulation evaluation, yet are accepted for publication (Chun, Young, Honda, Belcher & Maskarinic, 2012), diminish the perception and importance of authentic patient identities and quality cultural awareness training with simulation.

The importance of authenticity is reinforced in work with adolescent SPs who co-constructed their characters with program staff based on the individual SPs history. The authors highlight that authenticity was more important than uniformity and that performance was easier when the role was closer to the SPs personality (Bokken, van Dalen, & Rethans, 2010). Both age and ethnicity need to match the character portrayal as well (Cleland, Abe, & Rethans, 2009). The final word goes to Nestel, Burn, Pritchard, Glastonbury and Tabak (2011) who declare that SP roles should, at a minimum standard, include the patient's ideas, concerns and expectations.

2.8 SP programs worldwide

SP roles, recruitment, and training of SPs and management of programs have developed individually with many different approaches (Cantillon et al., 2010). Two comparative papers have attempted to document differences and similarities in SP programs across geographical boundaries, one in Europe, the other comparing Canada, Australia, Switzerland and the United Kingdom (Cantillon et al., 2010; Nestel et al., 2011). While both papers demonstrate some differences in recruitment processes and funding, these differences are less marked across the greater geographical area. In Australia, Canada, Switzerland and the United Kingdom the SPs are all paid for their work and trained for between 2 and 5 hours initially. Whereas in the European comparison that assessed 19 medical schools in four countries the differences were more marked. SPs were sometimes paid and sometimes volunteers, training was not uniform and neither was recruitment. Of particular note within these comparative studies is the SP demographic description. Nestel et al. (2011), for example, list the number of SPs, gender, mean age, first language and fluency in other languages amongst their categorizations. Overall the SPs studied are predominantly female with a mean age between 38 and 50 years of age. 97% to 100% speak the dominant language of the country. Interestingly, the statistics related to fluency in other languages show a very low level (3%) in Australia, and even lower (2%) in Switzerland. Contrastingly, 17% of the SP group spoke another language in Toronto and 20% in London, giving at least some indication of potential diversity within the SP pool. The Cantillon et al. (2010) paper has far less detail regarding SP demographics. Once again female SPs outnumbered males with the majority of all SPs over 40 years of age. In another study of SP groups linked to medical schools in the United States (US), again the majority of SPs were female and averaged 60 years of age (Abe, Roter, Erby, & Ban, 2011). Despite the information that is presented in these

studies, and the inferences that can be drawn from information such as language spoken, the lack of breadth of the surveys or possibly the limitations of data recorded in the SP data bases speaks once again, to the partiality shown toward the dominant identity characteristics. The value of knowing who the people are that participate as SPs justifies the studies. However the results showcase a glaring silence and potentially the absence of voice of both the real patient and proxy patient from CALD backgrounds.

Many papers have described training of their SPs and methods by which their SPs provide feedback to students and debated whether the SP should remain in the patient character to give feedback or not (Bokken et al., 2009; Cahalin, et al., 2011; Webster, Goodhand, Haith, & Unwin, 2012). What is apparent is that individual centres have developed internal standards and willingly share them, but as Rethans, Gorter, Bokken and Morrison (2007) note when describing the different training approaches, a "...clearly defined and accepted SP methodology that defines standards for SP training..." is recommended (p.546). Despite the lack of consensus on training and other employment conditions for SPs, the utility of sharing training resources and patient cases remains.

When discussing sharing simulation cases Cantillon et al. (2010) note that this would be more readily achieved within countries than between countries because of linguistic and cultural differences. Nonetheless, no indication of cultural diversity is provided in their study of SP databases across Europe. Nestel et al. (2011) note that all programs they surveyed were challenged by recruitment of special populations, and that substantial gaps exist with respect to ethnic groups, different age groups and males. Indeed, most of the literature describing SP interventions are devoid of cultural and linguistic traits of the participating SPs (Bokken et al., 2009; Cantillon et al., 2010; Chun, Young, Honda, Belcher, & Maskarinec, 2012; Nestel et al., 2010; Rutledge, Garzon, Scott, & Karlowicz, 2004). While the future prospect of new and increasingly specialized SP groups was foreshadowed by Nestel et al. (2011), they did not specifically consider the possibility of an ethnically and culturally diverse SP group in their suggested list. Although considering the SP role as representing the patient voice, a minimum level of diversity should be reflective of the diversity in the population being served. To this point the emphasis in the literature has concerned the work of SPs. I avoid the term "use of SPs", endorsing the critical position of Nestel et al. (2011) who describe this term as objectification. Rather, with an emphasis on the person who is the SP, I move to the literature concerning the experience or impact of the SP role on the people who are SPs.

2.9 What is known about SPs

Investigation of the effects of simulating on SPs or actors is reported as early as 1975. Using a comparison group of actors who had not worked in simulation, Naftulin and Andrew (1975) declared there was little difference in the emotional and physical consequences between groups. Two further observations were identified that echo a number of subsequent studies. The first was the extent to which real experiences or ailments contribute to authenticity. The other important observation related to method actors experiencing more difficulty de-roling and this was associated with the extent to which the actor had integrated the character being portrayed (Naftulin & Andrew, 1975). There is remarkably little difference in the findings over intervening years as the following descriptions will demonstrate, despite the development of more sophisticated studies and validated instruments.

Bokken, van Dalen and Rethans (2004) investigated stress symptoms in SPs using a questionnaire and they determined that almost three quarters of their study cohort experienced stress symptoms, although the severity of those symptoms was rated as moderate. They also noted that most of their SPs used method-acting techniques, which were a direct consequence of the training provided to the SPs. This 2004 study was followed up later (2006) with a focus group to explore the impact of simulation on the SPs. Boken, van Dalen and Rethans (2006), described their SPs experiencing negative effects such as exhaustion, dissatisfaction with the performance and continuing to feel or act like the patient after the performance. Comparably SPs report feeling unsettled by disturbing roles and choosing to discontinue those portrayals as a result of feeling unsettled (Woodward, 1998). In another study comparing SPs with musculoskeletal conditions with a control group; Gecht (2009) found the control group consistently perceived their health as better and concluded that teaching health practitioners did have an impact on the SP.

The negative effects reported by Bokken, van Dalen and Rethans (2006), were influenced by the type of role, with emotional roles most implicated in those effects. How many times the SP repeated the performance and the length of time between each performance were also factors (Bokken, van Dalen, & Rethans, 2006). A single SP may repeat a performance for new groups of students several times in one day, or multiple times in a week or at even longer intervals. As a result the authors produced a list of suggested measures to minimize the impact, including for example, limiting

performances to seven per day and changing roles after four years (Bokken et al., 2006). The authors identify a strength of the study as the transferability to SPs in other settings but a limitation as validity when transferred to high stakes examinations. However the only demographic criteria reported was age, which necessitates caution with regard to its transferability. A study particularly addressing SPs with cultural identity characteristics from other than the dominant cultural groups may identify very different outcomes where authenticity and method acting using real past experiences to inform portrayal are used.

Alternately, adding mindfulness training and positive reappraisal skills training to SPs undertaking emotionally taxing roles was said to reduce burnout by one third and mitigate the effects of those challenging cases on the SPs (Gerzina & Porfeli, 2012). While psychiatric roles are recognized as emotionally taxing (McNaughton, Tiberius, & Hodges, 1999) the personal circumstances of the SP are likely to impact their perception of a role. A person who has just suffered the loss of a loved one is likely to find any role related to breaking bad news more taxing. The notion of a role being too close to reality arises throughout the literature on SPs (Taylor, 2011; Woodward, 1998).

Woodward (1998) suggests that where SPs have unresolved problems in their own lives (that are close to the circumstances of the SP role) they refuse the part. Achieving closure or distance from an event is likely to enable the SP to use the emotional energy from the recollection without reactivating the situation (Taylor, 2011). "According to the SPs, the closer a role resembled their personal life, the harder it was to portray that role and the greater the impact of the performance" (Bokken et al., 2006, p. 784). This suggests a balance is required between sufficient insight into the effect of a situation in order to be convincing and authentic but not so close as to reignite past issues and present psychological risk. Spencer and Dales (2006) suggest SPs with emotional "baggage" at a minimum need more assistance de-roling but may inevitably be unsuitable as a SP. Boerjan, Boone, Anthierens, van Weel-Baumgarten and Deveugele (2008) found that SPs use their experience deliberately to enhance their performance and contrary to the discussion of this having a negative impact on the SP, suggest that this behaviour provides an emotional outlet that is helpful.

The relationship SPs have with their own health care provider is also an area impacted by their participation, as an SP. Sometimes the impact is greater satisfaction with their health care provider, marked by greater confidence and improved communication skills

(Gecht, 2009; Wallach et al., 2001). In another study the impact was described as a more balanced view with SPs becoming aware of the range of ability across health care professionals. With the more balanced view came a renegotiated relationship said to be more egalitarian (Woodward & Gliva-McConvey, 1995). At the other end of the spectrum Rubin and Philp (1998) reported that SP perceptions of their own care was negatively impacted one year after participating in an OSCE. Other SPs reported becoming more aware of their doctors clinical and communication skills and themselves being more assertive towards their doctor (Boerjan et al., 2008). Learning is implicated in the changes in relationship between a SP and his physician. Through particpating in the simulation the SP changes their expectations of what a satisfactory consultation is like, and applies this to life outside of the simulated environment. Other learning SPs report includes changing their consultation behaviour and developing more medical knowledge, learning to give feedback and using this knowledge in their day-to-day lives (Boerjan et al., 2008; Woodward, 1998). The SPs in these studies have all been adults; conversely some programs have also diversified to develop adolescent SPs and studied the impact of the experience with these young people.

Studies report work with both adolescent males and females generally recruited through school networks. These SPs have worked in both straightforward patient portrayals as well as portraying suicidal ideation and distressed risk taking behaviour (Blake & Greaven, 1999; Blake, Gusella, Greaven, & Wakefield, 2006; Bokken, van Dalen & Rethans, 2010; Hanson et al., 2002). Unlike adults the adolescent SPs reported no negative psychological or stress effects. They did however express positive benefits such as confidence, communication skills and like their adult counterparts, a sense of discrimination about the care provided by their own physician (Blake et al., 2006; Bokken et al., 2010; Hanson et al., 2002). An important finding with wider implications than simulated patient methodology is the observation by some teens that their portrayal helped them recognise the futility of risk taking behaviour such as smoking and illicit drug use (Blake et al., 2006; Hanson et al., 2002). Following SP portrayal the adolescents felt more prepared to resist these negative life choices. Some teens did request the opportunity to be presented out of role to the learners at the conclusion of the simulation. This was related to the concern that they would be judged as risk takers outside the simulation (Blake et al., 2006). The concern was resolved in the program by changing the protocol to allow the SP to introduce themselves out of character. So while this concern was readily resolved it raises an important idea about the SP resuming their own identitiy after the simulation. The adolescent SPs wanted to distance

themselves from the role portrayal, while in Woodward's (1998) study, adult SPs complained about being treated as if they were the person they had portrayed after the simulation. Woodward's (1998) poignant example of a SP being approached by an audience member who had a similar experience after portraying an incest victim is striking. The author explains that receiving validation for the non-preferred identity is a threat to the central identity and magnifies the inability to de-role after a scenario. Overall the benefits such as learning, communication skills, comeraderie and employment outweigh the disadvantages (Spencer & Dales, 2006), and help answer the question, why do SPs participate in health education?

2.10 Motivation to be a SP

The motivation to be a SP is probably something that can only be determined in hindsight. Indeed, many lay people have never heard of the term simulated patient and take some time to grasp the meaning, in my experience. Once working in a program, motivation can be considered retrospectively. Certainly many of the factors put forward in the literature require experience as a SP to develop insight into the rewards.

Most SPs report enjoying the work as a SP (Abe et al., 2011; Cleland, Abe, & Rethans, 2009). The enjoyment is frequently linked to a feeling of being appreciated by the program staff, participating in something altruistic and feeling useful. Other SPs appreciated the social aspect and the sense that they were doing something important for the learners (Bokken, van Dalen, & Rethans, 2004; Cleland, Abe, & Rethans, 2009; McNaughton, Tiberius, & Hodges, 1999).

While most studies addressed payment as a motivator, none placed it highly. In fact McNaughton, Tiberius and Hodges (1999) point out that for their SPs money alone would be insufficient motivation to continue. Considering that some programs reported in the Cantillon et al. (2010) study of SP programs in Europe rely on volunteers, it is clear that money alone would not sustain interest. The work in many SP programs is not constant enough to provide a salary and rates of pay differ widely where payment is offered. Cleland, Abe and Rethans (2009), discuss the implications of low pay to the perceived value of the role. The authors suggest that where programs have insufficient resources to pay their SPs the market rate, it may be better to run the program on a

volunteer basis. Volunteer SPs would be motivated by the social, altruistic and learning opportunities and not de-valued by low pay.

SPs recognize the educational aspects of the role and list these amongst their motivations. As noted previously many SPs report improved communication skills, knowledge of the skill of their doctor, knowledge about health and the health care system (McNaughton, Tiberius, & Hodges, 1999).

One particular group of SPs stands out for their motivation to be a SP. Like those SPs previously described, they nominate altruism as a motivating factor. However, this group is specifically interested in "improving the way doctors interact with patients of color" (Everett, May, Tressler Nowels, & Main, 2005, p. 77).

Health practitioners and students learn cultural sensitivity using a range of different techniques, some of which include SBE. By reviewing the literature of SBE efforts to teach cultural competency I will reveal the current accomplishments in this field. SPs are working in a number of culturally orientated programs, and although the extent of CALD SP presence in these programs is difficult to gauge, I will show nevertheless the importance of CALD SPs for authentic learning. Finally, it is necessary to review the impacts of culture on health to understand why the SPs in Everett et al's (2005) study sought to improve the interaction between staff and "patients of color".

2.11 Culture and simulation

Encountering diverse populations has focused the challenge on health care providers to ensure communication and decision making meet the needs of all clients. Ozkara San (2015) claims that the United States has more foreign born residents than any other country in the world and lists examples of those diversities as "race, ethnicity, gender, age, sexual identity, socioeconomic status, disability, language and geographic location" (p.228). The need for cultural competency training cuts across all disciplines (Hagoel et al., 2011) but there is a lack of consensus regarding how it should be taught (Allen, 2010; Beach et al., 2005).

Whilst an understanding of cultural schema may act as a guide, it is not possible to learn these for every situation nor would this be desirable. Learning cultural norms risks

stereotyping and endorses the idea that culture is unchanging and overlooks the awareness of within group difference (Allen, 2010; Beach et al., 2005; Hagoel et al., 2011).

Beach et al. (2005) note that positive outcomes are associated with educational interventions regardless of duration, whether they are experiential or focus on either concepts of culture or specific cultural information. Whereas Hagoel et al. (2011) recommend that educational interventions include basic cross-cultural issues, an understanding of explanatory models of illness as well as appreciation for different preferences in provider and patient interactions. Wain et al. (2016), discussing healthcare of indigenous Australians caution that cultural competency training can overlook within group diversity and can unintentionally contribute to the perception that a characteristic of the group is their disadvantage.

Using a range of SBE techniques to teach cultural competency, Ozkara (2015) argues, can provide learners with practical experience. According to her review of the literature, four distinct methods of SBE for cultural competency were identified. These were high fidelity manikin based simulation, low fidelity manikin based simulation, SPs and integrating international concepts into simulations. Morrell, Sharp and Crandall (2002) note a resistance to cultural competency education based on the belief by learners that they already knew this information. Their choice of a SP intervention was intended amongst other aims to generate a critical incident and cause discomfort amongst the learners, thus moving them from unconscious incompetence to conscious incompetence, an outcome they had not been able to achieve with other forms of cultural education. Wain et al., (2016) expand this concept in strategizing how to uncover unconsciously held racist beliefs. “Cognitive disequilibrium” as a result of exposure to a challenge to previously held beliefs can open the individual to new learning and understanding (Wain et al., 2016, p. 2).

Garrido, Dlugasch and Graber (2014) introduce an interprofessional and cultural competency simulation using student actors and allocated role-plays for the characters. They explained that the environment was enhanced with culturally specific artifacts such as religious props and herbal remedies. The scenarios created related to people from Korean Christian, Mayan Mexican and Bahamian Jehovah’s Witness cultural groups. In developing these simulations Garrido, Dlugasch and Graber (2014), identified that commercially available simulation scenarios were not culturally customized, and

that Hispanic and African American characters are often generalized without any detail of subcultural characteristics.

Several authors report using manikin based simulations with cultural content embedded (Grossman, Mager, Opheim, & Torbjornsen, 2012; Haas, Seckman, & Rea, 2010; Roberts, Warda, Garbutt, & Curry, 2014). Roberts et al. (2014) acknowledge that manikin based simulation emphasizes the biomedical aspects of care over social and cultural concepts of illness. Nevertheless, they assert that by using the features of a high fidelity manikin, the speech can be changed to a language other than English, and the biological physical and social environment can be manipulated to support realism. This is consistent with Grossman et al's (2011) findings that also relied on stage dressing the scenario with cultural objects such as clothing and ethnic oriented jewellery. Grossman et al. (2011) found that after completing two culturally enhanced scenarios, students' perceived cultural awareness improved. Correspondingly Haas, Seckman and Rea (2010) allocate culturally appropriate patient names, consider manikin attire and provide visual cues, such as patient information brochures in languages other than English, to signal students to the cultural background of their patient. While these examples share common approaches of introducing cultural contexts and reportedly raise student's cultural awareness, there is an absence of criticism of their shortcomings. The use of dress and artifacts of culture are themselves a stereotype. I question whether the patients portrayed could not show the depth and difference in cultural subtype that is represented in the real world. Then again, the degree of patient fidelity described is foreseeably sufficient to meet the aim of the simulation, and allow a skilled facilitator to draw out cultural assumptions and students own cultural belief systems, which is a worthy first step.

Other simulation techniques reported in the literature include the use of games using second life applications that immerse students in other cultures (Allen, 2010). Rutledge, Barham, Wiles and Benjamin (2008), extend this concept with a detailed report of a virtual web based hospital in combination with video recorded simulations and a personal response system. The patient scenarios were developed from focus groups to ensure the patient rather than educator perspective was presented. Participants included men and women from African American and Filipino American ethnicity, diversified with abused women, lesbian, gay, military and elderly people. Using SPs who record verbal and non-verbal responses the profile of the virtual patients is created

(Rutledge et al., 2008). This innovative and thorough application of detailed cultural diversity is a leading edge example of simulation and culture working together.

Courtney-Pratt et al., (2015), report the first three dimensional cultural immersive simulation utilizing a video situated in a developing country. In this simulation the learner experiences the intervention from the perspective of the patient by wearing the 3D glasses through which they are exposed to a range of foreign stimuli, while also experiencing tactile and olfactory sensations. Similarly to Morell, Sharp and Crandall (2002), this experience unlocked the learners by challenging them to consider cultural competence differently.

Foisy-Doll (2013) provides an interesting account of leading the innovation of simulation education in Qatar. This example takes traditional immersion in another culture, which is often a student elective opportunity, and combines it with teaching simulation. Foisy-Doll (2013) shares cultural assumptions and lessons learned such as students discomfort with Western women's dress to explore learning. Foisy-Doll (2013) challenges us to "exemplify excellence in cultural competence within every learning event" (p. e69).

In summary a range of simulation approaches to teaching cultural content are recognized. These simulations approach the content with various levels of fidelity and authenticity. Some approaches provide detailed cultural insight whilst others could be described as recognizing patients from other cultural backgrounds for the purpose of cultural awareness only. Some of the highlighted accounts of cultural education in simulation, present elements associated with quality simulation based education such as authenticity and patient derived content. But, it is noteworthy that the majority of programs emphasize communication and other non-technical skills. Thus programs using cultural content embedded in technical skill acquisition are absent from the literature. This suggests a degree of tokenism in portrayal of cultural content only for cultural awareness training. This then risks an emphasis on difference much more than acceptance of diversity in all patient interactions. The role of SPs in cultural diversity training is growing and will be discussed in detail in the following section.

2.12 CALD SPs

The body of knowledge related to simulated patients from culturally and linguistically diverse (CALD) backgrounds is obscure and difficult to locate. Many evaluative reports of cultural SBE interventions focus on the outputs related to learning and rarely discuss the ethnocultural identities of the SPs. Often the detail related to the specifics of the SPs ethnicity, culture and other demographics along with the number of SPs in the intervention are not provided, as will be shown in the following discussion.

To avoid the potential for cultural stereotyping associated with learning cultural schemas alone, a nurse practitioner program set out to develop simulations in which learners could uncover culturally competent assessments and undertake cross-cultural negotiation. In partnership with a medical school they gained access to the SP program that had over 600 SP cases. Yet in order to undertake the cultural assessment the cases needed to be culturally enhanced as they did not include the detail of diverse populations the program needed. While Rutledge, Garzon, Scott and Karlowicz (2004), describe a thorough process of identifying and embedding relevant and authentic, patient sourced cultural content, it is noteworthy that with 600 existing cases none were suitable. This is possibly an example of the dominant cultural group being represented in standard scenarios that rarely pay respect to diversity unless it is a learning outcome. Also while the authors note that patients had to be recruited from cultural groups to ensure realistic encounters, they did not detail the extent to which this mix of backgrounds was available amongst existing SPs or numbers of CALD people in the program (Rutledge et al., 2004).

Similarly, in a report from the University of Hawaii where a cross-cultural OSCE was developed to assist resident medical officers to work with the people from the Republic of the Marshall Islands (RMI), the SP details are imprecise. The intervention details the development of two cases and notes that RMI healthcare workers performed these cases, but does not expand on the actual numbers of SPs recruited and trained. A précis of each of the cases prepared is provided and it would be useful to understand how those SPs recruited fit the scenarios created (Buenconsejo-Lum & Maskarinec, 2004). Ndiwane, Koul and Theroux's (2014) paper describing student learning outcomes from a culture OSCE notes that faculty could evaluate the students' ability to understand the patients' explanatory model of illness; however, in describing the intervention it is documented that the SPs were identified and prepared only. Whether these people were

existing SPs or the program had to recruit new culturally diverse people to fit the scenarios is unknown.

Even where the student cohort is relatively large and a seven station OSCE is developed, one case is embedded with cultural concepts (African American) and two SPs are noted to belong to an ethnic group other than the dominant white group (Guiton, Hodgson, May, Elliott, & Wilkerson, 2004). Presumably no cultural characteristics were created for the Hispanic SP, although regardless of whether overt characteristics were designed I contend that the SP would bring individual cultural values that may differ from those of some of the students and mainstream society. Once again, no detail of the CALD SPs is provided except that two people were trained to play the patient for each case (Guiton et al., 2004). Miller and Green (2007) address the issue of cross-cultural characteristics being present in only one station of a multistation OSCE event. They acknowledge that ideally cross-cultural skills should be addressed across all stations, but that time and resource constraints prevented this. Miller and Green (2007) go on to disclose that students were also frustrated that the cross-cultural elements were not more embedded across OSCE stations. A student quoted in the paper raises the tokenism of a single minority SP by saying "…we really narrow the idea of cultural competence by having the only minority patient be about cultural competence" (Miller & Green, 2007, p. e81).

Altshuler and Kachur (2001) may be one of the few exceptions to the token CALD OSCE phenomenon. They report a six station formative culture OSCE for medical students where all six patients exhibit ethnic, cultural and religious diversities. Although scant detail of the program is provided, Altshuler and Kachur (2001) indicate some stations include SPs while others are paper and pencil exercises. Aeder et al. (2007), working with Altshuler, describe using actors to play the roles of SPs. They note nevertheless that when representatives of the required culture are not available they remedy this with intensive education to actors who do not represent the culture. This is interesting in light of the authenticity arguments of Nestel and Kneebone (2010) and the perspective of Long-Bellil et al. (2011) that follow.

In terms of other cultural variations the literature reports a SP program that concentrated on presenting patients with low literacy. The characterization chosen for the SP was an American adult who had not completed high school (Manning & Kripalani, 2007). Using SPs to convey low language literacy can also be managed from the perspective of the patient who does not speak the language of the health care provider.

For SP interventions this usually requires another simulated staff member to act as interpreter. Zabar et al. (2006) term this person a simulated interpreter (SI). The additional personnel, to play both SP and SI, may pose additional cost requirements where the program uses paid simulated staff. In the Zabar et al. (2006) example; a husband and wife team were recruited to play the SP and SI and the same pair presented to all 76 resident medical officers. The authors note that commonly seen mistakes included talking louder to compensate for language barriers, talking to the patient and not the interpreter and seating positions for a three-way conversation. Escott, Lucas and Pearson (2009) note that ethnically diverse and bilingual simulated patients (BSP) were rare and therefore had to be specifically recruited for their program. They observed that the SPs used their own cultural backgrounds and personal experience in developing the scenarios. By including the SPs real cultural background in the scenario, the complexity of multiple social, cultural and ethnic diversities were incorporated and could be authentically replayed by the SP. The program had 20 BSPs from seven language groups (Escott, Lucas, & Pearson, 2009).

Ewen, Pitama, Robertson and Kamaka (2011) identify indigenous SP programs as relatively new in medical curricula. They provide insight into three such programs operating in Australia, Hawaii and New Zealand. These programs exist to enable their students to meet and interview indigenous people to understand their diverse experience in health interactions. Whilst total numbers of indigenous SPs in each program studied are not provided, the availability of indigenous SPs is identified as a challenge for all of the sites. Significantly these SP programs report they provided a voice or avenue for indigenous SPs and in doing so "shifted the relationship from learning *on* patients, to learning *from* patients" (Ewen et al., 2011, p. 41) [their emphasis]. This observation is echoed in Chun et al's (2012) account of a SP culture OSCE in which they note the patient is viewed as the expert of his/her illness. This patient-centred approach emphasizes the power base residing with the patient to direct one's own care. But, as noted by Skelton, Lai and Louden (2001), this distribution of power is not sought by all people, and in some cultures the patient is reassured by and expects a show of power from the doctor.

Abe, Suzuki, Fujisaki and Ban (2009), provide insight into another aspect of CALD SPs in their study of Japanese SPs. While their purpose was to survey the SPs regarding their willingness to participate in physical examination skills testing, other cultural and gender observations are enlightening. The authors list concerns for privacy and human

dignity and the risk of relationship damage with the SP amongst the barriers to including physical examination. In describing what Abe et al. (2009) call cultural norms the idea of internal shame is presented. An example presented is body self-consciousness amongst women leading to unwillingness to participate in peer teaching. This is contrasted with UK and US medical student studies showing acceptance of this practice (Abe et al., 2009). Understanding the cultural norms of women in Japan and their reluctance to disrobe, would I imagine be an important lesson for staff working in any country where ex-patriot Japanese women patients could be encountered.

In a final example of SPs working in cultural contexts Long-Bellil et al. (2011) provide an excellent account of programs working with SPs with disabilities. Long-Bellil et al. (2011) aptly report that people with disabilities are best placed to educate students about living with a disability. While some disabilities are not visible many traits and characteristics of disability cannot be realistically depicted. Of the seven programs featured, only one uses people without disability portraying individuals with a disability, in this case an inability to move on one side of the body (hemiplegia). Once again the appreciation of authenticity is central to the choice of SPs with the authors regarding this as bringing credibility to the simulation. They also note that SPs without disabilities could harbor their own preconceptions and stereotypes that could impact the learning adversely.

Despite significant limitations of literature related to CALD SPs it is clear that some common elements exist across very different domains of SP diversity. Authenticity of the cultural state is highly valued, yet in spite of this, recruitment and retention of suitable SPs is challenging. Everett et al. (2005) state, "There is a gap between recruitment and retention of Caucasian SPs compared to minority SPs" (p. 74). They add that African American and Latino people are under-represented in SP databases. In their study of Latino and African American SPs they noted a desire to work in scenarios with cross-cultural communication elements and real life issues rather than stereotypical dimensions of their race or language characteristics.

This exploration of CALD SPs has demonstrated the lack of finite detail concerning the extent of CALD SPs, relative to the dominant cultural group in programs. Cultural information is either not recorded in SP databases or not reported or both (Bokken et al., 2009; Cantillon et al., 2010; Nestel et al., 2010). I understand from personal interactions with SP coordinators that CALD people are poorly represented. In those

programs discussed in this section the numbers of SPs were provided in only one report (Escott, Lucas, & Pearson, 2009). Zabar et al. (2006) point out that case specificity means that a learner needs multiple exposures to CALD people to develop skill and one CALD SP interaction undertaken competently may indicate good communication rather than cultural competency. Inclusion of cultural details in SP databases and in ordinary scenarios would enable additional practice opportunities. However, cultural competency is taught using other SBE methods; it is worth reviewing these studies to understand how other methods of cultural education in simulation augment the seemingly small numbers of CALD SPs.

This research begins the process of addressing a void in the literature and indeed knowledge of SP methodology. CALD SPs are a minority group worldwide and the literature fails to identify the magnitude of this problem. What is known about SPs focuses on existing SP groups for which the cultural variation is not reported but is assumed to be from the majority culture of the population.

2.13 Intersectionality

Members of minority groups are often subject to other disadvantages (e.g. socioeconomic or educational disadvantages), have jobs with higher occupational hazards, live in areas with higher environmental hazards, such as pollution, and are less likely to have health insurance (Betancourt, et al., 2003). In recognition that multiple factors beyond just ethnicity or culture intersect to oppress some people, the need to view the impacts of culture on health broadly become evident. CALD people have poorer clinical outcomes including a higher prevalence of adverse events and errors coupled with reduced health maintenance behaviours (Courtney-Pratt et al., 2015). Individuals inhabit multiple locations of oppression in a dynamic process that shape their experience and can be viewed using a paradigm such as intersectionality (Bates, Hankivsky, & Springer, 2009).

Intersectionality is described by McCall (2005), as “the relationships among multiple dimensions and modalities of social relations and subject formations” (p.1771). Considering race, class and gender as independent variables does not reflect reality. Instead, individuals exist as members of all groups concurrently and it is at the intersection of these groups that identity is recognized (Trahan, 2011). Therefore, intersectionality seeks to describe the complexity of different dimensions of social and

cultural categories within a person's life, such as ethnicity, gender or sexual identity, and how these act on experience simultaneously.

Intersectionality grew from the work of Kimberle Crenshaw, who challenged the prevailing ideas that favoured black men in antiracist politics, white heterosexual women and the binary application of sex or race in discrimination cases (Carbado & Gulati, 2013). Crenshaw (1991) argued that in identity politics various identity categorizations are used to exclude or marginalize those who are different, but ignores intragroup differences. Looking at race or gender separately cannot capture the intersection of racism and sexism in black women's lives. The complexity of race and gender cannot be overlooked without understanding that poverty, lack of job skills and childcare requirements, for example, are intragroup factors of gender and class (Crenshaw, 1991). Using rape crisis services as a powerful example, Crenshaw (1991) illustrates why these intersecting axes of identity are important. Rape crisis funds, she contends, are allocated to standards of need for white and middle-class women. Yet, counsellors spend resources managing problems other than rape when the victim is a woman of colour. Intersectionality therefore "aims to make visible the multiple positioning that constitutes everyday life" (Phoenix & Pattynama, 2006).

Whilst it is not my intention to analyze culture per se, it is the lens through which the experience of CALD SPs needs to be viewed and as the organizing force of this research. I will now briefly examine the perspective of culture and research.

2.14 Culture and research

As this review of the literature has shown, the visibility of CALD people in simulation is minor. Although diversity may exist within SP groups, for the most part it is not recognized. Papers such as Everett et al. (2005) suggest that minority SPs are underrepresented in SP groups when compared to population demographics. Research with CALD SPs is, I contend, a mechanism to reflect the socio-demographic context of patient representation that should be present in health professional simulation. Geia, Hayes and Usher (2013), suggest that as researchers we should expand on the work of others by enriching research methodologies with a deeper understanding of lived experience.

Drawing on the work of Nestel et al. (2011), refraining from the term "use" of SPs, and considering this in light of Arzubiaga, Artiles, King and Harris-Murri (2008) who object to the term research "on" minority groups I seek to position myself as working "with" CALD SPs.

Geia, Hayes and Usher (2013), discussing Indigenous research, say the habits of research are Eurocentric and as a result have silenced and made invisible many people. I argue that this extreme position felt by Indigenous people is a factor for CALD people as well. Health disparities for minority populations may be driving the research agenda as well as the increasing diversity of the population (Yancey, Ortega, & Kumanyika, 2006). Further lack of inclusiveness in research may skew the results through best-case scenarios and diminished capacity to benefit with privileged populations (Yancey, Ortega, & Kumanyika, 2006). The health status and health needs of diverse groups are not well understood (Han, Kang, Kim, Ryu, & Kim, 2007). As a recommendation, Yancey, Ortega and Kumanyika (2006), advocate the establishment of journal standards to include sample composition rather than assume unacceptably that the sample is European American and therefore white. Taken a step further, the assumption that underlies Euro-American whiteness is that all white people are alike and have the same traits and characteristics (Martin-McDonald & McCarthy, 2007). The need for a nuanced examination of diverse people is applicable to SP research as well.

Culture blindness assumes equity is achieved by ignoring difference. Though, the result of this blindness means that research knowledge that could ultimately impact policy development is informed only from the perspective of the mainstream (Arzubiaga et al., 2008). Additionally, research that does heed culture is often limited by failing to recognize that everyone's values, assumptions and practices represent culture and that culture is not static and differs within groups (Arzubiaga et al., 2008). My research seeks to hear the perspectives of culturally and linguistically diverse simulated patients but does not assume that membership of a racial or cultural group represents any aspect of the group, only that of the individual. How then to hear the individual nuanced view of each distinctive CALD SP?

The socially constructed narrative of personally meaningful experience is negotiated between the individual, his or her social environment and the larger cultural milieu (Wang & Brockmeier, 2002). Narrative forms are therefore culturally shaped and culturally sensitive. Wang and Brockmeier (2002) point out that the way a person

conceives of themselves will manifest as different forms within their narrative that are culturally created. They suggest that some cultures will cast themselves as central characters; others will focus on relationships, whilst others are routine bound and refer to moral rules. All reflect culture specific conceptions of themselves (Wang & Brockmeier, 2002). Narrative then is a method that accommodates cultural conceptions of self that I seek to capture.

2.18 Conclusion

Simulation based education of health professionals is a growing pedagogy with significant benefits to learners, instructors and patients. Although many modes of SBE are available, working in simulation with SPs brings particular benefits which include representation of the patient's voice and the ability to present challenging human interactions such as difficult communication.

One area in which communication can be challenging and subject to significant barriers is in health care interactions with diverse populations. Although health education recognizes the importance of health care providers developing skills to effectively communicate with and care for CALD people the methods are varied. Authenticity and genuine in-group diversity are necessary to avoid essentializing and stereotyping ethnic and cultural groups.

Working with CALD SPs to teach cultural competency content is rarely reported in the literature. The numbers and diversity of existing SPs is difficult to gauge and infrequently recognized in SP literature. Therefore, little is known about CALD SPs and yet their value to diversity education and, more broadly, in simulation to represent the real diversity in the community is respected.

The importance of capturing the complexity of the health care interaction for diverse populations in culturally competent healthcare education is vital to minimize the risk of culturist, racial and essentializing explanations for health disadvantage amongst minority groups.

To help us understand how CALD SPs live their identity, I will share their stories of experience. Using interpretive narrative methodology I hope to shed some insight into the lives of SPs that may otherwise not be available.

In the next chapter I will describe the methodology linked to the theoretical framework for this study. In doing so I will show the synergy of method, methodology, theoretical foundation and how they fit the research question, exploring the perspective of CALD SPs.

Chapter 3

Philosophical Perspective, Theoretical Framework, Methodology and Methods

> Did he have a mother?
> "I did have a mother," said the baby bird. "I know I did. I have to find her. I will. I WILL!" (Eastman, 1960).

3.1 Introduction

In this chapter I will discuss my use of a constructivist philosophy as well as the influences of postmodernism and feminism. This discussion will relate the philosophical underpinning of my research to the theoretical framework of intersectionality as well as the methodology of narrative as posited by Polkinghorne (1995). The methods undertaken and their congruence with the philosophy and theoretical framework of my research will be highlighted. Finally, I will describe the special treatments and ethical implications of research with people from CALD backgrounds.

The choice of research approach, says Creswell (2003), is influenced by the research problem, the personal experiences of the researcher and the audience that will ultimately read the outcomes. Where little is known about a subject or the topic has not been investigated with a certain sample or group of people, such as CALD SPs, exploratory qualitative methods are useful (Creswell, 2003). Indeed, qualitative approaches allow the researcher to creatively customize approaches to the research design contrary to the traditions of quantitative studies (Creswell, 2003).

In choosing to study a group of people with particular qualities I understand that I open the door to an argument of identity politics in research (Griffin, 2012). I am a white, middle class, educated woman, researching in my country and city of birth. My heritage is English and Australian. Griffin's (2012) suggestion that the conception that ontology and epistemology assume "synonymy between what you are and what you do research on" (p.337), will be addressed later in the chapter.

Constructivist theory has multiple ties to adult learning through experiential learning, reflective practice and situated learning to name some but not all of its manifestations

(Rutherford-Hemming, 2012). In simulation based learning, regardless of the simulation technique employed, the learner undertakes an experience followed by a reflective exercise known as the debrief. Constructivism underpins the process as the learner constructs knowledge by reflecting upon the meaning of the action in the simulation scenario and following debrief (Rutherford-Hemming, 2012).

Constructivism has helped me to understand the acquisition of knowledge in simulation. Associated learning theories explain how students learn using a constructivist approach. Working from an area of strength and familiarity with constructivism, for which I have a pre-formed affinity, was my starting point. Ponterotto (2005) suggests that reviewing paradigmatic schemas to assess whether they are suitable, understandable and credible is a valid strategy. Ultimately my aim was to adopt methodology with coherent philosophy, methods and data (McCall, 2005).

3.2 Philosophy and theory of constructivism

3.2.1 Constructivism

Ontologically a constructivist belief accepts that reality is multiple, constructed and influenced by factors such as history, context, experience and perception. A participant and researcher construct reality through the interaction they share. As a consequence there are multiple meanings of the research data (narrative) as well as multiple possible interpretations (Ponterotto, 2005).

Bruner (2004), exposing a constructivist approach to narrative, reasons that in telling our stories we continue to interpret and reinterpret our experience or "world make". In describing world making he says that life, like narrative, is a construction of the human mind (Bruner, 2004). Multiple truths, individually constructed, are influenced by factors such as class, gender, race and ethnicity as well as culture and age (Liamputtong, 2013).

Following the work of Emden (1998a), who sought to understand nursing scholars and used constructivism to conceive the stories that emerged from her study, I saw strong parallels to my study that were influential. Using constructivist approaches Emden (1998a) recognized how inseparable the stories were from the narrators. And when meshed with other stories, deep contextual understanding was provided about nursing scholars and scholarship. Accepting Emden's (1998a) influence, I sought the community

of stories to create a deep contextual understanding of the CALD experience of being a simulated patient.

Constructivist researchers accept their own influence in the research as the participant explores their own reality, and the researcher and participant develop an interpretation (Liamputtong, 2013). In order for the participant to articulate their meaning sufficiently, a research method with thick description is ideal (Liamputtong, 2013).

Where the chief product of research work is language based and data collection involves interactive communication, the realm of constructivism is known as social constructionism (Foster & Bochner, 2008). In drawing a distinction between constructivism and constructionism using narrative as the dimension, Sparkes and Smith (2008) describe the plurality of social constructionist inquiry. Narrative constructivism they say is primarily concerned with what a person thinks while engaging in social interaction. This inner world where meaning is created, identity affirmed and understanding achieved, is shared through stories the person tells. Within the inner thought process a person can be influenced by matters in their social world and then absorbed into the personal world. Even though recognition is given to the social impact of narratives it is for the purpose of influencing and sense making internally (Sparkes & Smith, 2008).

Conversely, narrative constructionism, Sparkes and Smith (2008) explain, is the means through which our worldview is shared through social relationships. The shift of focus is from the inner thoughts of the individual to a relational construction of reality.

Narratives in this perception are "forms of social construction through which human life and our sense of self are constructed, performed and enacted" (Sparkes & Smith, 2008, p.299). Social constructionism is said to give more significant attention to "relatedness and the social aspects of narrative in the self and identity-construction process" (Sparkes & Smith, 2008, p. 300). The argument preferences the idea that identity is formed, maintained and altered as a result of social interaction.

Finally, while it would appear that constructivist and constructionist approaches are in opposition, Sparkes and Smith (2008) demonstrate the significant similarities and points of consistency. They stress that the co-existence of the approaches are possible. Ultimately this study was concerned with the realities constructed between people and

therefore takes a constructionist standpoint. Lincoln and Guba (2000) classify social constructionism as relativist, capturing the idea that multiple truths exist, and this is consistent with the aim of this study: to uncover those multiple realities that exist for CALD people working as SPs.

A social constructionist perspective influences the method of data collection. The interview is an ideal choice as it highlights the interaction in developing a dynamic and shared understanding. The interview is implicated as a mechanism to create meaning between the researcher and participant, and recognize both parties as having and contributing to knowledge (Koro-Ljungberg, 2008).

A social understanding of the world where knowledge and truth are constructed is the emphasis of constructionism. Reality is socially defined as it is interpreted through the lens of subjective experience. It is the understood reality but not the objective reality of the natural world that is the focus (Andrews, 2012). Despite the focus on subjective reality, it is possible to recognize objective reality as well. Through routine and habit, patterns are born that over time are embedded to such an extent they become accepted as objective (Andrews, 2012). Andrews (2012) goes on to posit that social constructivism is criticized most significantly for its approach to realism and relativism conceptualized as multiple realities.

The realist position suggests that data reported is the one true reality and does not allow for interpreted findings (Andrews, 2012). At the other end of the continuum relativism suggests that any number of findings is possible and therefore no definite truth is possible with all possibilities having precedence, one over the other (Andrews, 2012). Burningham and Cooper (1999) challenge the realist critique of social constructionism suggesting it has been given undue prominence. Instead, taking the perspective of using empirical case studies based on social constructionism, Burningham and Cooper (1999) show that realist criticisms that social constructionism denies reality is not demonstrated and that many studies take a mild or contextual approach. In a mild or contextual approach the social constructionist assumes that what is known about the reality of a problem can be used to consider the claims made about it. Conversely, in a strict approach, the existence of a problem is ignored and only the claims made about it considered (Burningham & Cooper, 1999). Not considering the ontological aspect does not deny its reality; rather, the point remains to consider the socially constructed meaning and significance of the aspect.

Vera (2016) in his review of the original work of Berger and Luckmann, 50 years after their seminal text "The social construction of reality", points out the diffusion of the original concept of social construction. In contemporary literature Vera claims the term is used as synonymous with "not natural" (p.4). The original intent of the term drew attention to what people conceived as real in their everyday life. In an ironic twist Vera (2016) points out that the meaning has become socially constructed into something unintended and alien through social intercourse in the intervening years. The intent and purist interpretation of reality was those items "regarded *as* reality", "socially viewed *as* reality" and "taken for granted *as* reality by ordinary members of society" (Vera, 2016, p. 9, original emphasis).

3.3 Significant other philosophical and theoretical influences

3.3.1 Post modernism

This study echoes the values of my work *with* simulated patients and research *with* culturally and linguistically diverse people. In keeping with this inspiration the postmodern influence of "social science about human life rather than *on* subjects" (Lincoln, Lynham, & Guba, 2011) is an underpinning value that strongly influences this study. Postmodernism seeks to test the boundaries and challenge the status quo and in doing so expand the range of understanding to hear the myriad voices of experience (Lincoln, Lynham, & Guba, 2011). The purpose of "listening" to the range of voices is to focus on questioning our previous thinking and knowledge rather than a call to action (Cresswell, 1998).

In this examination of the CALD SP the research focuses deliberately on the cultural milieu of Australian society and seeks to understand the lived experience of people who work as CALD SPs from their perspective. The context is the contemporary health education environment and its teachers and learners interacting with CALD SPs. With deference to the multiple perspectives of the individual SPs emerging from different cultural and ethnic groups, generations and arrival mechanisms in Australia, the issues of power, hierarchy and marginalization can be recognized and deconstructed (Cresswell, 1998).

Knowledge, from a postmodern perspective is fluid, contextual, historic and discursive rather than all encompassing (Ironside, 2001). This perspective fits a narrative

methodology and the reflexivity of the recognition that the interpretation of the narratives is my own. Readers will feasibly infer other understanding and knowledge influenced by their own culture, context and history. The CALD SPs will retell the stories of their narratives in other contexts and for other purposes, and the knowledge attached to the re-telling for both narrator and listener will comfortably be different.

Emden (1998a), citing the influence of several theorists including Roof , demonstrates the fit of narrative research within a postmodern context. Considering the cultural norms within individual stories as told in the context of the cultural understanding of the time the story occurred, that in turn shaped the understanding of the narrator's life, provides a postmodern avenue to consider bigger cultural stories. While we consider, for example, culture from our current context, the nuances and inconsistencies of cultural norms of yesteryear become evident and delineate our barely perceived grasp of postmodern culture (Emden, 1998a). Significantly Emden (1998a), acknowledging the theoretical influence of Bruner (1987) and Roof (1993) in her own work, further suggests that postmodernism and cultural difference raise the question of "how people make sense of their lives within a past, present and future" (p. 34). Thus postmodernity influenced my interpretive scheme, using significance, value and intention representing past, present and future (see chapter 5, for more analysis discussion).

3.3.2 Feminism

Comfortably accepting the changes in personal subjectivity over time is critical to feminist research and epistemology (Bloom, 1998). "Metaphors of motion are often used to characterize subjectivity as a process that takes place within the world" (Bloom, 1998, p. 4). The feminist influence of non-unitary subjectivity encourages women to think about the world around us in new ways. When considering the stories of CALD SPs through the theoretical framework of intersectionality it is vital to accept that a single immovable identity is unrealistic and essentializing and denies the complexity of these people's lives. Following on from the postmodern interpretive scheme of significance, value and intention and its representation of time, the change in identity experienced through emancipatory events and different social environments experienced by the SPs were emphasized through the feminist perspective.

A feminist approach to enquiry is concerned with social justice and inclusiveness. Feminism recognizes multiple ways of knowing and values both cooperation and

collaboration, as well as mutual respect and trust (Ironside, 2001). Working with SPs to develop scenarios, through training and preparation and in delivery of simulations to learners, has facilitated the development of relationships. Some SPs identify strongly with me, others less so, and all become vulnerable during training as they try on the characterizations and emotion fitting for the scenario. We critique the flow of character detail, to the learner, as we rehearse and try on different approaches and strengths of performance. We troubleshoot together and I present difficult situations for the SP to manage in order to prepare the individual for as many eventualities as time permits in the preparation phase for simulation. I have an established history and context working in collaboration with SPs. Equally we develop rapport and trust as we train and embody characters then allow critique. The influence of feminism is acknowledgement of the inherent values that have already been established between the SPs and me.

A limitation of feminist influence is the lack of mechanism to consider diversity between women (Ironside, 2001). The importance of in-group diversity is sought amongst CALD SPs. Griffin (2012) considering the integrity of feminist research between researchers and participants with different identity constructions or cultural belief systems suggests the accusation of neo-imperialism has justification. I am not immune to the vulnerability Griffin (2012) describes in developing a study with people unlike myself. The postmodern influence away from identity category based descriptions, coupled with feminist non-unitary subjectivity provides an escape from essentializing positionality. While cultural and linguistic qualities of SP participants may be identity-category based, the group known as SPs is less so and for this group I achieve likeness.

This research focused on the multiple voices of the participants after specifically identifying a perspective in SP methodology that was under-represented and was thus silenced. The voices of CALD people as represented by CALD simulated patients were disenfranchised in mainstream SBE. Feminism challenges the conventional approaches to health education and draws attention to the ways established approaches to SBE privileges and encourages some groups over others; in this instance majority people over those who identify as minority (Ironside, 2001).

3.4 Researcher's stance

A transactional epistemology consistent with constructionism that supports learning through social interaction was appropriate to the aim of this research. Seeking to uncover how people perceive their experience and reality reflects the argument that reality exists regardless of whether participants are aware of it (Refai, Klapper, & Thompson, 2015). The methodology is needed to reflect the emphasis on relationships and subjectivity of the participants. Social constructionism emphasizes the study of "everyday knowledge (non-theoretical or pre-theoretical thought), and not only ideas (scientific, philosophical, or mythological theorizations)" (Vera, 2016, pp.8-9). Therefore, where the research aims to make sense of an aspect of the social world, social constructionism is an appropriate instrument (Andrews, 2012).

Post modernism, with an emphasis on cultural difference and multi-vocal elaboration, enables the complexity of different realities to be captured. As a perspective postmodernism allows for presentation of subjective opinions and leaves readers the possibility of interpreting the findings or experiencing those stories, in the context of this research, in their own ways and influenced by their own situations (Pihlainen, 2013).

From the postmodern perspective, accepting that knowledge belongs to the participant and is ingrained in their cultural and linguistic world, the question of authority or control can be suitably addressed. Guba and Lincoln (2005) suggest that approaches that embrace messy text that attempt to portray contradictions and truth of existence while expanding understanding and voice, break through oppression and redress power imbalances. When working with a group of CALD people who are not part of the dominant majority, this is a vital consideration. The research seeks to be emancipatory and avoid authority that prescribes how we fashion our world, but instead listens to how the world is perceived. Similarly feminism is an approach committed to overcoming oppression associated with inequality, in an emancipatory fashion.

Feminist research approaches frequently acknowledge the situated knowledge of researcher and participant established through connections of personal, professional or political identity (Griffin, 2012). Additionally, the shifting identities of the postmodern feminist consider the complexities of gender, race and class as formations of control. Control or oppression is portrayed via fluid conceptualizations of experience, places and

spaces (Olesen, 2005) that are suited to discourse and narrative. The postmodern influence opened up the perspective of feminist research to disabuse the need for sameness of experience and gender (Olesen, 2005).

In moving away from issues of sameness, the recognition of the researcher's attributes contributing to the research direction was established. Olesen (2005) provides a number of examples of a shared identity construct between researcher and participant that challenge the notion that insider knowledge was privileged to full access, or stable and static. CALD SPs represent individual intersectional identities of their ethnicity and culture, changed by circumstances of immigration, employment, age, gender and generation. While the complexities of these identities are sought and relevant to this inquiry, the idea that an insider view was possible would serve to essentialize their perspective.

A feminist research perspective therefore acknowledges identity and accepts the different configurations of identity within and across groups. The necessity for shared understanding between different standpoints positions the researcher and participants as negotiating meaning and representation (Koehn, Neysmith, Kobayashi & Khamisa, 2013). The emphasis in feminist research flavoured by postmodernism, shifts the focus from the emancipation of the "whole" to the individual and provides the means to recognize difference within groups and avoid static categorizations.

The purist perspective of race, or culture or even gender is superficial and needs to be considered as a differentiated concept. While this differentiation brings complexity, the feminist approach provides an avenue for considering multiple perspectives. Individuals live with a dominant culture but may adopt other cultures or at least cultural behaviours and change according to the moment and context. This is the complexityof experience this research seeks to witness and explore.

Lincoln, Lynham and Guba (2011) note the benefits of interweaving more than one perspective to develop an interesting and rich methodology. The complexity of intersectional identities, and the aim to bear witness to the stories of people working, as CALD SPs, requires the richness of methodological approaches adopted.

In justifying why I used the philosophical and theoretical perspectives that I have, it is also worth considering others that may have been suitable. The ontology of critical

theories is concerned with power and control and emancipation from oppressive structures. The methodology of dialogic and dialectical inquiry for the purpose of social transformation (Lincoln, Lynham, & Guba, 2011) sits in parallel proximity to the constructionist approaches outlined. However, the outcomes of critical approaches are transformational in nature, seeking to produce social change whereas a constructionist approach, whilst sharing a belief that knowledge is socially constructed, experiences the subject vicariously and gains knowledge through reasoning and conversation (Lincoln, Lynham, & Guba, 2011).

Both positivism and post-positivism present a more scientific approach and as such the outcomes are intended to predict phenomenon. The influence of the researcher is disconnected through efforts to create objective measurements. In line with the desire of objectivity the researcher is the only voice (Lincoln, Lynham, & Guba, 2011). Oliver (1998) notes that quantitative methods have limitations when the complexities of lived experience are sought and can only partially examine such problems. Therefore these approaches would be unsuitable for the breadth and depth of understanding sought.

To return to Griffin's (2012) argument about ontology and epistemology and synonymy; I assert that I have a personal, and professional connection to my research. Notwithstanding the issues of power between researcher and participant and the risk of essentializing the research participants, I reject the position of patronizing advocacy. As a SBE facilitator, I value authenticity to avoid stereotypes and provide meaningful learning. Drawing upon the argument of Jaschok and Jingjun (2000), positioning oneself in relation to any undifferentiated group excludes the intersectional positions of the individual and creates a hegemonic discourse. I do not seek the insider position of homogenizing "we" but instead I have sought methods to challenge individuality and approach multiculturalism from the perspective of advocating attention and responsiveness to the needs and claims of CALD SPs (Scuzzarello, 2015). While a focus on difference favours ethnocentric thinking and paternalistic attitudes (Williamson & Harrison, 2010) the methodology therefore needs to pay homage to the individual without focusing specifically on difference. "Idiographic research focuses on understanding the individual as a unique, complex entity" (Ponterotto, 2005, p. 128) and constitutes the perspective of this research.

In the following section I describe the theoretical framework of intersectionality and narrative methodology. Social constructionism, influenced, as described, by post

modernism and feminism are congruent with the methodology of narrative. The theoretical framework of intersectionality is also in keeping with narrative as a fitting methodology that explores the lived reality of participants.

3.5 Theoretical framework – Intersectionality

As defined in Chapter 2 the concept of intersectionality provides a mechanism to recognize and describe the confluence of identity groupings present concurrently in a person's life. The importance of understanding this confluence is the recognition of multiple dimensions acting simultaneously and the diversity within groups that the range of possible different intersectional positions creates. Recognition of mutually constitutive identities is a central principle of feminist thinking according to Shields (2008).

More contemporary uses of intersectionality in the literature do not specify the available social identities; therefore they allow a broader conception that emphasizes variation and fluidity of social locations and processes (Gopaldas, 2013; Hankivsky, 2012). The intersectional locations along multiple different combinations of social identities create different lived realities that can be recognized for research, policy or law (Trahan, 2011). Importantly, in the interwoven nature of these categories, the impact of one on another can be to either strengthen or weaken another characteristic at the point at which they intersect (Winker & Degele, 2011).

Bowleg (2012) asserts that most social identities are multiple and intersecting, yet much research dealing with health disparity considers the systems of privilege and oppression, such as racism or sexism, independently. While we all have intersectional identities the focus is often on historically oppressed and marginalized groups such as racial and ethnic minorities and lesbian, gay, bisexual and transgender (LGBT) people, those who are financially disadvantaged and those with disabilities. Importantly, Bowleg (2012) adds that the intersectional position of people is recognized from their own context and through their view rather than "their deviation from the norms" of the position of the prevailing cultural group (Bowleg, 2012, p. 1269).

Intersectionality is not additive and does not suggest that the effects of one category can be calculated by summing the effect of another, such as race plus gender. Rather,

intersectionality attempts to interrogate the interaction and examine the different impacts that lead to control, exploitation or privilege (Grunenfelder & Schurr, 2015; Hankivsky, 2012; Koehn, Neysmith, Kobayashi, & Khamisa, 2013; Trahan, 2011). By understanding the effects of oppression and privilege, intersectionality as a theoretical framework adds value to this research. Considering issues of culture, ethnicity, language and migration mechanism in CALD SPs, for example, it would be superficial to treat all identity constructions as sources of oppression. This fails to capture the experience of a successful migrant retailer who simultaneously experiences discrimination and disadvantage based on her ethnicity and English language ability while enjoying the advantages of successful business privilege (Trahan, 2011). The differences in power and the effects of those differences on the individual's health thus become apparent (Davy, 2011). "Power imbalances and discrimination, as well as positive health care experiences, are understood as unique to each individual's constellation of intersecting identities, social roles and the broader social and political contexts in which they exist" (Koehn et al., 2013, p. 446).

Carbado and Gulati (2013) echo the idea that intersectionality exposes both ends of the privileged-to-oppressed spectrum by reminding us that white heterosexual men have intersectional identities. By arguing for the differentiation of intersectionally marginalized and privileged groups, they attempt to disrupt the perception that intersectionality is only concerned with marginalized categories (Carbado & Gulati, 2013). Bowleg (2012) echoes the idea that all intersectional positions are not equally disadvantaged. She uses the example of high socioeconomic people having better health outcomes, but demonstrating that this is not universal with the educated black women having higher infant mortality rates than less educated white women.

A criticism of intersectionality is the potential complexity that results from an infinite host of differences (McCall, 2005; Phoenix & Pattynama, 2006). This is certainly a struggle I understand, and yet any reductionist tendency would risk essentializing and homogenizing entire groups (Viruell-Fuentes, Miranda, & Abdulrahim, 2012), whereas my purpose is to gather multiple perspectives within the context of CALD SPs. Intersectional research, Gopaldas (2013) says, instead, stresses the inclusion of all voices. While Grunenfelder and Schurr (2015) recommend owning the complexity and developing approaches to capture the identities and power relations that shape people's lives.

Hankivsky (2012) cautions that intersectionality as a research paradigm is not prescriptive, with no particular design or focus on method. She instead suggests a conceptual shift to the way a researcher understands and interacts with difference. This requires careful and reflexive thought about how my selections may influence the results and interpretations of the research and my intersectional position as the researcher. Which differences are examined is shaped by data availability, interest and emphasis of the research and researcher positionality (Dhamoon & Hankivsky, 2011). Bowleg (2012) suggests that the challenge of determining categories should be countered by conceptualizations that are broad enough to demonstrate positions of privilege and oppression simultaneously.

While recognizing that lack of a guideline for intersectional research is a challenge, as a theoretical framework Bowleg (2012) recommends that an intersectionality informed stance informs the commitment to understand how multiple identity categories work together to influence a person's reality. Shields (2008) recommends a "both/and" strategy entailing the individual identities as well as the intersections and their emergent properties, considering interpersonal, contextual and structural categories. It is through this lens that intersectionality informs the research of CALD people working as simulated patients.

3.6 Narrative Methodology

Narrative methodology is situated within both the social constructionist and postmodern paradigm. The social constructionist emphasis of knowledge being socially and culturally grounded in discourse through social interactions forms the basis of the application of narrative (Mitchell & Egudo, 2003). Postmodernism's contribution is the importance of multiple perspectives and questioning of objective truth in favour of reality grounded in everyday life (Mitchell & Egudo, 2003). This is congruent with the personal, social and contextual elements of experience described by the philosopher John Dewey who initially shaped Clandinin and Connelly's work in narrative inquiry (Wang & Geale, 2015).

McAdams (2005) says a story is a way to organize a life into past, perceived present and anticipated future. As all the different identities of self are constructed within stories, the teller re-organizes the content to gather critical experiences, important relationships

and represent their values and norms to portray that identity (McAdams, 2005). The resulting story is not "the one and only" life story but is instead he says, a representative of the plethora of possible images, metaphors and significant moments the person has in their repertoire. Each person chooses the stories they tell and these would differ, depending upon their aim in telling the story and potentially the audience and context (McAdams, 2005).

Meaning is developed as a person shapes and orders their stories. The process of choosing what to tell or not tell, and explaining their actions and thoughts, aids reflection and identification of consequences as well as linkages (Chase, 2011). Narrative therefore is capable of giving insight into the lived experience of the narrator with attention to their cultural context and the maintenance of identity (Chase, 2011). Through the narrator's stories the researcher enters the world of experience of the narrator and together they construct an understanding of the forces and beliefs shaping and influencing the narrator (Denzin, 1971). Wang and Geale (2015) describe this understanding as an insider's view, signifying the depth of understanding of the participants' perspective.

As a story unfolds we recall the events that are important but do not include all the minutiae in the telling routinely. The actions are told, accompanied by the consciousness of explanation and choice, thus privileging the listener to two landscapes as Bruner (2004) describes them: the action landscape and the landscape of consciousness. This insight into consciousness results in richness and detail, beyond just an account of an event to include cultural and linguistic perspectives (Bruner, 2004). The experiences that shape peoples' lives and influence the way they identify themselves are articulated and revealed through the narrative process (Wang & Geale, 2015).

The researcher seeks specificity in storytelling from the narrator so that events are told in detail. The focus in narrative is away from participants generalizing about their experience (Chase, 2011). The narrator controls the detailed telling of a story, as they present the elements they deem important. Meaning is then developed in concert with the researcher as further aspects are requested or clarifying elements are invited (Riessman, 1993). Importantly, the context and interaction of the participant and researcher influence the data (Lieblich, Tuval-Mashiach, & Zilber, 1998).

There are three predominant methodological approaches according to McAlpine (2016), who lists sociocultural, naturalist and literary as types. The sociocultural type addresses the stories told as part of participant practice in particular states. This would seem fitting for a study of simulated patient activity where the simulation is the particular state and the participant practice is the simulated patient experience. However, the naturalist methodological approach focuses on rich description of significant issues, and spotlights the experiences of the person and the meaning that person has drawn from the experience (McAlpine, 2016). This naturalist approach is the nexus of this enquiry with concern for the experiences that each participant has had that lead them to work as a SP, and the meaning and relationship that each person applies to being a CALD SP. For this reason I refer to the participants as CALD SPs rather than SPs with CALD backgrounds. Each of the participants self-identified as CALD prior to identifying as a SP. The naturalist, narrative methodological stance focuses the enquiry on the experiences of the individual predominantly. While group membership as a SP is relevant and even a vital element, I do not seek a study of SP experience in isolation but rather to know of the CALD people who undertake the SP role.

3.6.1 (Culture and) Narrative

Narrative is a research method that can be used to uncover nuances and give voice to those who may otherwise have been silenced (Wang & Geale, 2015). Narrative is frequently used to represent subgroups in society who are often discriminated against such as women, cultural and ethnic groups (Lieblich, Tuval-Mashiach, & Zilber, 1998). The research method needs to be suitable to the research question or problem. If real-life experience is sought to answer a research question then narrative suitably explores the subjective inner experience (Lieblich, Tuval-Mashiach, & Zilber, 1998).

Narrative analysis, says Daiute and Lightfoot (2004), facilitates the holistic examination of issues in people's lives and thereby elicits "descriptions of identity, knowledge, and social relations from specific cultural points of view" (p.xii). And further, that narrative is an appealing method of inquiry because it provides context for examining identity and development, and also provides insight into the multiple intersecting forces in play between self and society (Daiute & Lightfoot, 2004). The adage about something being too good to be true comes to mind when I consider the methodology of narrative and my path to investigate the lived reality of people from diverse backgrounds using the

framework of intersectionality. From the outset narrative methodology appeared a good fit. But, the more I learned about narrative the closer the fit between the research question and the research method became and the more congruous with my theoretical framework.

Connelly and Clandinin (1990) set out some useful clarifications of language concerning narrative. They argue that narrative is both a phenomenon and a method. This is true for my study. My phenomenon is the narrative of CALD SPs. Narrative is the term I will use for the unified whole or episode of the events told from each participant (Polkinghorne, 1995). Polkinghorne (1995) talks of storied segments creating the boundaries of the narrative. I will use the term 'story' to indicate the multiple segments that create the unified whole narrative. The meanings of narrative and story differ between the seminal authors. Connelly and Clandinin (1990) define the phenomenon as story and the inquiry as narrative, whereas Bruner (2004) alludes to stories or narratives as if these terms are interchangeable.

The method I am using is narrative also. In order to follow the work of Polkinghorne (1995) I will describe this as analysis of narratives. I will describe my methods in detail in later in this chapter; however, analysis of narratives, Polkinghorne (1995) says, moves from the stories to common elements. In this instance the common elements are themes and threads.

The narratives that will be presented in chapter 4 and the appendices represent the voice of the CALD SPs rich culture and values. While my presence in the stories is inferred through open-ended questions I used to elicit storytelling and my encouragement and probing, I cannot and would not claim neutral observation but seek to expose my own subjective positioning. Riessman (2008) says the response of the listener is implicated in the storytelling. In keeping with this, I have preserved the authentic language, cadence and grammar of the participant's spoken word and avoided discursive control in presenting the narratives (Presser, 2005). I chose to present the narratives "as told" to preserve each person's own constructions and avoid shaping my participants accounts. Holloway and Freshwater (2007) state that images, metaphors and content of stories are all important effects and individual characteristics should be retained.

Narrative takes into account where we have been, where we are presently and suggests future direction (Martin-McDonald & Biernoff, 2002). In seeking to understand the cultured, socially shaped lives of CALD SPs, narrative serves to pay homage to past and present while preserving the nuances of intersectional identity. Identity is a vital concept common to SP work, culture, intersectionality and narrative. Riessman (2008), a notable narrative expert, says the construction and performance of identities is central to narrative inquiry.

3.6.2 Fit of narrative methodology to this study

As little is known about the people who work as SPs and, in particular, CALD people working as SPs are hardly recognized in the literature, this research aimed to expose something of the experience and perceptions of CALD SPs. The outcome measures include insight, mindfulness and awareness. Lindsay (2006) describes outcomes of narrative research as "exploring experience for meaning making, knowledge construction and living a life in more awareness" (p. 41). The methodology needs to be suited to the underlying purpose the narrator has for telling the story (Treloar, Stone, McMillan, & Flakus, 2015). Storytelling enables the capture of the subjective experience of the narrator and in the analysis of narrative; meaning can be drawn from the study. Treloar et al. (2015) explain that narrative inquiry studies the development and transitions in people's lives, making meaning retrospectively from the narrator's point of view. In doing so, the uniqueness of individual action and events is exposed.

Holloway and Freshwater (2007) suggest some qualitative data collection techniques lead to fragmentation. In narrative the stories may not be told chronologically; nonetheless the narrative is considered as a complete text and the coherence of the whole is important to connecting events, responses, understanding and motivation. These are significant aspects of narrative methodology that are desirable in this research: "The very act of relating the story brings together and links the fragments to create a coherent whole" (Holloway & Freshwater, 2007, p. 709).

When investigating specific populations and seeking detailed insightful information the research methodology must be congruent with those intentions. Narrative research fits those aims and is noted to amplify the voices of the oppressed and disadvantaged

(McQueen & Zimmerman, 2006). Finally, narrative provides a deep understanding from the participant's perspective.

Intersectionality and the idea that identity is located at the intersection of categories, such as race and gender, are central to this research. These characteristics shape experience and cannot be captured readily with quantitative research (Trahan, 2011). Reducing the characteristics of identity to categorical variables fails to recognize compounding effects and overlooks the issues of culture and environment. The meanings and effects of these forces are relevant to the individual. It is the meaning that is ascribed by the individual that can be captured in a rich detailed account through narrative.

3.6.3 Limitations of narrative

In collecting data through interview to form a narrative, the relationship between the researcher and participant needs to alter to reflect that of narrator and listener. The shift from generalized answers to structured questions becomes broad open questioning inviting storytelling of specific instances (Chase, 2011). In simulation facilitation it is necessary to explore the frames of reference of participants during the debrief. Simulation participants are emotionally activated and frequently exhibit heightened emotional states. Accepting this situation the simulation facilitator works through the reflections and encourages the participant to explore their action and inaction. Similarly, the narrative interviewer works with the narrator to encourage them to explore their experiences and bears witness to the emotions that surface (Chase, 2011). Kirsch (2005) acknowledges that even commonplace impersonal interviewing can lead to revelations of deeply personal and emotionally laden information. She extrapolates this point to link the rapport and trust implicit in the feminist research style to more open communication, despite the flow of information being largely one sided.

The results of an analysis of a narrative study are not intended to be generalizable (Martin-McDonald & Biernoff, 2002). The study represents insight into the experience of a small sample of people. Chase (2011) contrasts the observation that while narrative allows us to see through the window into the narrative environment through stories

told, it also limits our visibility to what can be seen through that window and nothing further, suggesting part of the environment may not be visible.

Connelly and Clandinin (1990) state that a frequently levelled criticism of narrative is the pre-eminence of individual over social context. In their discussion of individual psychology this may have bearing; but the influences of social constructionism and postmodernity consider the social reality of the experience as lived by the individual in context. Therefore, theoretical influences emphasize social context and in my view address the criticism.

3.7 Methods

3.7.1 Recruitment

Research participants were identified from an existing pool of CALD simulated patients recruited for a distinct program of cultural diversity training. All members of this SP group identify with an ethnic or culturally diverse group. I took part in this program and worked with the SPs in training and delivery contexts. This was a unique group according to information available in the literature, and through personal interaction with simulated patient program coordinators nationally and internationally, where no other distinct CALD group of SPs had been identified. Therefore, the assemblage of this group presented an irreplaceable opportunity to learn from these distinct CALD SPs. Each SP had previoulsy consented to being contacted to participate in research in future.

In order to ensure prospective SPs had adequate experience of the SP role, only those who had worked as SPs for at least six months were eligible. As the program continued to recruit and train new SPs, over the period of data collection, additional people became eligible, having fulfilled the minimum experience criteria. In total 45 SPs were eligible to participate in the research over a 16-month period.

The overall participant group was drawn from the SP pool developed for health educators north and west of Melbourne. While a convenience sample is recognised as a limitation of this study, the opportunity for exploration of the experience of being a CALD SP presented an invaluable and irreplaceable opportunity. Creswell (1998), when discussing sampling, allows that convenience sampling may be useful in a number of

contexts including when seeking a politically important or marginalized case. A person may be convenient, but represents a critical case providing access to important insights.

In order to create some distance between my previous work with some SPs and the research I was proposing, the invitation to participate was sent via email from my principal supervisor who had neither prior knowledge of the SPs nor any relationship with potential participants. An "information to participants" document (Appendix 2), describing the study, its purpose and anticipated input sought from each participant was attached to the email as well as a copy of the consent form (Appendix 3). It was anticipated that each person would have the opportunity to consider the request and potentially discuss this with family and interested others. The attachments were provided in English only, as a recruitment requirement for the program to which the SPs belonged was English literacy.

By creating some distance between the request to participate and the researcher, by using my principal supervisor as the intermediary, meant the SPs decision to participate could be communicated without explanation. Only the details of those SPs who expressed willingness to be contacted were conveyed to me. Thus while this process was designed to allow freedom to choose to participate or otherwise, my relationship with SPs from previous work could not be overlooked. To some extent, for those people who chose to participate, the development of rapport was already underway. Hardy, Gregory and Ramjeet (2009), in discussing collaboration, stress the importance of the emotional aspects of interaction they consider vital in self-discovery. While they recognize the challenge this presents to traditional research paradigms, moving from objectivity to subjectivity, the ability to collaborate to achieve shared meaning is fundamentally important (Hardy, Gregory, & Ramjeet, 2009). Conversely, Griffin (2012) notes that working on topics to which you have too great an affinity can create bias and compromise the work. Sameness can act as a barrier (Griffin, 2012). In this instance I had a professional relationship with all SPs but not a personal relationship. Nonetheless the feminist research perspective emphasized the importance of developing a relationship that was mutually beneficial, while establishing and maintaining boundaries to protect confidentiality and trust (Kirsch, 2005)

An initial response to the email invitation resulted in interest from several potential participant SPs, which initiated a snowball sampling technique. Ladge, Clair and Greenberg (2012) note that a snowball sampling technique is a useful strategy when

researching a unique population. Participants refer others who possess the characteristics of interest (Perez et al., 2013). After I met with initial participants to explain the research in more detail, those participants in turn contacted other SPs who then expressed a desire to be involved.

In considering the sample size Liamputtong (2013) advises there must be sufficient data to address the research thoroughly rather than seek a representative sample. Stanley (2008) observes the potential for narrative studies to generate so much detailed material that it becomes difficult to account for it all, despite the typically small scale of these studies. These perspectives influenced the recruitment strategy. Initially I had aimed for 20 participants but as the first round of interviews resulted in such detailed accounts, it was evident sufficient data was available.

In total 11 SPs participated in all aspects of the research. While collected together as CALD SPs, each of the participants was distinctive and acknowledged a unique range of identity intersections. I will discuss this more in chapter 5 as I analyze each person's intersectional position at the time of the research data collection. Demographically, recruitment resulted in eight females and three males. Ethnicity, age, gender and the pseudonym of each participant are detailed in table 3.1.

Table 3.1: Participant's pseudonym, age, gender and ethnicity

Pseudonym	**Age**	**Gender**	**Ethnicity**
Gabir	49	Male	Ethiopian
Lian	43	Female	Chinese
Chinh	40	Male	Vietnamese
Hwei-ru	60	Female	Chinese
Kabill	20	Female	Zimbabwean
Alessia	68	Female	Italian
Leyla	49	Female	Lebanese
Abida	60	Female	Iraqi
Chenai	24	Female	Zimbabwean
Khyath	25	Male	Indian
Ona	27	Female	Iraqi

3.7.2 Data collection

In accordance with the intention to capture values, beliefs and actions, the method used was primarily narrative. In-depth interviews were used in order to facilitate development of a narrative. Narrative interviews used open-ended questions which encouraged the participant to construct their story. Eleven participants were interviewed twice.

The first interview used open-ended questions to facilitate the sharing of participant's stories as SPs. The researcher refrains from interrupting the story in order to reduce their influence in the way in which the story is framed (Doody & Noonan, 2013). Where a participant was struggling to get started, the interview questions helped establish a conversation that allowed the interview to flow without interruption. Where a participant was speaking freely and telling stories the interview questions were secondary and only used to restart a new or substory.

The second interview asked probing questions to uncover important substories. The researcher studies the first interview and reflects on the stories that are told and considers what was not told. The second interview presented the opportunity to pursue story lines, seek detail and clarify understanding. This second meeting furthers the collaborative effort between the researcher and participant and facilitated the process of co-construction of understanding (Hardy, Gregory, & Ramjeet, 2009). An opening question during the first interview, for example, was "Please tell me about your experience of being a simulated patient?" Whereas during the second interview a probing question would refer to something the participant had said and sought further information. For example, "The issue of life experience preparing you for the SP role is interesting. Can you elaborate on that?" Griffin (2012) recognizes the build-up of intimacy in situations with repeat interviews. In the second interview the rapport and understanding between each of the participants and me eased the process of probing and enhanced the interview dynamic.

The interviews were negotiated with each participant at a mutually suitable time. Participants were given the option of suggesting the interview location, providing this was safe and feasible, and agreed to by the researcher. The interview locations varied from public spaces such as coffee shops and libraries and participants' homes. All were held in the participants' home locale with none suggesting they travel to me. Doody and

Noonan (2013) observe that consideration of the interview site may enable the participant to relax and importantly experience some level of control. This observation bore out my intention to create opportunities that rebalanced the power relationship between the participants and me by consciously affording participants the choice of location. According to Beckman (2014) feminist methodology highlights mechanisms that promote more symmetrical power dynamics.

A third contact took place after interviews were developed into narratives. The process undertaken to create the narratives is described in detail in section 3. 7 (Emden, 1998b). The purpose of this contact was to share the participant's narrative with them so they could review, edit or change, as they saw fit. As a narrative researcher it is important to recognize that the story always belongs to the participant and therefore must be told or shared, as they choose.

The third contact can constitute another interview. In this research the participants were all contacted by email or telephone, or both, and sent a copy of the narrative. I explained that I wanted to share the narrative and seek any feedback they wished to provide. This checking process was an opportunity to assess my understanding of the narrative and offer participants the chance to negotiate meaning (Doyle, 2007), as well as reaffirm their ownership of the narrative. Essentially this also functioned as a rigour strategy (Morrow, 2005). I offered to attend in person and read through the narrative with each person in deference to those whose English literacy may inhibit this process. None of the participants pursued this offer. One person required an organization name to be removed, as she was concerned this would identify the organization. This SP provided substitute nomenclature that was less defined and the change was made. Another SP asked for telephone follow up. During the phone follow up this SP expressed her concern that she had not provided me with useful information and her narrative was just a whole lot of her musing and storytelling. I was able to reassure her that the narrative was rich and edifying and she was satisfied at the end of the conversation. She did not seek any changes.

Qualitative interviewing is a prominent data collection technique suited to a constructivist approach. In constructivist philosophy the interview is seen as an interactional event in which the researcher and participant engage in co-constructed collaborative meaning making (McLachlan & Garcia, 2015). McAdams (2005) says narratives of the self can be collected in interviews which co-construct identity.

Interviews provide opportunity for the researcher to observe the participant whilst they converse and stimulate self-exploration and discovery (Doody & Noonan, 2013).

Additional data collection methods were reflective journaling and field notes from participant observation. As an embedded experience for me as a white female simulation expert I had opportunity to continue to observe some of the participants in SP roles within simulations. I also participated as a SP during the research period. This involvement reminded my understanding of the sensations and pressures of being activated in a simulation, similar to that experienced and described by the SPs.

3.7.2.1 Data collection procedures

McCance, McKenna and Boore (2001) suggest that interviews are the most common method for generating a narrative. They share three forms of interview from the work of Fielding (1993): structured, semi structured and unstructured interviews. Riessman (1993) says avoiding interruption with standardized questions will sometimes result in long stories; however, she notes that typically narrative is interspersed with questions, answers and other forms of clarifying discourse. This messiness beyond the strict classification of interview forms is what I experienced. Working from Riessman's (1993) recommendation, Lai (2001) developed an interview guide using open-ended questions. Initial questions function as icebreakers and questions that follow are developed to enable participants to focus on the research aim. In semi-structured interviewing the structure enables similar information to be gleaned and creates a sense of order, but permits the freedom to follow new ideas that emerge during the interview (Doody & Noonan, 2013).

The interview questions in the first interview were developed following Lai's (2001) proposal. They served to introduce the purpose of the research to focus both the participants' and my thoughts on the experience of being a CALD SP. My opening question (How long have you been a SP?) was not so much an icebreaker as a strategy to invite the participant to consider the entire time they have been a SP rather than the recent past, although as a relatively objective question it eased participants into the interview in a non-threatening manner. It was not necessary to ask all of the questions in the schedule. Often the stories the participant had shared, passed through the content anticipated by a prompting question, in some detail. (See Appendix 3 and Appendix 4 for the consent form and interview guide respectively.)

At the commencement of the first interview I described the research program and the contribution of the interviewee, including reminding each person of their right to withdraw from the research at any time. Each person then completed and signed a written consent to participate in the research and was offered a hard copy of the information sheet that had previously been sent by email for their record and retention, if desired. Permission was sought to audio record the interview with a digital recorder and subject to permission the interview was recorded and transcribed verbatim. All 11 participants agreed to audio recording. As an introduction I explained that I wanted the participant to tell me their stories. I encouraged them to tell me what they thought was important, relevant, and in a way that had meaning for them. "Feminist epistemology suggests that oppressed groups are less likely to distort reality to retain privilege and intentionally seeks out the voices on the margins of power status (Beckman, 2014). Guided by this feminist principle, the data collection proceeded with open questions and the freedom to frame answers from the perspective of what was important to the individual rather than according to the researchers frame. This helped avoid a researcher-biased view of what was relevant and reflected another element of feminist perspective.

The duration of first interviews was between 25 and 72 minutes. Some of the participants were more naturally inclined to tell stories and embellish the stories with detailed description and sub-stories, while others while answering all the questions in the schedule were less inclined to tell detailed stories.

Face-to-face interviews facilitated sharing of ideas and enabled dialectic and dialogic exchange. Repeat interviews after study of the initial transcripts enabled probing questions to support new knowledge and understanding (Ben-Ari & Enosh, 2012). The interview questions for second interviews arose from reading and re-reading the original interview transcript. The questions related sometimes to detail in stories that were told or sought clarification of an aspect of a story. Sometimes the participant added to an existing story with a more detailed account, at other times they told new stories as a result of a probing question.

The duration of second interviews was between 28 and 82 minutes.

3.7.2.2 Narrative interviews

Audio-recorded interviews were transcribed verbatim. This produced a fixed and working version of the interviews. The procedure for transforming the interview featuring my voice into a narrative was a complex undertaking. Riessman (1993) notes that the transparency of language cannot be assumed and that intonation, pauses, and emphasis should be considered. Yet, consideration does not suggest a script for this procedure and Riessman (1993) stops short of suggesting that discourse markers and listener participation automatically be included in the narrative. Instead she states, "There is no one, true representation of spoken language" (Riessman, 1993, p. 13).

The interviews of CALD people, all of who developed English literacy as a second language is replete with language structures and uses, reflecting their heritage and language background. Creating narratives sought to retain the original language to enhance the individuality of their account. The use of language is a powerful tool to represent the spoken voice and retain the image of culture and ethnicity. I wished to retain the coherence of the story as told but remove my voice and other extraneous content.

3.7.2.3 Shaping each interview as narrative

While several authors describe processes for developing narrative (McCance, McKenna, & Boore, 2001; Oliver, 1998; Polkinghorne, 1995; Stanley, 2008) many do not provide sufficient detail. Emden's papers on theoretical perspectives (1998a) and analysis (1998b) promised sufficient detail for others to follow. Her purpose, studying nursing scholars, reported desiring similar knowledge to that which I sought. Importantly, she reported that no key meanings were lost while retaining a sense of the whole story (Emden, 1998b). I therefore adopted Emden's procedure as my guide with minor modification; I have provided Emden's guidance in full and then outline the variations I made and the rationale for doing so.

1. Reading the full interview text several times within an extended time-frame (several weeks) to grasp its content.
2. Deleting all interviewer questions and comments from the full interview text.

3. Deleting all words that detract from the key idea of each sentence or group of sentences uttered by the respondent.
4. Reading the remaining text for sense.
5. Repeating steps three and four several times, until satisfied that all key ideas are retained and extraneous content eliminated, returning to the full text as often as necessary for rechecking.
6. Identifying fragments of constituent themes (subplots) from the ideas within the text.
7. Moving fragments of themes together to create one coherent core story, or series of core stories.
8. Returning the core story to the respondent and asking, "Does this ring true?" and, "Do you wish to correct/develop/delete any part?"(Emden, 1998b, p. 35).

The following list details the process I adopted.

1. I commenced by transcribing the first four interviews myself; this aided my understanding of the nuances of the data. While every interview was different I was then able to define the manner in which the following interviews were to be transcribed professionally.
2. I read and re-listened to the recordings of all the interviews, even those that were professionally transcribed. Because of the accents of the participants, every interview was returned with timestamps where the speech could not be understood. In a few cases the transcriptionist had misheard a word or phrase and this had to be corrected.
3. I then devised the questions for the second interview. These related to stories that were started but not apparently concluded, or for which there was scant detail. Sometimes I requested elaboration or asked the participant to think about why they felt or said what they had, seeking motivation or explanation from their perspective.
4. I then repeated steps 1 and 2 for the probing interview for each participant. This resulted in two interview transcripts for each participant.
5. Using the initial interview, I removed all interviewer questions and comments. I identified stories within the interview and then looked to the second interview to see if the story was revisited. Where additional detail was provided this was added into the original story.

6. Where a new story was provided I had to identify where this fitted. I did this by considering the context of the new story in the second interview in relation to the probing and clarification from the first interview, as well as how this story arose in the context of the overall transcript. The sequencing of the story determined its location in the overall narrative under development.
7. I read and re-read the interviews to ensure that meaning remained as stable as possible and that the narrative made sense.
8. I removed words that detracted from the meaning of the sentence with care, as these were often mannerisms of speech and language that I considered inherent in the person's portrayal of life.
9. "Misuse" of English as befits many participants was disconcerting. I had to find a balance between readability and unintentionally "Anglicizing" the participant's voices. I resolved to change the language minimally to maintain the integrity of the individual story.
10. I repeated steps 7, 8 and 9 several times until satisfied that the key ideas were retained. My preference remained for thick description and avoiding compact stories (Flyvbjerg, 2011).
11. The narrative was returned to each participant. They were reminded that the story was theirs and they could therefore make any changes they wished.
12. Working from the developed narrative I then commenced the analysis described in the following section.

3.7.2.4 Reflective journaling

I undertook reflective journaling periodically throughout the research period. This journaling enabled me to record my own reactions to situations and new ideas as they occurred. Some reactions related to working with SPs in simulation, or interacting with them before and after simulation sessions. Other reactions I wrote about included my own discoveries, growth and reactions as the research process continued. As I developed my identity as a researcher I became aware of my emerging distinctiveness in approach and influence. This reflective strategy served to encourage the process of researcher reflection and assisted my recollection of my personal growth (Martin-McDonald & Biernoff, 2002).

Constructionism influences the development of knowledge of the researcher through the process of the research. In interaction with others I developed new ideas and knowledge. Ortlipp (2008) suggests the researcher's own choices and assumptions influence the nature of research outcomes and can be captured through consciously acknowledging those values. The journal may be incorporated into the data set as the reflections of the researcher, or be used as an aid to memory to assist in recall of decisions and influences as part of the reflexive behaviour of the researcher (Janesick, 1999). I used reflective journaling to uncover feelings, values, biases, experiences and heighten understanding as appropriate for feminist influence (Beckman, 2014; Griffin, 2012; Ironside, 2001)

The researcher is able to offer a more precise description and explanation of their role in the research through the use of a journal. This is critically important, according to Janesick (1999), to address the researcher's position. Houghton, Casey, Shaw and Murphy (2013) describe an audit trail outlining decisions and rationale for these as a vital aspect of rigour and note that a faithful description achieved through recording notes makes this possible. While decision points can, for example, be provided through analysis software, the personal contributions address the researcher's self-awareness in the decision process (Houghton et al., 2013). Mulhall (2003) reports that field notes may be messy and incomprehensible to outsiders but adds that sharing the analysis decisions is expected when claiming reflexive validity.

While reflective journaling may be seen as associated with claims of rigour the journaling itself does not enhance the rigour, rather the process involved of critical self-evaluation of the researcher's positionality and how this may impact the outcome is crucial to research rigour (Berger, 2015). While this is one purpose for maintenance of reflective journaling this was not my only purpose.

Reflective journaling was an important marker in my movement from conscious incompetence through to conscious competence and as such was a salve for my confidence and self-esteem. My journey was recorded as a process of successes and failures as well as interest and points of disinterest and frustration. I offer a sample of a reflection from my journal demonstrating the elusive importance of confidence and competence:

> I moved through candidacy and ethics with relative ease and maybe started to buy the propaganda that I could do this as much as everyone around me. In the presentation for candidacy I was nervous which wasn't to do with making the presentation because I am a confident presenter, it was more the same confidence thing that someone would call me out as a fraud and I would show some basic research ignorance.
>
> In fact during the presentation the reverse happened. I felt that I was taken seriously and treated with a respect I hadn't deserved and regarded as if I had some credibility.

The journal was the place where I could interact with my feelings about the development of the project and, in many ways, normalize the thoughts associated with my growth and development.

3.7.2.5 Field notes

Field notes were recorded as hand written entries in a journal immediately after each interview. The notes included observations of the SPs dress, mannerisms, the location where we met and behavioural observations. These notes augment the recording by providing rich detail and recall of the context of the interview. While I had worked with the SPs over a period of time, this was the first time I had interacted with any of them in settings outside of a simulation work environment. I was interested in their behaviours and the different interactions that emerged when they were away from work. Connelly and Clandinin (1990) report that field notes are frequently used in narrative studies and are an active recording of the construction of events.

Field notes were written after the interview usually when I had left the immediate area. During the interview my focus was on initially developing rapport, ensuring the interviewee felt comfortable to talk openly with me; I did not want to disturb this process with note writing. The feminist influence of communicative, other-centred interaction in the interview space was important to me as a mechanism to encourage and inspire safety (Griffin, 2012).

Field notes described the setting and the participants place in the setting. I noted behaviour, role and how I established or followed the lead of the participant. The SPs perceived me in a variety of ways including as their guest, friend or supplicant. I also

described the participants as people out of the SP role in their own environments. I made observations of technique in recording the interviews as well as documenting questions for me to consider for future interviews. An example was “How strongly can I lead Chinh into telling a story? Can I say tell me, as if it is a story?” Koch (2006) suggests field notes assist the researcher to think about their own role as well as the research process.

Mulhall (2003) defines field observation as either structured or unstructured. The former is deliberate with scheduled observations of physical and verbal behaviour using taxonomies developed through theory. The latter, inclusive of my technique, is used to understand cultural behaviour and is based within the constructivist paradigm (Mulhall, 2003). As such the researcher enters the field without preconceptions and observes whatever behaviour they choose including their own contribution. Emerson, Fretz and Shaw (2001) acknowledge that field notes are selective, as the researcher gives attention to those things considered significant and in doing so ignoring other elements. My conception of the field was inclusive of all my interactions with research participants and therefore included simulation settings, where they worked as SPs as well as the places we met for each of the research interviews. My research role was described in the consent process so each participant understood my role as that of observer and participant (Mulhall, 2003).

Field notes are written as descriptions, experiences and reactions to events and do not include interpretations or theory (Emerson, Fretz, & Shaw, 2001). As a collection of thoughts and reactions it is unknown at the time of writing whether it will be valuable or impact the larger project (Emerson, Fretz, & Shaw, 2001). Conversely, Mulhall (2003) asserts that the concepts and events involve at some level theorizing and analysis. While I did not explicitly analyze the notes I recorded, the construction of observations became more focused over the research period, so that initial interviews described broadly the circumstances and considerations, while latter field notes recorded more specific observations. This change is in keeping with a beginning albeit unconscious application of analysis as suggested by Mulhall (2003).

3.7.3 Analysis of narrative

"Interpretation and analysis [of narrative] is inevitable because narratives are representations of life experiences (Lai, 2010, p. 79). Researchers gain admittance to the life of the narrator while they interpret their thoughts and actions themselves. The researcher works with the narrator to understand how stories are constructed and told and may undertake analysis that conflates their own analytic schemes with the interpretive model of the narrator (Denzin, 1971). In both the initial narrative interview and in the analysis the researcher is an active participant.

The narrative invites multiple interpretations. Each reader applies their own pre-assumptions and experiences and develops their own interpretation. "A good narrative results in a compelling message for the reader": a message that may cause the reader to "nod in agreement, pause in reflection, or take action" (Alvermann, Obrien, & Dillon, 1996, p.117 cited in Oliver, 1998). The power of narrative methods therefore arises from the reader understanding the stories from their own context and defining their own possibilities from that understanding (Oliver, 1998).

Two types of narrative methodology were identified and described by Polkinghorne (1995). The first "narrative analysis" produces stories with emphasis on plot and configuration as analytic tools. The second "analysis of narrative" uses narratives as data and "produces paradigmatic typologies or categories" (Polkinghorne, 1995, p. 5). I expand here on analysis of narrative introduced as my inquiry style in chapter 2. Classifying data to belong to a category or concept helps to define the item and elucidate the features of the category that suggest its membership. The focus is similarities rather than differences (Polkinghorne, 1995). Managing individual parts and categorizing them to sets can order the data. Polkinghorne (1995) describes the process of constructing sets by examining the identity of each item. The construction of sets can be termed themes and the items contributing to the themes thought of as threads.

Carr (1986) explained that in narrative formulation the three dimensions of plot (i.e. past, present and future) relate to the three dimensions of human experience (significance, value and intention). Connelly & Clandinin (1990) suggest that the past conveys significance, the present is concerned with value, and the future conveys intention. This construct guided my interpretive scheme when considering each of the narratives.

After reading through each narrative a number of times I determined that stories or sub stories within each narrative were rarely told in their entirety and then concluded. The story was added to, repeated and referred back in the midst of other sub stories for a number of reasons, including emphasis, or to draw attention to a similarity or difference. This is reminiscent of consequential sequencing where one event gives rise to another but these are not necessarily always chronological (Riessman, 1993).

In the first step I identified the points of significance and made margin notes. For example, a SP could be describing a period of isolation. This may have been in reference to a sense of power or control. The point of significance was thus named according to my interpretation of the overriding issue. I then searched the narrative for all the references to this point of significance. I conceptualized these points of significance as a sub story. Riessman (1993) acknowledges that most narratives have discrete units with clear beginnings and endings that can be detached from the surrounding discourse. Connelly and Clandinin (1990) describe the beginning middle and end as the basis of plot and relate this to past, present and future. To identify that I had located the complete sub story and ensure coherence, I searched for and classified the start, middle and end of each sub story.

Each of these sub stories is a content area based on a topic of significance addressed during the interviews. I labelled these sub stories threads, as they represented the fabric that made up the overarching narrative, but had unique qualities and could exist independently. I documented each of the threads and attached this to each narrative. Each thread was documented in an abridged fashion using a mix of quotations and interpreted observations linked to the narrative. Graneheim and Lundman (2004) discuss shortening the text and they term this process 'condensation'. The essential point they say is that the thread (meaning unit) is shortened but the core is preserved. Each thread was named for the meaning purported. Table 3.2 provides an example of the process described. Each narrative had an average of 7.45 threads with the range 4 – 9. I termed this my first stage of analysis as this created an in- depth examination of the areas of significance in each individual narrative.

Table 3.2: *Example Kabill Thread 3*

Significant issue	Thread	Thread name
Change, transition	Start: Life changed, longing for mindfulness, "things I was blind to" Middle: I have two identities I am Australian and African, conservative and open minded, labelled myself and yet don't want to be labelled End: Accepting, not offended by racism, expectations of behaviour, adaptation	Living with mixed meanings

At supervision meetings I would report and discuss my interpretations with both supervisors so they could assess my progress, but this approach also enabled discussion. While both qualitative researchers, my supervisors have different research interests and could therefore comfortably act as critical companions and advocate alternate perspectives. Frequently we agreed on interpretations; however, on occasion I reassessed data following supervision meetings. Barbour (2001) suggests the content of disagreements between multiple researchers is valuable as it alerts researchers to alternate explanations.

In the second stage of analysis my purpose was to examine the threads across all 11 narratives and group these according to similarities. "Creating categories is the core feature of qualitative content analysis" (Graneheim & Lundman, 2004, p. 107). The items within the categories are inspected to ensure they display the common attributes of the category (Polkinghorne, 1995).

Each thread was annotated with the narrative number and thread number. This annotation allowed for recall of the original narrative to check meaning and consider the thread in the entirety of the narrative during analytical thinking and decision making. Each thread was typed out and cut into an individual item. This provided an intense review of all threads and created a format that could be more readily worked.

The threads were sorted into an initial category and assigned an emerging category name on a blue card. As the initial sort progressed the emerging categories were

reassessed. A number of ideas emerged within some categories which became new category headings and the original category was sorted into the new areas. Polkinghorne (1995) says concepts are discovered that give categorical identity to items in the data set. Each category was reviewed and new headings emerged, which were recorded on yellow cards. The different coloured cards allowed me to track whether a category held position from the initial sort or had developed as a result of re-assessment. Re-assessment expanded and collapsed groups as they were sorted and re-sorted. Using blue and yellow codes of the original and reassessed categories demonstrated the genesis of some groups.

Where a category had only one thread, this category was eliminated and the thread re-sorted. It was clear that a number of threads although sorted to a category were also relevant to other groups. Each of these threads was reconsidered to ensure it had primacy in the allocated position.

Another read through occurred in which the thread was documented in its primary position. It was then considered what other categories it could be assigned to. The thread was also considered for other categories to which it could make a contribution. In this way some threads made a significant contribution to one category and corroborated other categories. The threads often told complex sub stories that incorporated multiple ideas and feelings. As asserted by Graneheim & Lundman (2004, p. 107) "…owing to the intertwined nature of human experience, it is not always possible to create mutually exclusive categories when a text deals with experiences."

The threads were checked, re-read and considered in light of the whole narrative from which they emerged in order to ensure that the meaning remained true. Polkinghorne (1995) emphasizes the recursive movement between the data and emerging themes until a "best-fit" ordering is achieved. The themes are therefore inductively derived from the narratives (Polkinghorne, 1995).

At this stage of the analysis, 17 separate categories had been identified, 11 of which were original, emerging blue categories and six that had been reassessed into a new category with a yellow card. The 17 categories were then considered to see if these yielded any patterns. Each was reviewed to identify similarities and differences looking for alignment. The category headings were assessed and four themes emerged: Being a

SP, Otherness, Identity and Learning. A review of each theme was conducted to ensure it had substance and represented threads from the narrative.

The theme tentatively labelled Being a SP, whilst representing a category of threads, failed to differentiate the concepts within well enough. Using Polkinghorne's (1995) description of paradigmatic analysis in which themes are revealed, offered insight that the threads within this category were not clarifying the features of membership of the group. Each item (thread) was re-examined to heed its identity. As a result, two distinct although related themes were revealed. These were The SP imperative and The SP existence. Each theme embodied mutually exclusive concepts and therefore determined as two distinct themes rather than a continuum of one concept or a subordinate concept. Figure 3.1 shows the stages of analysis to reveal the themes.

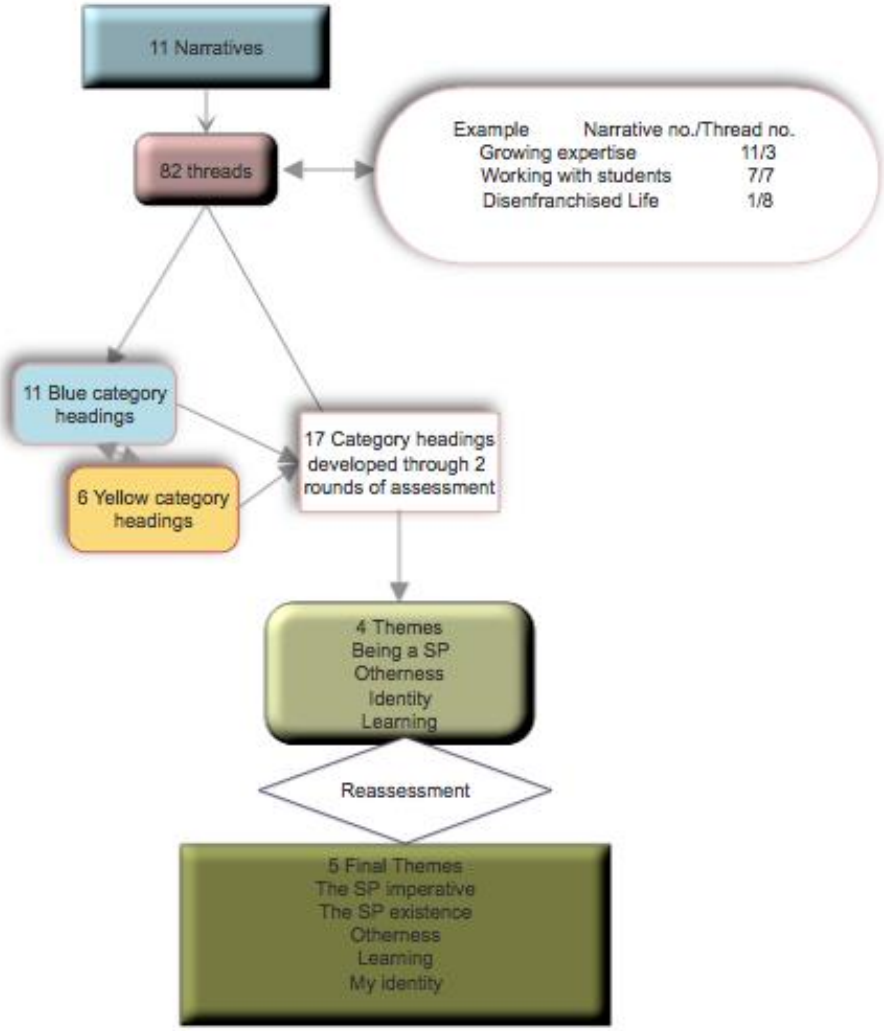

Figure 3.1: Stages of analysis

Working recursively, the final stage of analysis tested the original categorization by reviewing each thread and assigning it to one of four themes. As anticipated, most threads moved with the category heading into the theme group. Nonetheless, six categories were split between themes when considered for best fit. This splitting of categories over more than one theme was differentiated by the significance of the thread. This was an important final review to ensure the significance value or intention of the thread, as the interpretive scheme was the driving force for fit, rather than trying to force a fit of a category as a complete object. Thus the thread rested with the final attributes of the theme according to Polkinghorne's (1995) description rather than remaining in a category. The final split of each of the categories into their associated themes is detailed in table 3.3. This table also demonstrates the narrative and thread numbers that contributed to the themes.

Analysis of narrative revealed themes that exposed the significance, value and intention in the stories of the participants. However, the identity categories of the participants were not exposed through this process, despite important reference to identity through the themes of *Otherness* and *My identity*. The theoretical framework of intersectionality provided an avenue to recognize the characteristics of identity and in turn the compounding effects of intersectional categories that exposed oppression and privilege. Augmenting the analysis of narrative with an intersectional analysis was intended to deepen the potential understanding achieved through rich description, by exposing the meanings and effects of these intersectional forces for the individual.

Table 3.3: Allocation of categories and threads in themes

Theme	**Categories**	**Threads** Narrative No/Thread No
The SP imperative	Empowerment, rebalance the negative – split	6/8, 11/1
	Impact of SP work	4/6, 1/6
	I get relief	3/1, 2/1
	Helping my community	3/4, 6/5, 3/3, 11/4
	Real experience	4/3, 3/5, 4/5, 8/5, 7/5
	5 categories	**15 threads**
The SP existence	Image as professional SP	2/8, 2/7
	SP development	6/4, 9/4, 6/2
	Student feelings – split	9/6, 10/6, 4/2
	My developing skill – split	11/3, 11/2, 4/1
	Observation of SP work	1/1, 1/7, 10/2, 10/4
	In the simulation – split	7/7, 10/5, 6/1, 3/7, 2/6, 1/5
	6 categories	**21 threads**
Otherness	Multiculturalism	4/4, 10/3, 6/9, 7/6
	My background shapes me – split	3/2, 7/8, 7/3, 7/1, 2/4, 5/2, 8/6
	Being different	10/7, 11/6, 1/8, 11/8, 11/7, 2/3, 6/7, 8/4, 6/6, 1/9, 9/1
	Empowerment, rebalance the negative split	3/8
	In the simulation – split	9/1
	I have a message – split	2/5
	6 categories	**25 threads**
Learning	Learning	11/5, 1/4, 10/1, 6/3, 2/9, 5/1, 8/3
	I have a message – split	3/6
	My developing skill – split	9/5
	Student feelings – split	9/2
	4 categories	**10 threads**
My Identity	Identity	1/3, 1/2, 9/3, 9/7, 11/9, 7/2,
	Empowerment, rebalance the negative – split	2/2, 7/4
	My background shapes me – split	5/3, 8/1, 8/2, 5/4
	3 categories	**12 threads**

3.7.4 Intersectionality analysis

As identified in chapter 2 the purpose of intersectionality is to describe the complexity of different dimensions of social and cultural categories within a person's life. Beckman (2014) notes that intersectionality has advanced the feminist agenda from the second wave recognition of white and male privilege, to incorporate characteristics, behaviours and values from multiple social identities. In order to understand how categories, such as ethnicity, gender or sexual identity, may act on experience simultaneously for the participants of this research, an intersectionality analysis was conducted.

The analysis aids understanding of the everyday experience of the SPs by enabling recognition of the categories of identity that each person recognizes in their story. As intersectionality is traditionally concerned with oppression and privilege, this form of analysis serves to recognize how the dynamic flow surfaces in each person's life. The identification of the intersectional position does not imply that this is a static definition of power and categorical inequalities in each person's life. Rather the positioning of intersectional points aids in the reflection of understanding of perspectives and meaning within the narratives. Additionally, the intersectional analysis deeply augments participant's thick descriptions and the setting by consideration of the explicit sociopolitical and psychosocial contexts from which the stories emerge.

Intersectionality analysis has been classified as anticategorical, intracategorical and intercategorical depending on the mechanism through which the various positions of identity are considered (Winker & Degele, 2011). The eight-step process of intersectional analysis described by Winker and Degele (2011) was chosen because it provides a multi-level approach on the basis of "representation, identity and structure" (p.53). This method provided opportunity to study the intersectional position of the individual as well as across the group for all narratives.

Winker and Degele (2011) acknowledged that some aspects of a person's life cannot be categorized. In spite of this, their purpose is to define for the individual what norms, principles and interpretive schemes impact them. "Starting out from the social practices of a person we are able to reconstruct identities they construct, as well as the structures and norms they draw on: in the process of subjectivization, which categories do social actors relate to?" (Winker & Degele, 2011, p. 57).

My purpose in using intersectionality as a theoretical framework has been to explore the layered and individual differences and positions of each participant. As previously noted, I reject the essentialization of this group of SPs as ethnic or cultural and the consequent creation of a homogenized group. CALD SPs are under-examined and conflating this group would ignore intragroup difference and result in inadequate understanding, which leads to inadequate grouping as "others". Equally, to consider all differences under the auspice of culture masks the effects of the experience of each individual (Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

Examination across the series of narratives was sought to understand the different ways intersectional positions affect each participant. By examining the patterns of intersectional positions and therefore taking into account the differences between each person, this stage of analysis identifies broadly the range of intersectional positions (Grünenfelder & Schurr, 2015).

The eight-step process of intersectional analysis as proffered by Winker and Degele (2011) provided an avenue to consider each person's intersectional position as well as comparing outcomes across the series of narratives. The final stages 6, 7 and 8 of Winker and Degele's (2011) analysis deal with, "supplementing structural data, deepening the analysis of denominated representations and, elaborating interrelations in the overall demonstration" (pp. 61,62). These stages concerned gaining understanding through research of structural power relations, understanding ideologies prevailing in certain contexts and achieving a goal of generalization beyond the case and type. These stages were outside of the requirements of understanding that were sought to know the participants of this study and therefore were not required. As a result I modified the process and undertook the following stages:

1. Each complete narrative was combed for any terms or words that could be considered self-positioning. Sometimes these words described identity constructions, at other times symbolic representations and still others social structures and structural categories. People speak about themselves through differentiation, identifying what they are, through recognition of what they are not (Grünenfelder & Schurr, 2015; Winker & Degele, 2011).
2. Each term was entered into an individual table within one of three columns: Identity construction, Symbolic representation, Social structures and structural categories.

3. Using colour to aid coding, each identity construction was then marked according to the four categories of class, gender, race and body that Winker and Degele (2011) argue are historically relevant to unequal allocation of resources.
4. Entries in the social structures and structural categories were then linked using the same colour code. According to Winker and Degele (2011) this stage enabled inductive examination of the way social practices relate to the abovementioned four categories of power relations, directly or indirectly.
5. Using multiple identity constructions that each person recognized in their narrative, each table was then examined to determine which categories appeared at the level of Symbolic representation and/or Social structures. Winker and Degele (2011) state that categories that cross to other levels of representation are represented by the columns in each table. These are regarded as the most important constructions as they are interwoven through the various aspects of the participant's life. The representations may be in conflict or alignment. This forms the final stage of the individual assessment.
6. The stage of comparing and clustering began with assigning groups or types where the types have some resemblance that can be explained. Similar to a thematic analysis the types should exhibit internal homogeneity with sufficient external heterogeneity (Winker & Degele, 2011, p. 60). Following scrutiny of the relationships that had been identified across multiple columns of each participant's table, a list of terms as paired concepts was generated. These concepts were paired because they were related either as synonymous or opposing as shown in table 3.4. While individual words did not make obvious the context or full extent of meaning, it enabled reordering and changing. Manoeuvering of these paired terms was required, looking for patterns and associations. As this analysis deconstructed the narrative to understand the elements of identity it was important to check meaning in entirety. Each term was frequently referred back to the context of the original analysis and from there to the entire narrative to ensure that meaning remained true.

Table 3.4: List of terms generated from individual analysis in paired concepts

Scared	Powerful
Safe	Freedom
Different	Prejudice
Communication	No English
Judgment	Curious
Roles	Real life
Trauma	Support
Education	Not understood
Weak	Strong
Actor	Appearance
Labelled	Defender
Hurt	Safe
Advocate	Authority
Illness	SP acting
Recognized	Judging
Labelled	Appearance
Values	Stereotypes
Learn	Ignorance

Winker and Degele (2011) stress the importance of allowing the data to speak and not "demarcate a priori the subject constructions" (p.60). As the terms were considered, four groups emerged: Shielding emotion, Taming stigma, Influencing image and Overcoming ignorance. These intersectional groups are examined in detail in chapter 6.

3.7.5 Research rigour

Multiple standards of quality are applied to qualitative studies under the typology of validity, credibility, rigour or trustworthiness (Morrow, 2005). Although some quality criteria are seen as bound to certain paradigms, others are general and apply across the board (Morrow, 2005). In the following subsection I discuss the relevant aspects of rigour and show how these applied to this research, in order to demonstrate to the reader that their investment in time and reflection in this study is meaningful. As Lincoln, Lynham and Guba (2011) affirm, rigour enables trust to accept that human phenomenon is worthy of attention.

The accuracy of the story told by the narrator is often raised as a point of validity. Chase (2011), reflecting on the work of Polkinghorne, reminds us that the researcher's role is

not to discover or prove accuracy of the event, but instead to understand the meaning ascribed to the event as told. Because our frames of reference differ from those of the narrator and the ultimate audience as researchers, it is vital that we accept and portray the meaning we ascribe as one of multiple possible interpretations and demonstrate that the interpretation we offer is viable according to the story provided (Chase, 2011).

3.7.5.1 Reflexivity

"Reflexivity refers to the continuous process of self-reflection that researchers engage in to generate awareness about their actions, feelings and perceptions" (Darawsheh, 2014, p. 561). In narrative influenced by social constructionism the researcher should not be distanced from the data collection and meaning making that ensues in the interview process. Rather the researcher accepts they have an active role and are a part of the process (Refai, Klapper, & Thompson, 2015). My influence in research design, data collection and interpretation is important. My positionality must be displayed honestly and authentically within the text (Oliver, 1998; Presser, 2005). Presser (2005) adds that feminist researchers are sensitive to their place in hierarchies of knowledge construction and therefore document the positions we hold in relation to the study and the participants. Darawsheh (2014) agrees that research writing should be reflective and confessional, rather than objective and realist, but extends the discussion to include reflexivity in the design data collection analysis and dissemination phases.

Throughout the research I describe my assumptions and interpretations as a way of informing the reader of my perspective as well as managing my subjectivities (Morrow, 2005). My reflective journaling was a strategy to know myself and uncover my assumptions. Journaling can make conscious thoughts and actions that influence the research about which the researcher could be otherwise unaware (Darawsheh, 2014).

Critical companions or a research team can assist the researcher to maintain reflexivity by challenging assumptions or posing alternate explanations for consideration (Morrow, 2005). I have been mentored during the research journey by two qualitative researchers who have challenged me to think outside the square. My membership in wider communities of practice related to simulated patients and to simulation more generally have enabled me to speak generally and more specifically about the research process. Through the questions and perceptions of listeners I in turn have heard different perspectives and identified my own assumptions.

3.7.5.2 Authenticity

Narrative does not lay claim to the criteria of generalization. Instead, Connelly and Clandinin (1990) posit the criteria of transferability. They cite Peshkin (1985), inviting the reader to consider the narrative and allow it to influence their understanding and "shape their thinking" (p. 8). In order for this empathic approach to occur the narrative should be accessible so the reader can recognize associations with another context (Connelly & Clandinin, 1990). In developing such an association the reader is able to develop new insights that can lead to transformative outcomes (Woods, 2012). Similarly, Stake (1978) classifies this recognition of the particular in new and novel contexts as naturalistic generalization. He goes on to explain that naturalistic generalization is born of experience and is derived from tacit knowledge. Rather than creating predictions these naturalistic generalizations give rise to expectations.

Transferability is aided by thick descriptions (Geertz, 1994; Flyvbjerg, 2011; Polit & Beck, 2010). Thick descriptions do not just refer to extended participant quotes but provide detail of the research context and participants (Graneheim & Lundman, 2004). In this way readers can deduce whether similarities exist between their environments and the research context and make the desired associations (Houghton, Casey, Shaw, & Murphy, 2013;Polit & Beck, 2010).

Morrow (2005), examining authenticity from a constructionist paradigm, describes fairness as the requirement that different constructions be solicited and honoured. Lincoln, Lynham and Guba (2011) add that acting affirmatively and ensuring that all voices are represented in the reporting of research was a necessary part of fairness. In this manner dissent is not to be marginalized or minimized. I have confidence that the participants' views were represented in the narratives produced through the process of member checking (described in more detail in section 3.6.3). Through the process of member checking of narratives the participants had the opportunity to identify biased or unfair representations (Morrow, 2005). All complete narratives are available in this thesis to ensure that no voice is minimized.

3.7.5.3 Dependability

Drawing on the work of Patton (2002), Morrow (2005) adds dependability and triangulation, explaining the former as a systematic approach and the latter as capturing and respecting multiple perspectives (Morrow, 2005). Dependability is achieved through a process of documenting the stages of the research process in sufficient detail to be recreated. Whilst my interpretations are connected to the data it is vital that the manner in which the interpretations were reached is explained. Triangulation is achieved through the inclusion of SPs from different intersectional positions including age, gender, ethnicity and arrival mechanisms in Australia. The data sources of field notes and observation also add richness and depth. Loh (2013) suggests multiple interviews and repeated listening to interview recordings and reading of transcripts also constitute the triangulation processes.

Morrow (2005) also expands the concept of *verstehen* or the extent to which participant's meaning is understood deeply to include context, culture and rapport. Contextual grounding is vital to deep understanding and must occur deliberately.

Narrative is a method particularly suited to understanding cultural frameworks. However, a deliberate choice of intersectionality as a theoretical framework has created the primary lens that Morrow (2005) alludes to through which culture can be viewed. Rapport between the SPs and myself is established through our pre-existing relationship of work together and their free will entering into the research process. Our work in teaching culturally competent health communication via simulation together permits my entrance into the field, where according to Morrow (2005) I would otherwise be an outsider, in a credible manner.

3.7.5.4 Representation

Representation deals with the question of whose reality is represented in the research and whose perceptions are described in the findings (Morrow, 2005). Methods for addressing this include probing and asking for clarification in the data collection process. Another method as previously mentioned is engaging in member checking. Morrow (2005) critiques the process of returning the transcript to the participant suggesting this memory test is not viable. Instead she suggests determining whether the research represents the interviewee's meanings. Organising two separate interview

meetings for each participant meant that after a thorough examination of the transcript and adequate reflection on possible interpretation, I could go back to the subject and seek further explanation. Although this clarification occurred during the initial interview, my focus was on allowing the story to flow uninterrupted. I would hold major points to clarify or expand until the story was told, but in the second interview the depth of clarification was far greater.

Member checking was undertaken after the narrative was formed from the two interview transcripts. In this way the participants could attest to whether their meaning was truly represented. The participants were also given the opportunity to change, delete or add any content to the narrative to clarify, extend or delete a story. While none of the participants chose to make changes beyond points of identification, the checking process enabled misconstrued meanings to be amended.

Lincoln, Lynham and Guba (2011) outline voice as a quality criteria associated with representation. They describe the movement by researchers to a position abandoning abstracted opinion in favour of genuinely facilitating participants speaking for themselves. The tension between being readily understood and interpretive changes in narrative is something I have had to negotiate. The voices of participants in the narratives presented in this research are genuinely theirs. Leaving the language mannerisms and speech mannerisms intact was a deliberate choice as a true representation of real voice.

3.7.5.5 Credibility

Credibility covers a number of concepts from the perspective of the methods used in the research. Graneheim and Lundman (2004) suggest the first step for assessing credibility is consideration of the context, participants and data gathering approaches. They explain that participants with wide ranging experience provide input from a range of perspectives. The mix of CALD SPs outlined in table 3.1 (see section 3.7.1) demonstrates a range of ethnicity and age. Both males and females are included although the female participation rate is far higher and acknowledged as a factor in all reports of SP group demographics.

Another aspect of credibility raised by Graneheim and Lundman (2004) is the “meaning unit” used for analysis (p. 110). By considering the amount and style of text used to

develop ideas or themes, the authors suggest that several paragraphs are too broad and therefore likely to contain multiple meanings, whereas single words (unless they are symbolic or metaphors) are likely to be too fragmented. The suggested management is to demonstrate how meaning was determined and allow the reader to see the process and therefore judge credibility for themselves (Graneheim & Lundman, 2004). The description of the analytic phase and the worked example in table 3.2 are opportunities for the reader to judge the process of analysis and meaning units that I ascribed. Thick descriptions can also include examples of raw data so that readers can understand how interpretations are made (Houghton et al., 2013).

Barbour (2001) explains that reviewing coding frameworks can challenge subjectivity in data analysis and that this should be an activity of supervision sessions. While not advocating the need for researcher concordance, Barbour (2001) adds that this activity gives rise to insights that may not otherwise be available, and creates opportunity to consider competing explanations. The process of working together manifests feminist research principles of mutuality, cooperation and support (Hall, Stevens, & Meleis, 1992). As described in section 3.7.3 the process of discussion of my interpretation enriched this research. Systematically, over a period of weeks, each of the narratives was reviewed and discussed and at times debated. This process was not intended to repudiate individual perspectives but rather to acknowledge multiple views (Barbour, 2001).

3.7.5.6 Verisimilitude

Narrativization is about perspective and interpretation. Riessman (1993) admits that individuals construct different narratives about the same event and that a story retold, does not remain constant over time. "'Trustworthiness' not 'truth' is a key semantic difference: The latter assumes an objective reality, whereas the former moves the process into the social world" (Riessman, 1993, p. 65). Connelly and Clandinin (1990) observe that empirical data is central to narrative, but that this does not make narrative into fiction: rather the focus is on real peculiarities of life. As such verisimilitude is an important criterion to judge narrative rigour (Connelly & Clandinin, 1990).

Verisimilitude is writing that seems real and alive, that is capable of transporting the reader into the world of the writing and a criterion of a good literary study (Loh, 2013). Therefore the lifelikeness (Oliver, 1998) of narrative is more powerful and sought after

than truth. Riessman (1993) differentiates between truth and trustworthiness to capture this sentiment.

The importance of verisimilitude is that in sharing the emotion of a story with the narrator the reader is immersed in the experience and learns vicariously of the situation (Loh, 2013). This mirrors the experience of simulation as a learning technique. In simulation we understand that activating the learner, such that they feel the emotions of the situation, increases the fidelity and allows the learner to transfer the simulated context to the real environment. Loh (2013) explains that understanding decisions permits insight, and deepens empathy.

3.8 Cautionary stance

Research with CALD people requires an understanding of the implications of power and privilege. Many minority group people feel silenced and their stories rendered invisible through Eurocentric and exclusionary research practices (Geia, Hayes, & Usher, 2013). It was important to position this research "with" CALD people, not impose "on" them, to build trust and respect. Yet, as low levels of participation of ethnic minority groups are represented in research, it is vital to purposively study the impacts of ethnicity and diversities, given increasingly diverse populations (Yancey, Ortega, & Kumanyika, 2006).

While I use the collective term CALD I do not propose any form of homogenous othering. I have no wish to obscure differences therefore I will deliberately position each of the participants according to their own identity constructions in the analysis chapter to demonstrate their individuality. Nonetheless, for the sake of succinctness, the term culturally and linguistically diverse (CALD) attempts to mark all the opportunities of diversity replete within the group whilst this study renders CALD SPs as the "knowers" (Martin-McDonald & McCarthy, 2007).

Cultural competence coupled with a pre-existing relationship with all SPs in this study meant I used an individual approach in interviewing each participant. The differences manifested as place of interview, presentation of a small gift, such as flowers or chocolate, purchase of refreshments, such as coffee or a light meal, and availability for weekend or after hours' meetings. These factors were influenced by age, cultural customs and traditions of SPs. Han, Kang, Kim, Ryu and Kim (2007) state that

researchers should display culturally competent knowledge and incorporate individual traditions and cultural values into relationships. They add that age specific lifestyle practices and ethnic media should be used where appropriate.

3.9 Ethical considerations

An ethical plan was submitted to the Human Research Ethics Committee of Victoria University in June 2013 and approved with one query regarding who would transcribe the interviews. Approval was granted (HRE 13-146) on July 15th 2013. The action of completing the application formalized recognition of some key ethical issues that needed to be managed and will be discussed here.

Participants with specific cultural needs and sensitivities were my select research group. Accessing an existing group of SPs, who had been recruited because they were willing to share their cultural and ethnic experience in teaching contexts, indicated a number of starting positions. These included that SPs had all been screened and were deemed able to communicate verbally in English. It meant they could understand the concept of cultural identity and were accustomed to sharing this information through simulations. When considering ethical implications of research with CALD communities it is recommended that the unique characteristics of the participant population are considered rather than assumed vulnerabilities (Trimble & Fisher, 2006). As a researcher I have experience with teaching culturally competent communication and working with CALD SPs. I was able to use the cross-cultural negotiation framework and open-ended questions to negotiate appropriate boundaries with the SPs who volunteered for the research. While all SPs had been assessed as able to communicate in English verbally; the option was provided for the researcher to read the information for participants in the research document and consent forms to participants, if requested. Additionally, a verbal recorded consent agreement was available for any SP who preferred this alternative. None of the participants requested reading assistance or recording.

In order to facilitate informed consent it is necessary that a participant understand the request being made, including the implications of their agreement. For many cultural groups this includes the opportunity to discuss the request with family or community members. Prospective participants need to be informed about their right to withdraw,

even when the research is underway (Ransome, 2013). To facilitate understanding, all participants were sent information and provided with a copy of the consent form, and allowed time to consider and consult before responding with their acceptance. Each person was also offered the opportunity to submit questions via email, as this may have felt more culturally comfortable for some people in preference to face-to-face questioning. The first meeting with potential participants involved discussion, explanation and question and answer period. At the beginning of each interview the consent was re-affirmed, as was the opportunity for questions. Adams (2008) adds the issue of other people mentioned in narrative stories and the question of their consent. While he does not offer any abject solutions to this issue, he does prescribe reflexivity in considering the crafting of narratives about others. This presents a dilemma in some of my narratives where participants discuss family members. I have changed some of the details of those people to protect their anonymity.

Chase (2011) suggests that detailed stories in narrative can leave participants feeling vulnerable. Returning the completed narrative to the participant can provide an opportunity to check the story when the manner in which it will be used is known, thus enabling permission to be re-checked. Relatedly, in co-construction of understanding, as occurs in qualitative interviewing, Holloway and Freshwater (2007) suggest that participants retain more power and control in narrative as they are not required to follow the dominant discourse. As such participants can define their own identities and experiences and in so doing be active agents of their own character (Holloway & Freshwater, 2007). This is in keeping with feminist research that pursues techniques that eliminate hierarchies of knowledge construction (Presser, 2005).

The use of narrative may give rise to retelling difficult or painful stories or recounting loss. Holloway and Freshwater (2007) suggest that this is how people position themselves, reconcile events and move forward, by re-examining their past in a manner that befits their present. It is noted though that the relationship between the researcher and narrator is not intended to be therapeutic, and that the researcher must ensure that the safety of the participant is protected, or assistance provided to re-establish safety via counselling should the patient's equilibrium be upset by recollection or retelling. As a registered nurse, and experienced simulation facilitator I was attuned to the psychological distress displayed by some participants in relating their stories. When the participant showed distress I encouraged them to take some time to regain their composure. I asked each person how he or she was feeling at the conclusion of the

interview and reminded participants that I could organize additional support, if needed. When Kabill disclosed her suicide attempt as a teenager, I was concerned that she may feel vulnerable after the interview. I spent some time checking on her, and reminded her that the story was hers and that she could edit the story any way she chose. In her second interview I reiterated this offer; however, she was content to leave the story unchanged after reading her completed narrative.

An interesting benefit derived from narrative is that the participant answers the trigger question without structure provided by the researcher. This results in less influence in what is an unequal power relationship where the researcher is part of the dominant discourse as a health professional, educator, employer or researcher (Holloway & Freshwater, 2007). Traynor (1997), from a postmodern perspective, considers power as a fluid concept to move it away from binaries such as liberation and oppression or us and them, to accept differential access to power. This is worth considering across a research project such as this where the CALD group of participants leaves out other groups of CALD SPs who may have different views. Therefore whilst acknowledging power differentials this view reminds me of the power or lack thereof within and across groups. While theorizing we should also be mindful of those not represented. Power performs unconscious functions that influence language, structure and arguments (Traynor, 1997).

In considering the distribution of power, an extension is the notion of narrative privilege. By narrative privilege Adams (2008) asks who has the ability to tell or listen to a story. And beyond this, how language and our reliance on proper textual form could influence ethical demands of storying. Adams (2008) suggests improperly written stories may be deemed inferior or even invalid. At Adams' (2008) insistence I have considered the morals of the person, story and text representation with an understanding of the power I have over the medium to represent the language abilities of the participants and to situate the story within the language system and affiliated norms of CALD people. This process is in keeping with a feminist perspective and the principles of language in framing and naming issues and avoiding judgement.

The management of power is influenced by Western ideas of behaviour. Western beliefs value the negotiation of situations and within relationships. The opportunity to talk and set rules in a research relationship could be seen as constructs of equalizing power according to Skelton (2001). Nonetheless in many cultures the participant may be

inclined to resist this attempt to equalize power, preferring to defer to a perceived expert as a measure of politeness (Skelton, 2001). Having an understanding of my participants through previous work with them in simulations; I was aware that in some interviews I would have to accept deference as offered while in others, working on rapport and trust, I was able to establish a more mutual and balanced relationship.

As a mechanism to protect the participants who engage in storying, it is necessary to apply a pseudonym to written transcripts and reports associated with the research. Original documents that could give rise to recognition of participants and prevent anonymity will be securely stored in a locked file in a locked office. Digital recordings may be stored on a secure and backed up computer drive with password protection. Participants will be made aware of plans for data storage and reporting as part of the information required, providing informed consent to participate.

It is a requirement of the university that records be preserved for this type of research for five years after publication. Participants and researcher are protected during that period, and a data management plan is required which outlines the material stored, its location for traceability and integrity of the project. The data management plan was approved by my principal supervisor and lodged with the Victoria University Office for Research, ensuring succession despite potential organizational and employment changes over the period of storage (National Health and Medical Research Council, 2007).

3.10 Conclusion

This research project rests on the opportunity to create greater awareness of the experience of CALD SPs. The methodology and research influences reflect my belief systems and the respect I have for the participants. The people who participate are acknowledged and valued and the knowledge developed was mutually constructed. Participants are not “objectively mined for data” (Adams, 2008, p. 186).

The methodology, design and methods of this program were determined according to these values, to achieve the aims of the project and to be congruent with the information sought. I have shown that narrative is an appropriate way to develop an understanding

of the perceptions of CALD people working as SPs that enables their culture beliefs and identities to be differentiated.

In describing the methods I have given sufficient detail to enrich the process of those who read and may wish to recreate similar research. This is in keeping with the breadth of thick description and will enable the rigour of the process to be identified.

In recognition of the special nature of working with CALD SPs as research participants, I have identified areas of special treatment and the ethical challenges I have been cognizant of. The treatment of the ethical and moral imperatives has demonstrated understanding of the general principles of ethical research but in a culturally competent manner.

In the next chapter a selection of the participant's stories will be provided. The stories are long, complex and evocative; therefore not all of them can be shared in the same space although all are accessible here. I share the rationale for the stories foregrounded in the following chapter as well as access to the complete collection.

Chapter 4

Findings

"Are you my mother?" he said to the cow. "How could I be your mother?" said the cow. "I am a cow."

4.1 Introduction

This chapter presents the narratives of three CALD SPs. The remaining eight narratives are presented in their entirety in the appendices. The length and detail of the stories preclude the presentation of all of them within the body of this thesis. All of the narratives contribute understanding and unique insights into the sociocultural life of the narrator, and therefore provide insight and understanding of the CALD SP.

The three narratives presented here have been chosen as examples of life journeys that have, and continue to exert, enormous influence on the participant. Each of them in turn influenced me and changed my perception of the life of an immigrant to another country. Each of these narratives is set in a different period of time and reflects various arrival mechanisms in Australia. The stories are told by women from different generations and age groups and originate in diverse regions of the world. Narrators encountered hardship that shaped their personality and identity, although the nature of the trials is different as are the responses of the individual to their life journey. Each story reveals a person who is a reflective individual and who knows herself well. The participants paint a picture so vivid that the reader feels they are walking alongside the narrator and watching the metamorphosis from old to new identity. As each person reflects on their life the reader feels as if they are holding the looking glass through which opportunity, acceptance and difference become visible.

The order of the stories within this chapter is arbitrary and infers no meaning. I needed to choose an order and decided that I would present them from oldest to most recent arrivals in Australia. A chronological presentation supports the changing circumstances and culture within Australia, as each story is told. I will begin by introducing each participant. Where I quote directly from my field notes I will use Comic Sans MS. I will then enable the participants to tell their story without interruption. To honour the narratives of participants I have separated them, so that each exists independently and

begins with the participant profile on a new page. My analysis and discussion follow in chapters 5 and 6.

4.2 Aleesia

4.2.1 Setting the scene

Aleesia is a 72-year-old dignified looking woman, dressed fashionably, accessorized tastefully, with matching nail polish and lipstick color. When we set up the interview she unhesitatingly suggested we meet at her home (not house).

When I arrived Aleesia emerged from the front door while I walked up the path and kissed me warmly on each cheek. I was struck by the strength of welcome and the effort to accommodate me like an honoured guest.

She seemed very happy to see me. I thought she must have been watching out for me, the way she was outside before I had reached the doorbell.
I was taken inside and introduced to her husband John. We stood in the kitchen as Aleesia explained she had made her special blend of coffee for me. John came back in and asked me to move my car into the driveway. He said the street parking was restricted but poorly signposted.
As I moved my car Aleesia stood at the driveway edge and waited for me.

We sat in a sun-filled sitting room with a large picture window overlooking a dense and prolific garden of flowering trees and shrubs. Aleesia explained that she was organizing a surprise birthday party for her husband and funding it with her SP wages.

As Aleesia sat there, the setting struck me as perfect. Sunlight filtered through the leaves outside and the large picture window to Aleesia's right as well as the small high windows behind her pulled the outdoors into the room. She sat in a deep lounge chair in the corner looking comfortable, and confident, reflective and peaceful.

Aleesia is talkative and happy; she laughs frequently and fills her stories with detail, unprompted. I wondered if she knows anything about narrative technique because she seemed to make an effort to fill her stories with detail.

4.2.2 Aleesia's narrative

I got an email from some other previous voluntary work that I had done, asking me if I'd be interested in partaking in this program as a simulated patient. As soon as I sort of read what the idea was, it appealed to me because I just felt it was so important, this sort of thing for me was very important because I have lived it, with my parents and also I have this this feeling about newcomers to this country, that we do the very best we can to be able to understand each other and have tolerance for each other, with all the different, all the people of different backgrounds and different religions and different culture and so on. If we could only just be … have tolerance, and understanding to me that's very important so I decided I would partake in the project, and may I just add this little thing I thought it was going to be voluntary work. It wasn't till later I realized it was going to be paid work, when I had a meeting with an organizer in a little café that's when she explained everything to me, so that was a bonus and this little idea came to me about John's (my husbands) birthday party. [*Laughs*]

I personally have experienced a lot of intolerance amongst people for other cultures and other backgrounds. Sixty years ago when we arrived my sister Iris and I were about, there was one other child that didn't speak, that was a non-English speaking child. There was an Italian boy who sort of became our interpreter for the first few months and we arrived at school and we had no language background at all and the teacher I mean in all fairness in those days the teachers were so inexperienced that they really didn't know what to do with non-English speaking children. So I was put right at the back of the class and left there. I mean I just sat there from morning until 3.30 just following what the others were doing. But that wasn't enough we were ostracized. I was definitely ostracized by the class, by the kids in the classroom because you know it was only a few years after the war and these kids were saying my father shot their fathers in the war and all that sort of stuff so that was very prevalent within that community and I remember having fights after school. Physical fights after school with kids because well I didn't even understand at the time so there was a lot of prejudice.

It was just about being different and not being able to communicate. That was a big thing not being able to communicate and I had no idea what was going on. And the

only thing that I enjoyed was arithmetic as it was called in those days because the teacher wrote the numbers on the board and I understood the numbers. And also I already knew and I remember this so distinctly and obviously he was teaching long multiplication or long division in grade 4 and I knew how to do them already because I had done grade 4 in Italy and I knew how to do them. They were very strict with math, arithmetic in Italy and they were straight onto them you know and I copied down the numbers and worked out the thing. The teacher looked over and saw me being very busy writing things down so he came over and he looked and he saw that I had the right answer and he just grabbed me and the book, grabbed me and took me downstairs to the office where the head master was “reb reb reb reb reb” I had no idea what they were talking about, and next thing I know, I thought I had done something wrong, I was terrified, I didn’t know what they were saying. I was terrified, because he literally picked me up by the arm, took my book down and then when they talked the Principal sort of patted me on the shoulder. We went, they talked, and then we went back upstairs and they gave me a book with all this maths in it, all this multiplication, division, addition, take away, in it and I spend my time doing that from morning into night. Because I had no idea about what was going on otherwise.

I was sad and I was very angry, for a time until I came to realize that it was the only way they could handle it and they started to realize that I wasn’t stupid. I think I almost and that’s another feeling I always felt that they thought I was, I was mentally challenged or something because I wasn’t able to communicate they just treated me as if I was handicapped.

As time went by and as I came to learn the language and then because I was able to communicate and then things turned. Although, I must say I was well and truly in my 20’s and maybe even a little older when I really became very comfortable with myself that I was of ethnic background. I have just gone through my drawers and trying to get rid of a lot of junk and you know you get little receipts for something or another and my name on those receipts is (*shortened and Anglicized)* rather than *(original Italian name)* just so I could sound more Anglo. It was very strong, very strong to try and fit in. I was very embarrassed by my name.

And also you’ve got to remember that in those days it was like these migrants have come in because it was so tough in their own country and they were looked down upon as if we weren’t civilized enough. There was no welfare. In those days your own family or friends would sponsor you and you were their responsibility until you

got a job. There was no such thing as unemployment benefit or stuff like that. Like my father came here first, because his brother sponsored him and he lived with his brother until he got a job and until he was able to go out on his own. He rented a home he cleaned it up, he fixed it and then he sponsored us out. But it was totally his responsibility that's why they called it sponsoring somebody because it was totally their responsibility whoever you sponsored to look after them, if they didn't get a job you just had to keep supporting them.

There were lots of jobs in the 50's. You've also got to remember that many of the migrants were professional and then when they got here had to start working in factories and so on. You know my mother had never worked in a factory. My mother was a homemaker you know that was what it was like in those days. It was like that here as well before the First World War when women started taking on roles. My mother had no English speaking skills either and she got my dad to write her a note to say "I'm a dress maker and I can use an electric sewing machine do you have a job for me?" And she went from one factory to another until somebody brought her in. Hickory used to be a family business of course in those days and they took her in, she worked for one week without pay to make sure she could do what they wanted. Then they employed her and then they paid her by piecework. So people like my mother came in they worked like mad because they needed the money and then the ones who had already been working there for years and would be taking it slow they started, because what they did then the employers was "OK if you can make 50 pieces in an hour then it's only over 50 that the rate is paid and so the people that were working there were really upset that these migrants would come in and spoil the whole system. I can also remember my Mum and it was probably all the stress and she suffered a lot with headaches and she used to down those Bex powders. Well they introduced my Mother at work because she used to complain of a headache or something and they would give them Bex. And then Bex became a normal thing.
My dad he used to work nightshift so he was home during the day and mum dayshift and then when Mum came home he used to start night shift and she would be home with us at night.

I was 10 when we arrived and I guess the following year when I was 11 my parents worked day shift both of them and I was the carer of my two younger sisters. My Mum and Dad would leave pretty early in the morning I mean that is something you would never do today I mean, you would be up for child abuse I would think? I would get my sisters ready, Iris for school and Aurora to be dropped off at a sitters on the

way to school, and I would do that and on the way back I would pick up Aurora and then we would go home and wait for my parents and I used to cook. I was 11. Now as I got older and I became a parent and so on. I see that as character building you know. It's made me what I am today. But of course in those days I didn't see it that way. Not one bit. I wouldn't eat my lunch during lunch time because I had salami and cheese, so I would be starving by the time, sometimes I would eat my sandwich on the way home if I wasn't fighting or ate it when I got home because my parents weren't at home so I would eat it then. That was very normal for migrant kids back in those days.

Then when it became vogue to be ethnic. Then I felt comfortable you know getting into it. After the Whitlam era, you know when multiculturalism and being of a different background became vogue. You know I'm just a plain old Aussie but you've got… once you start hearing those things around you, then you become proud of yourself and you bring it up then. You know I have changed my name back. You know not by deed poll but I do use it a lot. Because when I started teaching Italian I realized it was better if people recognized I did have an Italian background so I used both names. But it gave me back my identity and felt at peace with myself. But up to then, up to I'd say the 70's it was really denial. And this isn't only me I know a lot of my friends felt exactly the same because of course we have discussed it. They had the same sort of experiences and mind you, a lot of us because we were stronger, we overcame it. But a lot of people, two of my very beautiful friends of mine that come from Montmoro, my home town, that migrated here, ended up with mental problems. It was sort of they were just so torn between and just couldn't cope with what was happening that they ended up with mental problems.

One thing that really stands out is a lot of people kind of say "Well these people come into our country, they should learn the way we live, and do the way we do things why should we put ourselves out to them?" I experienced that as a child growing up here when we first migrated here. I overcame that beautifully, that's not a problem with me now, but I hear other people constantly talking that way. I'd like to hear the experience of the latest generation of migrants and think about our black friends that come from Africa, they can't even hide because physically that's how they look. Our children are so proud of their background and they are bringing up their own children knowing they have this different background as well. I can think about my life and I can talk about it and I do refer this to my children just so they can understand it. You don't forget but you do get over it.

I really do feel that in its small way this SP program it is a means to change. Yes its not going to change everybody's attitudes but its just one way of doing it, it's one area that can be addressed in that respect I find it most appealing to me to do that sort of thing. I'm in fact, very positive to feel we have got to this level where something is actually being done to understand cultural backgrounds. It was very important to me personally that we were training health practitioners because I had the experience with my own parents going through that.

My Mum had leukemia and she for eight years, she was diagnosed at the age of 60, it was a big shock to all of us of course and at the beginning it was more of a nuisance than anything else, but then it gradually got worse. And she had three lots of chemotherapy and the third lot virtually killed her but she was going to die anyway you know, but she just made that decision to have the third one. Although she knew that it probably wouldn't make any difference but I can distinctly remember her saying well if I don't really give it a go I'll never forgive myself. Yes so it was, that goes back how many years Mums passed away now about 23, 24 years ago now.

Even in hospital you know I have a distinct memory of us, of the Italian community, of everybody goes to visit and there are so many people. In the hospitals and so on and that was looked down upon. It wasn't welcome to have and that was a big problem and it's a pity that they didn't understand at the time that it was such a big deal for the Italian families to get together. A lot of other families as well get together and be there for each other and apart from the immediate family the others were regarded as nuisances and their were times when they couldn't come and visit and that sort of thing. That was one area and I'm just trying to think of some of the other things they didn't understand you know. Bringing food from home. Bringing food, of course my Mother couldn't eat anymore with all the chemo and stuff she was having. We were bringing the food and you know we felt a bit like we were doing the wrong thing, because we weren't made to feel that it was okay to do it you know "OK yeah if you want to do it, but there's food here, why can't she just eat this food?" Mum wasn't fussy she didn't ask for it but we just felt like we wanted to do that for her.

She loved lemony things. It wasn't even an Italian soup you know it was a Greek soup, that a Greek girlfriend of mine used to make that my Mother used to love. A chicken lemon soup. That seemed to be something that my Mother could eat, the little that she did eat and so it was important for me to take that into her. We were

made to feel that we were doing the wrong thing and so I think it's very important for the medical profession to understand culturally you know, what people are about the patients not only the patient but the family around the patient. This was about 20 years ago.

It had such an impact on me, and particularly my Dad too. Dad suffered from Parkinson's disease also. Both my Mum and Dad were diagnosed with these dreaded diseases around about you know just a month or two apart. They were both the same age it was quite a shock and by then Dad was, he was depressed about the situation so depressed about my Mothers situation he wanted to be there all the time, day and night at the hospital. They are unpleasant memories, but you know, that's okay, that's why I feel if I can do anything towards these types of programs then I am only too happy to do it.

It wouldn't have been a priority to get involved if the purpose weren't cultural education. You know if I had absolutely nothing else to do and I'm into doing a lot of voluntary work so that's fine but it wouldn't have been one of the priority ones. It really touched me and touched right into my psyche. So we started training from November of last year? Yes from November just on a year we got over the training and then doing the actual simulated patient work.

I've loved being a simulated patient. I really do, I enjoy very much being with these young people and they seem to be so receptive too. I really felt like I was welcomed, and that what we were doing was important. I really got that feeling and I have to laugh a couple of times I went in and apparently the facilitator was saying, they were very concerned because they really thought that I may have been ill. They didn't want to sort of disturb me in any way. They didn't understand that I was just going to be play acting, doing a role-play. That's rather funny. Yes when I came out of character and I 'd go "oh ah well now I'm back to me, I'm Aleesia really" and I'd introduced myself as I really was and they would all be wide eyed thinking that I'd come out from this sort of ill person to just a normal person. The students are so positive, the questions they asked, and like when I came out of character they all laughed because they thought…and I can remember you know in one class they were really worried because they really thought I was ill and they didn't know how to handle me. So they made me feel as if I had done a good job, and that I was convincing and they had really got something out of it. So all that made me feel happy and welcomed. I mean they were attentive when we played the role,

everybody was really engaged in what was happening they quickly changed from one interviewer to another and I just continued and I just felt welcomed. I even got claps. [laughing]

I am being myself, I am enjoying what I am doing. I feel it's something that's really worthwhile and to me that's not work. Work to me is something that you have to put a lot of effort into because it's something that you are doing because you need to earn money to do other things whereas for me it's not that. I'm doing it because it's something that I really want to do. I find it satisfying I feel that I am contributing in this manner and okay the money is a real bonus but I would have done it if it wasn't for money. When I was teaching, I loved teaching so much that I also didn't call it work I called it a paid hobby until it became a chore when I started to burn out, then I thought okay I'm going to finish now I'm stopping because it's becoming work.

I just feel as though I am doing something that's really worthwhile it's given me that sense of empowerment of, in effect, that I am doing something that's hopefully so worthwhile passing on something to somebody else who's going to utilize it. Hopefully in the right direction and it's going to be a snowball of somebody else getting the effect of that and so on.

You've got to deal with in those situations, you've got to deal with this horrific thing that's happened to your family, to your loved one, and then not to be treated the way you wish to be treated, is just awful and yes I was affected by it, as were my sisters and the rest of the family. My family love that I am doing this SP work. I have a son who is also a nurse Jackson. He's very proud of me. He thinks it's a worthwhile thing and the rest of the family think it's great.

When I first told him about it when I decided to do it and spoke to him about it he said "Oh Mum that's fantastic I'm so proud of you doing that" you know. His partner is also a nurse so we do tend to have nurses in the family.

I wouldn't say that in a practical sense being a SP has impacted on me, but it's made me think even more about these situations. Even just through doing the training I learned, I learned stuff there too about other cultures. I liked that. The fact that we learned about different cultures as well and how it affects people. With the young African girls, and then I met the Vietnamese gentleman. That exposure to other cultures, that to me, has been very positive as well.

When I met up with these other SPs I was able to say that I had visited their country and talk a little about that, so I found it really, really worthwhile that training we did together as a group. For me the training was enough, because I think my life experiences came into that, I couldn't say for a younger person or someone who hasn't had too much exposure I couldn't speak for them but for me personally it was. I think the experience is also more important than the acting because I'm not acting when I'm doing this because I really feel, I really can put myself into that situation. I don't feel as though I'm acting. Although I'm taking a role, it's a role I am very comfortable with and I know well, so to me it's not really acting. To me acting is something that you have got to learn and then bring it out there. I think that's already something you know, when they have come in from another country. They are facing something completely different, a different culture. In many cases they are facing being ostracized or that sort of thing. I mean the actual experience of the flight. I guess for many it would be the first time they had left their community so they do have a lot of experience. I think it's only if you try to get someone who is born here who hasn't had to experience that, they're the people you have got to convince that this sort of thing happens. But I think if you have had this transition, it doesn't matter what country you have come from, how old you are, how much experience you have had, you have had experiences. To be true to what you are doing you would have to have had some experience. You can teach it but you wouldn't get the same emotional portrayal. Because then you would be an actor, you've got to remember exactly what you have learned in those wonderful sessions that the SP program staff do and you can miss points whereas if you have experienced them you will put them into your head in your own manner and then you can just role-play it, not acting. I put myself totally in my parent's skin virtually. I have experienced that in their situation and then because of my own experiences and I virtually become my Mum if you like, in the true sense.

Anyone can play a SP with a medical condition such as pain because you have experienced pain of some other manner, you've experienced headaches, maybe you've experienced a broken leg or something like that. A physical pain can be the experience from a specific physical pain can be drawn from something you have experienced. But a cultural portrayal is an emotional thing rather than a physical one. So providing feedback would be different for a person who hasn't been through that experience because once again it is a learnt thing rather than a heart felt thing, because I think in that respect you've also got to learn the answers rather than give a

feeling of the response. For instance I think losing a parent, before I lost my Mother who I was very very close to, my Father was a good Father and so on but didn't have the same effect as when I lost my Mother. I must say if anyone before that lost a Mother my feelings my emotional feelings were nowhere near as close as after I lost my Mum and I experienced that loss. To be able to understand somebody else who had lost a loved one to that extent. Because you really need to convince your students and you can only convince them if it is something that you emotionally feel.

I only have to hear a story on the news about someone or with our asylum seekers or you know this terrible situation that we are in with the government and it makes me think. It does affect me you know. What the government are trying to do I mean, sending asylum seekers off to New Guinea, you know and just placing them in that area, it's just awful, I just can't understand it. They're going to be spending so much money doing all that, why can't we just embrace them, bring them here and let them start a new life? This is my attitude I'm very deeply affected by it, you know. And both sides of Government are thinking the same and they're bombarding the rest of us. And that's what people want, this negativity that we're getting from the government and then people start thinking the same way. But if the government could just be a bit more positive.

I remember with the Vietnam War, during that period of time, we used to get a lot of boat people in. Look at the Vietnamese community now? They are all part of the community of the melting pot and look with every generation we are going to have a bit more problems than with the first generation. When I talk about problems, its difficulties with the first generation, but after that we are just part of the melting pot. Why can't they understand that?

It's all reported that negative way and if you get that negative reporting and these Heads of Government, Head of State, you know that are fighting each other on which is the worst way to treat these people and they are not saying what is the best way, they are actually saying what is the worse way. And then it's reported. People get that negative vibe and then they think that way as well. I must say I become very angry with what's going on around me. It makes me more determined that I need to be doing something to help in whatever way I can for these people.

If the government would soften their ways I think Fraser was very good when the Vietnamese, he softened it and said let them in and people became entirely different in their attitude toward the boat people to what it is today.
I think this SP work can definitely make a difference. It's something. We are not just sitting there doing nothing. You know when they say even if it saves one child its worthwhile and that's how I feel about this. Even if it's one point out of 10 it's something, we are not just sitting placidly doing nothing about it. Oh God I wish this sort of thing was around when my parents were going through it. Particularly my mother. Whereas today they have these kitchens they've got microwaves you can put the food in there heat it up, let your loved one eat something that you think might help. It's such a change it's so beautiful now this sort of attitude.

There was one Italian nurse there where my Mother was and she understood that. She actually went out of her way to allow us to bring the food in. Also when everybody wanted to be there and there would be 20 people trying to cram into one room and particularly at the end when we knew Mum wasn't going to make it. It was like "Oh God" all the nurses would stomp around saying "all these people in the room" or something like that. If they could have only understood this is a cultural thing, people wanting to be together. Attitudes have changed I know that even in hospitals today but in those days it wasn't easy.

Look we had a dinner party here Saturday night and it was a beautiful evening until something came up about asylum seekers and one gentleman who was here said "As far as I am concerned I would drown the bloody lot" It just spoiled it.
It just spoiled it, it did. I had a couple of young French people here that were staying with us for 3 or 4 days they were 27, 28 years old and they were just, they just looked at me as if to say "Is he for real?" and he himself is a migrant from Britain. He's gone from England to New Zealand, from New Zealand to Australia and then he's got the audacity to say something like that.

And THEM they're always talking about THEM. They don't humanize it they don't talk about the people, the children, it's so negative. Why can't they show, perhaps what it was like in the Vietnam war time you know, when the boats were coming in and just show the positive sides that we've got out of that? Sort of let, allow people to understand, I mean we're a country of migrants for goodness sake. Was Captain Cook also a boat person? Did he ask permission to come into the country? No that's right he just stuck a flag there and tried to get rid of the ones who were already here.

Why doesn't the media, anyone, sort of take some of those positive stories and put them out there instead of everything's so negative. It's sad, so sad.

I must say how many of my friends at the moment are so racist about non-white nurses in hospitals. Boy do I hear a lot. I've lost a friend just recently over a discussion that we had, because another friend who was in hospital, a male member who was in hospital and there was an Indian nurse who was looking after him and she would have had to handle his penis. Now this is the story I was told and she said "No I can't do that it goes against my religion". And I said to this person "that's OK, I can understand that, all she had to do was go and get another nurse". She said "she did do that but if she can't do that then she shouldn't be a nurse". And I said "no no hang on a minute. She is probably a perfectly good nurse but that's one thing that goes totally against her religion or whatever as long as she took care of it by going and getting someone else" No that wasn't good enough we had this barney and now I don't know if she will ever talk to me again. Of course we have so many now you know so many Indian and Chinese nurses that it comes up constantly. "Oh we had this Chinese person we didn't even know what she was talking about, couldn't understand her or asked her for something …" It's racism. They are people and they are performing a task that needs to be done. Is there a problem with that? Just because he's a different color or wearing a turban or a nurse is a different color, not even because she can't carry out a specific thing it's because she is Chinese. That's about the performance of the person it has nothing to do with the fact that she is looking different.

I didn't really have any expectations of being a SP. I wanted to do whatever it took to partake in this project. I don't really think I came with any expectations as such. You are always a bit nervous to start with, when you go into something new, because you're never really sure you've understood it correctly to start with and also being in that situation with a lot of young people as well. But I really felt from the beginning the organizers put it out to us and I knew straightaway that I was in I felt very comfortable with going ahead.

I was a primary school teacher to start with but I also have taken adult Italian conversation. I'm involved as a tutor with Italian conversation class. I take 13 adult people that I work with every Friday so I don't have any problems with speaking in front of a group. That and being a classroom teacher I often have to have meetings where I have to speak to people. I've had a lot to do with teaching and training to do

different things and I've also acted, yes in small way once again voluntary work with directors to come out of the Victorian what do they call it? Where they learn to become directors? At the end of their course they have to write a story and produce it and so I've done some acting for these young people. A couple of times, I've done a couple of commercials. As an Italian Mother. They were on commercial television but I don't do them anymore because I hate commercials.

Perhaps giving students feedback. Yes that was probably the most challenging for me to a certain extent but once I was in the classroom and once the session happened it came naturally to me, to be able to sort of just maybe give some indication of something that could be done differently. But being a primary school teacher with little kids is different to working with adult students. Training in something specific so before it happened I was thinking about it but once I was in the classroom once the session happened it was easy for me to just evaluate and be able to give a response.

See occasionally during the sessions some students also said but it's still not a 100% natural situation, I felt sorry for them in a way, because they're still students in front of other students and they've got to put themselves out and some of them were you know a bit more shy and some of them came very natural but others were still a little bit nervous and I'm sure they were nervous because, I was role-playing, there was the facilitator or lecturer or whoever, the other students were listening in, so I'm sure that must be intimidating to some. Confronting to some. Some students did say that even though it is a set up situation it's better than talking to a dummy, so obviously then it's not an exciting thing talking to a dummy and they felt it was an extension of that.

I have thought about how this experience could be improved and I can't think of anything. I really can't think of anything because it's been such a new experience for me as well I have just felt it has been so positive. The only thing I could say is you need to draw people that have had experiences. It doesn't matter how much or how little experience the person has had in that sector they need to have some experience. It needs to be a person that's come from outside or experienced something as we have discussed before. You know that thing about the white picket fence. It's true being first or second generation it's very true indeed and your elders keep things alive. In a frozen culture, that's an important thing in a frozen culture. Because our parents still had, my father migrated here in the end of 1950 and went

back to Italy in 1972 and he was just blown out. He just could not believe the change in attitudes. I mean my cousins were already living with their partners then. Are you kidding I wasn't even allowed to go away with my boyfriend overnight. But in Italy they had moved on no different to what had happened here. So we called that our frozen generation. It means we are brought up by that culture of the parents that have left that country, whenever it might be. So they were still living that way. So when he got there Dad couldn't believe what was happening. Italy was moving on, but we were kept the same. Even our foods. [Chuckles] In Italy pasta is homemade. Festive pasta was what you went out and bought, that was festive pasta. So here in Australia they kept making the pasta if they had the time. So they go back to Italy and the Italians no-longer make all the traditional stuff they used to make. They have moved on they buy take away stuff, they use tinned food, whereas the culture here they are still making the traditional sauce. I go back to Italy and none of my relatives do that anymore whereas I've got an Uncle here who is 80. He and his wife are still making the tomato sauce and the prosciutto here in winter, it's a traditional thing even though if you get the temperature wrong you have to throw it away. It's a cultural tradition. But their daughters aren't doing it, I'm not doing it. The Italians regard that generation as backwards because they didn't move on. So when my father went to Italy they were saying "that's not how we are, we've moved on".

You know this image of the Italian family being really close, tight knit it doesn't exist in Italy anymore. They don't live in villages any more. The younger people move out, they go from North to South or from the South to North, work takes them, they can't be tight knit like that anymore. It's the same there. I do things differently to my parents and my children even more differently. It's just natural progression but there has been that generation where we have suffered we had to be Italians inside the home and then something else outside.

4.3 Abida

4.3.1 Setting the scene

Abida is a 64-year-old Iraqi woman. Her husband has also worked with me as a SP, so we know each other, although he is not a research participant. Abida is softly spoken with a strong accent and gentle in nature with porcelain skin and big blue eyes.

We met on a Saturday as Abida works and this suited her better. She suggested that we meet at her house. She then organized for me to meet another SP at that person's house, an hour and a half after her interview. She had organized this and presented it as a fait accompli. Abida greeted me happily at the front door but insisted I move my car into the driveway.

I couldn't understand the reason for making me move the car. The street while narrow was empty. I complied to be polite.

Both Abida and her husband were waiting for me when I returned to the porch and greeted me with handshakes and kisses. We entered a traditional but relatively new house and moved into the lounge room. I knew Abida was Christian as she had mentioned this a number of times and wears a gold crucifix on a chain around her neck.

The lounge has several large family portraits but is dominated by religious images and items. I sit on the couch facing a large tapestry depicting the last supper as well as photos and paintings of images of Jesus Christ. I hadn't realized the extent of Abida's religious devotion.

The coffee table was laden with bowls of fruit, nuts, pastries and chocolate and Abida spent some time making coffee, heating milk and organizing the room, turning off the TV, closing adjoining doors to create a quiet background, before settling beside me on the couch. Incongruously Abida seemed a little disheveled, definitely weekend style clothes.

After the interview Abida was insistent upon pressing gifts of food upon me. She presented me with glass bowls of chocolate and pastry which she said she had kept for me and that next time I would be staying for lunch.

4.3.1 Abida's narrative

I've been a simulated patient for 2 years. It was, first time I speak in front of a lot student, they can't get, they can't learn how to deal with different culture. Also it makes me to, go back to my experience, how we arrived here and how much we suffered until we settled in Australia.

Thinking about that again, sometimes, we think, me and my husband, but in the end we still we say, yeah we suffer, but it was good for my family, for my kids, for their future. And we are happy now. It was, it happened on purpose for us. I feel that, it's sad. I feel pain, I feel sad, I always, I told Bert, how much we suffered and really, it was sad. But, we have something in our mind to achieve it, our goal was, our kids. Their future. And that thing make us to just ignore everything. And we, we want to achieve the goal we are going.

When I remember that time, I say "Oh, how God is great." How much he protect us from all these, what we say, problems, and ideas was the working with the smugglering {sic} people we don't know them, but always we feel, we have something to protect us, it was our God, that's it. This is what was in our mind. And sometimes I feel sad when I remember, and I say oh no, it's okay now. I am good, thank God. This, I did this for my kids and now I'm very happy with them. Look, we arrived here with nothing, we start from zero, but now we have home to live in. I have my kids finish their Uni, they study, my son get married. This is my, this is the fruit we get from all this suffering life.

Really, our life in Iraq was, it was hard from the, since I was a kid when they kill my father, I was seven years old. My mother was alone. I was very attachable to my father, I love him so much. When I lost him all my life is changed. I remember when I was kid at school, when we get our certificate everyone happy their father sign their certificate; I was crying. I say, "I have no father to sign my certificate." Always I was crying for him. It was really terrible for me when I lost my dad because I was love him and he, we were very close to each other. And then my mum take the responsibility, there was fight between Kurdish and the government in Iraq; we moved from north, we left everything behind, even our house they burned it.

We left to Bagdad. We moved there like only my mum, she was the one take care of us, and she took me to school, to public school to enrol me. They say, "You don't have any ID. How we don't know you are not Iraqi." And she said, "Yeah, we are Iraqi, but everything is burned, they burned our village and everything is gone." They say, "No, we can't accept your daughter." I was seven, eight years at the time. She took me to this private school, it was French school. At that time they accept us, all the Christian, you know, they accept us at school, and then I start to study, I have to study English and Arabic and French. I don't know, only Assyrian, I speak only Assyrian. And you know, kids easy, they catch the language. I was, I love that. I'm very happy to learn French and English and Arabic. And then I was always feeling like I look at Mum, she was always sad. I say, "Oh my God, why you take my father? Everyone is happy with their father and I don't have father." That I think still until now inside me. It's still inside me. And then I grown up, I finished school, I start working, I start working in the, like a staff government, I work at Iraqi TV and radio in import section; I was first a typist and after two, three years I learned what to do and then they make me a coordinator and then our [laughs] manager, he taught me how to do the correspondence in English.

Because of my language and because I study in private school my English was good, my French was good at that time, I learn to manage the section. And then I get married and I was still working in the TV station; Bert was there. I met Bert there. And when I start working I understand the people around me; they don't like, they don't care about us, all the time I hear from them, "Oh, they are Christian. They work from their heart. Don't worry about them." No one talk to us, no one harm us at the time but they need our work only. And then when I get married Bert was, again he was working in a laboratory. In 1980 I think, 1979 they want him to come to Australia to do training for the, to change the video to cinema film, because he was doing the analyses in laboratory, the films and thing. And they accept him to come to Sydney for two month for training, and I was the one, I did the work for the paper for him. And one of the staff there, they say, "Oh, this Bert, he's Christian. Don't send him to Australia because if he go there he will never come back." And they stop Bert to coming. They change him with the other lady, Muslim lady.

Bert, he was very upset because they finished all the papers, it was Christmas time, they call me, they send me a telex, they say, "Abida, it's Christmas time. All Australia in holiday. We can't send the visa. Just wait for after Christmas. On January we will send it, they will come because they were ready to come." But his happened during

that time, they didn't want Bert to come and really it was very bad for me, it's affect me and affect Bert that they did this to him. It was terrible. I say, "Look, the discrimination they do. Okay, we work hard for you." "Why you don't respect us?" From the beginning in my mind I was looking to live in London; I love to come to Europe, but my mum, she never allow us. She said, "When you married you can go, but when you are single you will not go anywhere." It was in my mind but I can't do it because Mum doesn't allow. And then I told Bert, "Look, from now I will not live in Iraq. We have to leave."

During the war between Iraq and Iran, again, during the war Bert was in the army. One day I went to, I never go and buy bread, always he was the one, he bring everything for me. I stand in the queue to get bread, I was wearing a cross and one of the Muslim ladies, she just turned like this on me and she said, "You are Christian. Why you are standing here to get the bread. Let Bush give you bread." At that time America was bombing Iraq, and I look at her, I say, "Oh my God, what's wrong with these people?" I scared, I thought, "Oh my God, she will kill me now." In my own home, in my own country, and living there at the time. And I was very scary, really I'm, I'm very sensitive and scared person. I left everything and I went home. I called my mum, I say, "Mum, bring some bread because I don't have bread at home." One lady, she told me, I scared, I thought she will kill me. So she said, "Don't worry, don't worry, I am coming." And at that time when Bert coming from the army, he say, "I will not come back to the office." He was upset because they cancel his trip to Australia. And I say, "Look, we have to leave, we have to leave from here. We have to flee from Iraq." He say, "No, we can't." I say, "Look, if I sell everything we have to leave. I can't live in this country." It's, that was impact on me. And I say too, "One day they did this for me," and then we decide, both of us, to leave.

And then we left everything behind, even our furniture, it was there. We left everything there and we went through Jordan; from Jordan we catch plane to Bulgaria; and then from Bulgaria we stayed there about one year and eight month, it was very hard for me, we spent all our money and I start crying every day but thank God, Bert, he found like job in a shop, there was a lot of Arabic people there, they work in Bulgaria. Most of them, they are business people. We pay, I pay $2,000 for the smuggler man to take us to Greece because they were, in Greece we can apply to any country, Australia, America. We can't apply from Bulgaria, they don't allow us. Yeah, it was very hard, even the language, I start, one day I went to buy cheese for kids, I went to the milk bar, was like, and I ask him for cheese, he said, he told me,

“Neh.” I thought, “Yeah, I will give you.” And I wait for 15 minutes, everyone come and take thing and go. They don’t understand English. And I saw a lady, I told her, “Do you speak English?” She said, “Yeah, a little bit.” I say, “I’ve been 15 minutes here waiting for the man to give me cheese. He say yes, but he didn’t.” She say, “No, this mean ‘neh’, it mean no in Bulgarian. This is, dah, dah, dah, it mean yes.”

And then the smuggler man spend our money again, we give him the money. He spend them, it was Christmas time. Every time he took us to the border, three time he took us to the border between Bulgaria and Greece, and they bring us back. He say, “The road is closed and there is a lot of security. We can’t pass.” In the end we discovered that he has spend our money, he has no money to give to smuggle our people there and they bring us back. And then one Bulgarian, he say, “He is liar. He spend your money. He has to take you there.” And we ask him but every time we leave like in different place because the police, they don’t allow foreigner to live in Bulgaria and we don’t have any paper. It’s illegally. Yeah, all the time he change our spot. And then after one year and eight month he took us to Greece by, they took us from Sofia to the border by a truck, and then they told us, “You will walk for one, half an hour and then one hour and we’ll reach the bus there, meet for us.” They will meeting us there.

This was very hard for me. And I remember when we walk in the water for 4 hours, when we arrived in Athens, I just clicked, Bert we didn’t think. Some crocodile, snakes in the water, they will bite us, I said “Oh my God.” And that time, I scared. In the moment, I haven’t anything in my mind, just we reach the bus, this is what we are, was our goal. We walked in the water for 4 hours with my, three children. My daughter, Ann was 1 year, Mary was 2 years. We carried them. And Thomas was 8 years, walking in the water up to his neck, from Bulgaria to Greece. And we walk in the mountain and then in the land of corn. And then we go in the forest, the end stage was in the water, the last one. It take from 12:00, midnight, to 4:00 in the morning. We walked, my son walked the whole time And my husband carried the girls. And all the time he hear someone cry, “Mum, do you falling down?” I say, “No Habibie, it’s ladies, their kids, they fall in the water.” Yeah, but we are walking like a queue. Yes, in a line, but no one, even when I was looking on the water I feel dizzy and one man, he was very tall, he said, “Don’t worry Auntie, just hold my bag and don’t look in the water.” Yeah, until we arrived at 4:00 in the morning, we arrived in hill and the bus was coming at that time. We went up in the truck and we sit for two

hours from 4:00 to 6:00, they took us to Salanicki, and when we want to go out, I say, "Oh my God, we are all mud," you know, in the water

They took us in a truck, 40 family we were, with kids. Like sheep, they put us on the truck. When we arrived, and they say what we told you, you obey us because there's a border crossing and, from Bulgaria to Greece. And we, they told us stay, we stayed. Bend down, we bent down when there's the light come from the border, to check the border. And then there was nothing. They say now move. Quickly. If someone be late, you will stay here. It was scary. But, because we have something, a goal in our mind, we don't care. Yes, we obey them and we run after them.

We went to the station; he say, the driver say, "This is the station and this is the travel agent here. You can get your ticket from here or you want to go by train." And I want to go by train; other people, they come so, "Auntie, don't go by train because yesterday they got a lot of people in the train, it's danger." And then I give some money to the smuggler man to change it to drachma, to Greek currency. He took them and he give only $50 for my son. He ripped me. And I say, "How much the ticket?" They say, "One hundred dollars." I have only $50, I spent all my money. And one man, he say, "Don't worry, I will give you. We catch a bus at 8:00 in the morning from Salanicki and we sit in the bus, there was four Greek people with us; the bus was full with refugee, are all smuggler in, we are 40 people. And in the bus there was four people, two, three ladies and one man. We were very scared. We know if we speak like Arabic or Assyrian they understand we are refugees, they will call the police because at that time if you called the police they will give you a reward. And I say, "Please, no one speak any language. Make your kids silent because there is people here. They will know we are not Greek people."

And just one lady, she turned to me, "Where are you from?" but in Greek. *(Spoken Greek word)*. I say, "I don't speak Greek. I speak English. You speak English?" She said, "Yes." Oh my God, my heart start pumping. She said, "Where are you from?" I say, "Oh my God, help me." What I will say, and I don't know, like something. I say, "We are tourists from England," because all of us, we were blonde here, blonde hair, colour eyes. I say, "We are tourists from London, from England." "Oh," she said, she look at my kids, "Oh, Kookla Kookla," it mean doll, they are beautiful. She said, "Can I carry them?" I say, "Yes, yes just take them." I want just make her to turn her face from us. Yeah, I say, "Yeah, take them." She took Ann and Mary with her and they kiss them, start playing with them. And I say, "People,

careful. She ask me "Where are you from?" No one talk anything. Be careful." We were [laughs] zipped until we arrived in the restaurant they took us, they took us to Athens, it's eight hours. We went down, they have the restaurant that we all eat there and then we wash our face and we get back in the bus. I say, "No one say anything because she ask me." And thank God we arrived safely in Athens and we catch [laughs] taxi, everyone have, like I have my cousin address with me, I give it to taxi man, he took me to there.

When we arrived in Greece, I say "Oh, we are in heaven." And they welcoming us. Even when we went to police centre, they check, they ask us everything, how we arrived there, and they say don't worry, we'll give you a paper for 1 month it mean we will not tell you, go back again to your country, but this is just for checking. And you stay here, we respect you, and we help you.

We applied to the embassy, to come to Australia. We do the right thing. We went to embassy, and we get the forms, and we apply. That took a long time because we don't have first cousin in Australia. When we arrived at that time, they accept anyone, in 1994. But when, in 1995 the rule changed, they say if you don't have first cousin, you will not go to Australia. And we wait, I have cousin in Sydney, she wasn't first cousin. She's cousin, just from my mum's side. They say no Abida, you can't go. They refused me. We applied three times, they refused us, until the sister arrived in Melbourne, and then we say this is the first cousin for my husband.

When we went there I, we live three days with my cousin and I told Bert, "I feel bad. We are five people here in the house and we don't have money to pay for them, and we don't have anything to buy food. I have only $50. What can I do with the $50?" And my cousin, he was very keen to have us but, his wife, I don't know, I feel shy because when you go somewhere you don't have money it's look like it's bad. I told her, "Look, I heard there's a Mother Teresa missionary here in Greece. Could you take us there?" She said, "Yes, yes." I said, "Please today take us there," and she said, "No, because my husband, he don't allow, if he know he will be upset with me." I say, "No, don't worry. Tell him Abida said. It's my responsibility." And I said, "Please, please take us there," because I feel bad to sit and eat and sleep.

We arrived in Mother Teresa's missionary, we don't have anyone there, we don't know anyone there. They took the mums and kids, but the father stayed in different place. We stayed 4 month with Mother Teresa missionary. And one sister in Christ,

she was the manager there, she said “Abida, the Vatican Embassy, there is a new ambassador coming who is Lebanese, he wants someone speak English and Arabic and know how to cook, they need someone like you to go and work there.” I went and I worked there. He help us to come to Australia. He took all my papers and set an appointment with ambassador, Australian ambassador, and he talked to him. He told him, look we will take care of her, but she will stay in the queue according to the, old one, first people they applied before her, and we will be okay with her. Really when the time come, they accept us. We went to do the interview. We went to Australian Embassy and we did the interview and he ask me, “Look, I see your kids, they speak Greek well, and they know how to read and write. Did you send them to school?” I say, “Yeah.” He say, “How? You pay for them?” I say, “No, just I translate their baptism certificate and they accept them at school. They help me, the Greek people were very helpful.” And he say, “This the first time I have been here, how many years, I didn’t find Iraqi family send their kids to school. This is the first time. You should go to Australia. This family should go to Australia.” And I say, “My son, he study also English course because he’s, I pay for the English course.” He say, “How much?” I say, “Six thousand drachmas,” at that time it mean $US30, and then he say, “Oh no, you have to go. You have, this family should go to Australia.”

It’s important for me to share my story, because I want to let the Australian people how the refugee coming to Australia. Eagerly not illegally, legally. Yes. This is what’s good to make them know, how much we suffered. It’s not like they are born here, they didn’t see anything. They don’t know what’s happening around them. But when they live, know about us, maybe they will change their mind.

Not all of them are harsh, because some people they, when they know about us, and they hear our story, they say oh God, how lucky we are, and look how much you suffered to be like us here. They are, there’s people, they do realize, and they respect what we have. You know everywhere there’s good people and bad people.

Its important for health workers to know this because as you know, most of the people, they come the way we come, we have a lot of, we suffered a lot of problems there, in Greece we were okay, we can go and have medical check-up, but you have to pay. Sometimes you don’t have money. What can you do? You stay, when they arrived here, they have, a lot of health issues appeared. This is what they need, someone to take care of them.

One of those people is me. I never went to doctor in Greece if I'm not sick. Only we get flu, thank God. We were healthy. But I know a lot of people, they come and cry when I was there, because we stayed 5 years, we know language and we know the people, how to talk to them. They were crying. She had a lot of problem like women's issues. I say "Why you didn't go to doctor?" She said "I don't have money." I say "Okay, I will take you to my doctor." He was Greek, and I told him this lady, she had this problem, they do her ultrasound and say "Oh my God, how many years?" She said "This is 2 years." And I say, "Because she doesn't have money. I will do it all, on my, I will not charge her any money." He treat her, and he, after that he say "Abida if she need help, I will help her."

In Australia, I don't know what to say, because when we arrived here they welcoming us, and carry us on their hand, when I arrived here, like this. First thing they done for us was take us to check their eyes, their, it mean the healthy thing, they done test for the kids, everything they do it for, from the time we arrived, 2nd week, they took us, health issues, they took us there and check eyes, teeth, and we do blood test, everything. In Australia, especially for the new arrival, believe me they don't, left them maybe 1, 2 days and they come up to help them.

Sharing my story as a simulated patient was good for me, because this new generation, they don't know what's happening. When they hear our story, they just say "Wow, you go through all this and we don't know what's happening." Even if they are not that caring people, at the time when they hear the story, they change. Yeah they change their attitude, they change their way to deal with the people. When we finished, they say "Oh my God, we thought you don't speak English. And you are great, how much you suffered, how, we don't know all this happening to people when they come here." Yeah it make them really to go, how we say, from 180 degree.

A lot of thing in my life changed while I have been a simulated patient. First thing I will let you know, I was very shy girl, even when I arrived here, was the same thing. Yeah, because when I arriving here, the beginning, I was very shy person, maybe even I can't talk in front of public. But because of people, they encourage me and they push me, I start to talk when I do the simulated patient, it was like the second experience for me, yeah, to start again to talk, and I have more confidence. But when I start to work with the community and the SP instructor make me learn how to talk to public.

It was first time with the student, I don't know them, and poor thing they don't know what's happening when I talk to them, I was happy to make that story. It was the first time I talked to a group, especially student. And they are young student, it make me proud of myself. I was nervous before, because I say, I don't know how I face them or how, what they feel about me. It was a lot of thing in my mind, and when I start talking, when I was looking at them, they were just eagerly want to know what I am saying, what they're hearing. I was looking at them all like this and they watch and they want to ask more and more.

Yeah, but when I came to Australia everything is change and make me more powerful, more awareness and more I start to understand the people, the life here, how much freedom they have, how much love they have, they give you to make your life easy. Because how much experience I had before, and then when I mixed with the people I feel, "Oh my God, why I was like that?" Everything is easy and simple and lovely. I want to show people that I understand them. I'm less shy now and the language sometimes, I say oh I don't know what to say, I have to prepare what to say before I talk. This make me sometimes stop and then think it's helped me and keep me confident. My husband says now you are really talking and I be proud of you when I saw you talking with the people, with the groups, with the students. He say "You change a lot." My children say "Mum, we don't know what to say, your English wasn't that good, and, but you survived here, you went in mainstream, working with the people, and you could, you do good job."

And even sometimes at work, I help people and they told their friend, they said "Oh my God, your mum just coming here 10, 15 years ago. But she's working with a big, big, big community." Even when they were in high school, study French. They choose French language, and I was teach them how to read and write. When they went to school their teacher said, "Mary and Ann your pronunciation is very nice, who taught you?" They say "My mum." She said "I want to see your mum." I was speaking five languages. I help them write, and how they pronounce the words and thing. They say, oh perfect. But, and she said "Mum, our teacher want to see you." I said "Okay, I will go and see her." She was very proud of me and of my kids. I learned French in Iraq. We study English and French and Arabic.

When we, smuggler to Bulgaria, we learn little bit Bulgarian. We have to speak Bulgarian, because they don't speak English. And went to Greece, we learnt Greek. And I was teaching my kids, because I have my neighbours, Greek one, she was,

she lived in Canada for 10 years, and they come back to Greece. And I say, “Look Vicky, I want to teach Mary and Ann their lessons, just read it for me in Greek and I will write it in English for them, and just explain to me what’s mean this, this, this. I can help them.” And I was took their homework to her, she read it to me in Greek, and I write it in English. And she explained what’s the meaning and I come and teach my kids. In both way, I learn and they learn Greek.

First time as a simulated patient it scared me. I say “Look, to my colleague look, what we will say, what we will do, how we have to act?” I mean maybe we will, they need us to say some special thing or just we say our story or, we don’t know what will happen. When we deal with the students the first time, it was really, I say “Oh, it’s easy.” It’s not that hard for me. Because I’m talking what I have feeling. It’s something I created from different story, something was inside me, and it’s true. It’s not acting. What the students ask was, I feel it in my life. What they were asking, it happened to me. Nothing strange things they ask or I don’t know how to answer. I have experience of that thing. Whatever they ask, I go through. Yeah, the first session I say maybe, first time I feel, oh, I have to act this part, but inside me I say, “No, I have to do what happening to me.” It’s like I’m not say something is, wasn’t there. I will talk the situation I was going on when I come to Australia and what happened to me. Yeah, it’s the, like a truthing {sic}; I’m saying the truthing. This is make me stronger, yeah, and my panic is gone. [laughs]

In the training when the instructors talk, I feel it like, oh, this is easy. It’s not that difficult to do it. The simulated patient instructor, when she interview us practice, I told my colleague I love to work with this lady, I love it. I love the work with her, with the school and with what we are doing, it’s, we felt it’s something will be benefit for everyone. This is what, what’s my feeling was. When I hear different stories and different people, everyone start talking their feeling. Yeah, this is make me more understanding what to do when we do the simulated patient.

Maybe if they give me some hand, if they help me with the, what’s happening, we can learn different scenarios. But it’s important to tell stories like mine, if I wasn’t, maybe I can’t continue, because I don’t know what to say. Maybe, because I don’t have all this, what they going through, like much how I feel. Yeah, I feel happy to let people know how we’re feeling, how is the refugee feeling when they arrived in new country. Yeah, we tell the truth. This is what we feel. Yeah, it’s not like a film you

have to study to say what you say. Yes, this one, it's from your heart, it's coming from inside you.

I think SP cases include what refugee, I mean, the problems like the culture things, issues, and a religious thing. I think that covered all. What was covered, it's there. I say, for Muslim people, they have different issues, and they covered nicely in nice way, but I can't say. Because each culture have their different tradition and different ways to treat the man and the woman. Because especially the women, the ladies. They don't like the man touch them. No, in the hospital. If they have, even the Christian, they have health issue with the woman, they prefer to go, they don't like to be with the men. Yeah, and SP cases captured everything. How we say, you touch all the nerves.

Retelling a story similar to mine hasn't hurt me when I go back to what happened. But, we are human being all the time, especially when I'm, some problem happen to me, I remember. I remember the time I say "Oh my God." I sit with my husband. Sometimes I cry. Yeah, 'cause as I say, we are human being, we remember our past. We, lost my dad since I was 7 years old. Until now when I have a problem, I cry for him, I say "Oh, if you are here, I'm not having this thing." It's always happened. But when we did this for the University, no it make me happy. It make me happy. It make me happy to let people know what others suffering. This is what's the end from, and how to treat them in the future. They know these people, they have a lot of traumas, a lot of stress, depression.

When they come here, we have to be more kind for them, more caring for them. This is the end. This is for the people, yes. And I always talk to my community. We have always thanked this country. Always, I told them. Every morning when you get up, and say "Thank God I'm here." You have to kiss the soil of this country and say "Thank God" because we are lucky we arrived here. How much care they give us, how much nice life they give us. All the time, I tell them. Never forget what Australia done for you. Everyone, you know when the new arrival coming here, they are "oh, this is Australia, I want to go back", and I say "Just wait, I know it's hard for you, for the first month you arrived here. You see what they give you, what they, how much they respect you." And day by day, time by time, they say, come to me, "Abida, you are right. Now we feel what you told us. Now, we touch what you told us." I say "See? I told you. First time it will be hard for you, but after that, you will be very happy."

For us, how much we suffered in Europe, when we come here, just when the pilot say, “We landed in Melbourne.” I say “Melbourne, we are in Melbourne.” Just this thing it’s come, we are in heaven. From the moment we land here, in this plane, in this land, I say “Thank God we are in heaven.” When they come here, they feel little bit sad. They don’t want to go back, but they don’t know the future for them is more beautiful.

I want to tell you thing, something. When we build the house, when I arrived in Greece, I was very happy. I thanked God for everything. When I arrived here, more happy. We build our house, we clean it before one day, and we come to bring the things, we bring the crystal things before in small car. When I come here, the concrete man was working. He say “Abida don’t go in this, inside the house.” I say “Why?” He said “They broken in.” Oh my God, what we have in the house? We came here and we look, the kitchen. They take all the kitchen. And we called the police and everything. And we stay, we wait for the insurance to come back and put the thing, it take us 10, 15 days. We live without gas here, electricity, they cut everything. But we have electricity, we put some this small heater in the rooms. Fifteen days, and we always buy food from outside. I say, I start crying. I say “Bert, this is first time in my life we have been 20 years left Iraq, I didn’t feel I am alone. But today, I feel I have no family, I wish I have just one of my family here to take care of me and my kids.” This is the only time I felt lonely. In my life. ‘Cause with the family, with my husband, we are, thank God, lovely family we have, but that time, 15 days, it make me hate myself and I have to go and see my brother or sister. This happened to me. How much I suffered, how much I work hard in Greece. I was working very hard for my kids. But when I come I feel them, they are happy. I don’t think about anything. But those 15 days, I achieved what I want. I achieved, I came to Australia, it was my goal here, and we start our new life and we were very happy. And something slapped me. When you come from far away with nothing and you start with zero, and then you build like a small house for yourself, I said, “Thank God I don’t need anything. Just I am safe now, I have my own house, my own kids, they will live in.”

I say look, how much friend we have here, no one come ask what you are doing, what you eating, what happened to you, no one come and ask. I said “Oh, this is the first time in my life I felt I’m alone.” At the time when we moved here and you have been like five, six years in Australia, we have been six years, we moved here 2004.

At the time I have a lot of friends but when I came here for 15 days no one come and ask, “What happening to you? What do you eat? What, are you alright? Do you have like no electricity, no gas, no anything?” I felt really, really, I say, “I’m lonely now. I need someone from my family here.” If I have brother, sister, mum, anyone, they should come and ask. Now I have really very close friend.

When I went to Tasmania for five days, me and my husband, my friend come and check the kids, they ask. But thank God again I say, we have our life still. Yeah, this is what, when you don’t have family, what time you feel. If they’re here, if I have some brother, sister maybe. Aunty, someone. But everything is going well, and something coming, just change your life. Thank God, God listened to me and provided, and still He’s with me. I feel He’s always with me. Always I was find closed door and he open another door; close this one, open another. And he take us from better to better to best. Yes, until now, and always I told my kids, “You never lose your faith, because your faith will protect you. This is what protect me, this is what happen. If you lose your faith with God you will lose everything.” I feel safe when I am, I don’t scare now; I have faith. Any time I scare I just, “Lord help me.”

I really like to work with the simulated patient instructor, the way she talk, that attracted people to love her to work with her. When she talk, when she talk with the feel, with the people I feel she take from her heart and I have like same emotion thing coming from her to me. Yeah, I feel like she’s feeling. The sound, the way she talk, even her body language, all this make people to like to work with her. It’s very important. Yeah, the doctor, like his personality, he has right to talk to you in something but still, if he’s very tough you will be distant, you don’t like. But when you see he’s, really, really want, listening to you and looking for you the way that he listening, you feel more relaxed, more comfortable. And simple language, very clear, and this is also is very important. The instructor’s language is very clear; we can understand whatever she say.

If I had to learn another case if you like, explain to me and teach me how to do it, yeah, why not? Even if the way you give it to me, it’s, it will, it look like real because I know what to say because I have those experience. It’s refugee, refugee. That’s it. They go in the same situation. They have same what they suffering, we have the same thing. It’s look like, because even, it’s from different country. Others can’t do this because you didn’t know the way how they come and what they face in their way, like something I can’t do it in the, what they call them, the refugee camp,

because we didn't go there and we don't know how they treat them. This thing I've never experienced that one.

4.4 Kabill

4.4.1 Setting the scene

Kabill is a 24-year-old woman from Zimbabwe. She is softly spoken with beautiful enunciation that has a cosmopolitan lilt. An accent, but not attributable to a place or sound.

Kabill is modern and relaxed; clearly young, she could pass for 17 or 18 easily. She is quick to smile and smiles with her eyes as well as her mouth.

Kabill joined the SP program with a friend who has already participated in this research. When I contacted Kabill to set up the interview, she told me that she had spoken to her friend and knew what to expect in our interview. She suggested we meet at her local shopping centre in a coffee shop.

On the day of the interview Kabill was late and phoned to let me know and raised the issue of background noise. I had looked around the shopping centre and hadn't identified a quieter place, so was able to tell her this. Kabill couldn't identify another place to meet, so we went ahead. Kabill accepted my offer of coffee, but wouldn't let me buy her lunch.

I was surprised by the passion with which Kabill spoke about her marginalization which had never come out in our previous interactions. Also her protection of her younger sister from similar dislocation. This evolved to Kabill disclosing her own struggle with depression and suicidal thoughts, which caused her to cry as she told me this. I was surprised by this but most worried for her health, wanting to make sure the telling hadn't unduly reactivated the emotion of that time for her.

She reassured me she was okay. At the conclusion of the interview I reminded her that her identity was confidential and that she would have editorial right to remove anything she thought was too sensitive.

4.4.1 Kabill's narrative

I've been a simulated patient for almost a year now I'd say. A friend of mine sent me an email and said "You're doing social work. This looks like something that would help you as well as be interesting." So I thought I'd give it a go. At the time I wasn't too sure what I would get out of it, because I wasn't even aware of what simulated patient meant. But then after, of course, I'd done a few sessions I understood what she meant. And it was more informative to me than I think to the students. My friend is a social worker as well but she works in a multicultural community centre. She forwarded the email invitation to me.

The first time I was a simulated patient was a bit awkward. I had to play a character. Acting is strange if you have to put yourself in a situation that you've never been in before. I mean, I can relate to the fact that I am a minority group but I can't relate to refugee and asylum seeker backgrounds. So that was difficult.

I suppose because I can identify with ethnicity, I am African too, I just put myself literally in his shoes and said "How would I feel if I was going through something similar?" I know a few people who have been through that, not a lot. My country hasn't had wars. Their problems are more economic than war-related.

It's been interesting. Because I am a social worker student, it has been informative for me as well as the students. I got to learn more about cultural competence even than I thought I would, which is essential for the profession I have chosen to go into. I've worked with, I think, the allied health group, so doctors, speech pathologists. Who else have I worked with? Social workers, nurses. Yeah, I think that's all I can remember for now. I think it was really interesting to see how nurses and doctors use a more medical model in their approach when dealing with asylum seekers as opposed to social workers who take a more social approach to things, yeah. I was surprisingly pleased that social workers do tend to look beneath the surface. We're not trying to fix things, or explore emotions or explore the root of things. And that was nice. It was a nice feeling.

Overall I have found the whole experience exciting really. In a way it gave me validation. I felt as if I was, not teaching but helping the students be more aware of something that I feel passionate about. I am marginalised so I feel very passionate about people understanding what I face, what I experience, what my reality is. I

mean, being an immigrant is difficult, particularly because I grew up in a country where I was the majority. And then moving to a country where I'm a minority, I feel I was almost a voice for people. That's how I felt, yeah.

I'm from Zimbabwe. We were a British colony so we did have quite a few Caucasian residents but, yeah, predominantly African. The Caucasian residents are minority in numbers but not particularly in privilege because they still do have treaties and acts in place that protects them. So, but we've had civil wars to try and fight that. But they do have the majority of land ownership. And they do own most of our mineral resources. And they've managed to put sanctions on the country. So our current president can't grow the country economically without supporting them. So even though I was a part of the cultural majority there's still opportunities that other people are getting that I would never get.

I think it's easy to always know what you know because I've been on both sides, I've been the majority in my country, I've been minority in this country. I can see what we take for granted; I can see things I probably would have been blind to back in Africa. Things I have taken for granted are not having to prove why you live in this country. So I didn't have to talk about visas in my country; I belonged there. But now I have to identify. I have to be a migrant for the rest of my life. Even if I do change my status to citizenship, I'm not Australian born; I'm an Australian migrated citizen and I will always be in some sort of documentation about me. So that's become a part of who I am. That's become a part of my identity in this country.

I describe myself as marginalised in Australia because, for starters, I have to assume the title of immigrant, or permanent resident or someone on a bridging visa. I didn't even know that was a big thing, I have to identify as that every time I present at formal settings. I can never just introduce myself as Kabill. It's always, oh, I am now a permanent resident thankfully. But it's always "I migrated to Australia when I was 16 or I was on a bridging visa for so and so years." My skin colour's the minority in the country. Access to private health care. It's not as financially feasible for myself to access it as opposed to, as compared to someone who's been in the country for all their life, yep. And because my mother moved to this country later on in her adult life, she is not as, she doesn't have as much income as she would have had she been born here.

I think, simply put, I live in a country where I have two identities. So I can't be – in a sense, I can't be African in an Australian culture. I have to assume one in different situations and the other in a different situation. So that comes with that. So I'm trying to be open-minded when I've been raised in a conservative culture. So it's a part of me and then I have to tell myself that, no, you have to keep an open mind. It doesn't come naturally. I've never had options. I've always been told, "this is the way" and that's it and now I come into a world where I have to give people options. I have to give them, I have to at least give them enough respect to understand where they're coming from. So I do live, like, a conflicted person, it's a contradiction. One minute I'm thinking, okay, I've labelled myself, I don't want to be labelled, I don't know how to fix that. If I'm being honest, I wish I could not be labelled without labelling myself, but that's not a possibility, because it is true; I am a migrant. But I don't want people to look at me as a migrant, if that makes sense. I'm expecting people to look past the labels, but I do label myself.

I think, regardless of where you are, it always will be there. Even if I was back home, which I'd assume, oh, I wouldn't feel this conflicted, but I would still have a label. It would be, I don't know. Let me think, at this age, it would be, "unmarried", "a female".

A stranger would not treat me, would probably treat me the same way I was treated the first day I arrived here because, well, I guess it's a learning process. Like I said, I'm not completely offended by racism. I expect people to act the way they've been raised and the way they've been told how certain things are. Do I condone their behaviour? No. Do I acknowledge why they act that way? Yes. Is it hard to think that, when people see me, the first thing they acknowledge is my skin colour, before they ask for my name, before even when someone looks at me, they've already made assumptions based on just how I look. I have people, if I change my hair, which African people do a lot, I have people say, "Oh my gosh. I didn't recognise you. Your hair's different." My face hasn't changed. It's my hair. Just like how you would dye your hair blonde, brunette or jet black. I would still know it's you; it's just a hair colour or just a hair style. My face doesn't change. I mean, I'm not saying I don't snap sometimes. Sometimes I just go, "That's ridiculous. Really?" I'm pretty sure if you dyed your hair pink, I'd still know it's you.

Having a voice as a simulated patient is empowering. I know I've probably not made that much of a difference but in the small group that I have worked with, I feel that it's

important because at least, even if it's 30 people that know, 30 people that are aware, it's better than zero. So, yeah, it's empowering.

I think that, when I'm in character and then when we do the debriefing, I want people to look past what they can see and try and unpack what we've been discussing like. So see past this because there's more to it. It's easy to just say, oh, yes, these problems are because, you know, African. There's more to the African thing, with similar experiences and I would hope that you would expect me to look past just your skin complexion. I'm sometimes afraid that the way we do the skits, we are telling them to just look at the differences, but perhaps look at the similarities as well. You look past the person's colour; you look past the person's presenting problem. You might recognise something that's similar to you; they've had a similar trauma, they've had a similar emotion. So look past that and I know, because it's the health profession. We focus on fixing a problem so we don't always show empathy.

Well, for starters, things I have learned are I don't represent all of Africa. Africa's a continent. I knew that. But I was in a sense ignorant because I was only aware of my immediate surroundings, so my country but did I know that there were asylum seekers and refugees? Yes, maybe, not really. I was very protected with my life. And because my country had no wars, I wasn't really, well, there were wars before I was born but I was never exposed to, I haven't lived through it. I can't say I have. I couldn't say I could relate to refugees and asylum seekers. I'd never lived that life. But doing the program, the simulated program, because I had to put myself in character, I suppose I was more aware of the emotions and what they go through. And it just, it made me realize that maybe I am actually as ignorant as the rest. That's confronting.

I did think, well, considering that Australia has so many cultures, yes, I did need cultural competence education. I assumed that, being African, I would just, I don't know, all I'd need to know is being African. But then I had to learn to respect and understand the different cultures, the different religions. I had to learn more because it's easy to think that I'll go into a certain area with my set of values. I also have to acknowledge other people's sets of values and because we have so many of them in the Australian community, I had to learn.

Well, for starters, I do more research now with refugees and asylum seekers. I want to know more. And it's not something I would have done if I had not been a

simulated patient because I wouldn't have been aware of the experiences they go through or the trauma, that sort of stuff. I haven't worked with any refugees or asylum seekers, not professionally, but I do have friends that are doing the same or similar course that have personal experiences to being a refugee and an asylum seeker. I don't think I would have become friends with them anyway. I don't think it was something that I would have been interested in. Well, not interested, something that I wouldn't have had enough knowledge to care. So learning about this has helped me make a new relationship, it has made me advance but maybe more than the rest of my colleagues. I feel like I do have an advantage when I do a skills class and we have to deal with cultural competence and diversity because I've been exposed to that as a simulated patient so, yeah. I have told tutors and colleagues that I've done it. And they're like "Oh, that's very interesting." I made the assumption that they thought I would have those responses anyway because I'm a minority. But I think it's more to do with the fact that I did the simulated program.

I know people know that Africa's a continent. I don't think they understand just how different it is. These are 56 countries, if I'm correct, 56 countries with different languages, different cultures, different experiences, different economic situations, different political perspectives. We, well, I'll give you an example, Zimbabwe and Sudan. The difference there would be as similar as Zimbabwe and Australia. We are in the same geographical location but experiences, we're below the equator. So our country isn't as hot as the countries above the equator, which is Sudan, Egypt, Somali, Ethiopia. So, and we can even notice too, they have a darker complexion. That's related to the climate. I do feel as though people can differentiate the French from Dutch or German but they can't seem to differentiate African countries. Maybe it's the skin colour that confuses people. I'm not too sure. Or maybe it's just the assumption that because it's African we have to share one culture or one experience. I don't know. The funny thing about South Africa is my country is right next to it. So when people say "Oh, are you from Africa? Are you close to South Africa" I just always say "You do realize there are 55 other countries in Africa." [Laughs]. I think that there's been a little bit of popular media around South Africa. So it features in films and in TVs and books. I don't know. I'm trying to imagine why, South Africa is doing better economically than most African countries. It was the last country to receive independence so that makes sense.

The role of being a simulated patient I suppose I thought it would just be acting, like act in front of a few students and that's it. I didn't realize the impact it would have on

me. I thought it was just sitting in front of a class and pretending to be someone else. I wasn't too sure how the students would feel about it. So I was surprised hearing some of the responses, how they thought it was possibly the best thing they could have ever done. That made me feel proud. But the fact that it evoked so many emotions in me, that was the biggest impact. Being able to say things that I probably wouldn't have been able to say in a different setting. I could tell people some of the stereotypes they, not say but some of the stereotypes that we experience, I would never tell a random stranger that. I suppose it's, in a way, relieving that I can actually say it out "This is how I feel about certain situations."

There was one particular class where, this was during the feedback, and I asked a student if they could give me questions about things, assumptions they'd made and that sort of thing. And one of the students actually said they weren't aware that, because Africa has so many countries, they don't share as many similarities. She just assumed they all spoke Arabic. I think that's the common known language in Africa, Arabic. I don't even speak it. I never have. So in that moment, because it's something I've always heard but I've never been able to say "No, that's not the case" because I was able to say it then, it was liberating.

Sometimes I feel anger. Because you must understand that I do experience quite a lot of assumptions, a lot of stereotyping. Every single day. So to have students, I value students to be on an esteemed level because I think if you can make it through university, you can make it past ignorance. Well, should be able to, I hope. So I suppose I have a bit more faith in them. So being confronted with those stereotypes is disappointing maybe, yeah. So I could set the record straight in a polite way. You just think, “Oh my goodness. You should know better.” But then I’ve learned that I can’t expect that. I guess it's thinking about what I was taught in my country, which is understanding. We have stereotypes of our own too that we make on Caucasian people. So I suppose a person can only speak of something they know. And I can't blame them for what they've been taught. I don’t know how they’ve been raised. I’ll tell you one stupid assumption I had in my life. I thought every white person could speak English. So you can imagine my horror when I came here and I met white-skinned people and their English was poorer than mine and I thought, “how is that possible?” But that was the assumption I had all my life because English was for white people. So, of course, every white person had to speak English.

As an immigrant, you learn, you educate yourself a lot about the country you're in, to, I suppose, fit in. So I feel as if, because I've taken time to understand and learn your ways, the least you can do is learn mine or at least understand, not accept it, that's a personal thing, but just be aware of it. Australia is diverse. And health professionals will encounter different groups. So I think for a health professional to not know is unacceptable. You can never know everything because, even though I represent my country, I represent the reality of my experience in my country. But I suppose as health professionals, we already know that clients are individuals. So I would assume that, because you take that into consideration, you'll do fine. If you just make yourself aware and then also consider that every client is an individual, you'll be fine.

So I have to self-reflect and then when I hear someone else's story or if I interact with someone differently, before I get into attack mode, before I say, you know, this isn't appropriate, no this isn't, I have to acknowledge why that's your reality. So, for example, you prefer short skirts. Now, I might say, "I don't like short skirts". I don't know if this is an appropriate example but, then, maybe you've always preferred wearing short skirts and just because I okay, I guess what I'm trying to say is, what influences my choices does not influence your choices and I should be okay with that so having had to want people to treat me a certain way, I also had to learn to sort of accept that they behave the way they do. Because of their own history. So every symptom has a story, basically.

The assumption is well, I guess, here we say what do we say? What do they say? Ignorance is not an excuse. But I don't necessarily think that at all times, it's ignorance. I think it's not. If it wasn't a thing that I was accustomed to, I would have never thought of it. I can't expect you to know that this is inappropriate. I think a lot of it would be education. I come from a very conservative culture where it's one way or no way. It's not a lot of flexibility. It's what has been said and that's the only way. You don't ask why, you don't ask if it can be changed. It's that way. My parents taught me that there's, in education, you either go to medicine, you either go to law, you have a white-collared job. That was an assumption. That was how I was raised. So I look at people that do photography and I think, "Why are you wasting your life? What are you doing with yourself? How is that going to pay the bills?" and I've made an assumption that that's ridiculous. But this is a person's passion. This is a person's, that's what they want to do. So just because my parents taught me that's not the way, it doesn't mean it's not the way. We have famous photographers; we

have people that have made a living out of it. I think a lot of it has come with education and my migration so I've learned to just keep an open mind. It's a personal decision to keep an open mind. Someone could never tell you to do it. So I could have stayed and said, "No, you know what, the way I've been raised is the only way; I will not listen to outside influences", and I would have been someone else's nightmare. So I had to decide, then, people are different. People have been raised differently

After the simulation session to get over the anger I guess maybe ask, "How do you feel?" But then the tricky part is if you don't realize that I am angry about a particular thing, you won't be able to ask. So maybe I guess some people have tell signs, their face expression changes or they make a fist or something. But if it you can notice it, then just ask, "How did that make you feel?" And, if they're willing, I'm sure they would say, "Oh, I'm actually a bit upset because of this, this and this"

I feel as if it's been a good experience. Is it enough? I'm not entirely sure. Enough for the learners because what the experience gives them is my perspective. It doesn't give them the perspective of another person. And I think in a way that's limiting. So there's still room for more, I think. I'm thinking I don't represent all of Africa. I could never tell you enough for you to say, "Okay, I've got this. I can talk, I can deal with African community. I can relate." I think maybe more exposure. I don't know if that's feasible financially or if that is even a practical thing but just have different cultures talk to the students. Tell them this is "a" perspective, not "the" perspective, so that it stays with them. You don't want to go into a situation where you go in and you think, "Oh, yes, I remember that African I met and this is how I did it so this is how I'll do it". Because, even regardless of cultural difference, even if you were to meet a person from your exact same background, you would have to do the same thing, not assume that because you know how to handle this, you will have a grasp on this person's story. You don't know their story. Just daily frustrations as a minority. You have someone say I get asked too many questions about how I learned English and you just want to say, "Oh my goodness. I come from a country where they teach English". And you might not be able to do it to someone on the street because it might seem like confrontation but if you tell a few students, you let it out and then you let that go. It might not change the way that people relate to you, but you know that someone else won't have to deal with them.

I think because any profession that deals with people, you need that. You need to understand that, you only experience the world through your eyes. So that is going to be true for everyone. So it should be, it shouldn't be a subject that we do at some point in the course. It should be something that is hammered in from the word go. I actually think that we talk about cultural sensitivity and being diverse and all that and you just think, “Oh, of course I know how to talk to a person who’s different”. It’s until you’re in that situation where it’s uncomfortable to you when you realize those lessons were actually important. Until you’re actually made uncomfortable.

I suppose an incentive to be a SP would be to let them know how it could help them express maybe suppressed feelings. A lot of people want to be heard. I think everyone wants to be heard. So giving people the opportunity and letting them know that that feeling can come from doing the program. I think that would be an incentive.

I think the training was enough. I think you can't create too much because you would take away the authentic emotion from it. So the training was enough for me to, was enough to evoke an emotion and the rest was purely authentic. I think the good thing about doing this whole thing was I got a character that had a blank enough canvas to put in my emotion, even though I had to structure them within the context of that character. But I was still able to express some of those emotions. So I could talk about pain from loss, even though I've never lost a child 'cause I did play a character where I'd lost a child, I could put in the context of that character my experience of loss, even though it wasn’t related to losing a child, but everyone's got something, yeah.

Even though I don’t have refugee experience, I think in a way I am a refugee.
I hope people don't take this the wrong way but, I'm not in, I've been taken away from everything I'm familiar with because of the economic disadvantage. And I am placed in a group where I am constantly having to try and validate myself. That vulnerability is similar to a refugee's experience. I think anyone can have those emotions. It just depends on the context. So if you were to be put in the context of being isolated, you would have those emotions. I suppose most of the feelings that refugees would have include fear, loss, grief, pain. I would be thinking they are distressed, overwhelmed. I’ve never experienced the sort of hardship they have so I can only imagine it and I would not want to be in an area where I’m fearful for the life that I’ve left and being told I don’t belong and being told I potentially can’t be safe where I’m trying to go to. I

mean, yes we have laws, so they do have to go to the detention centres but a detention centres like a prison. I can't imagine them feeling some sort of safety, living like a prisoner. Then when they are re-settled they could be relieved but it's overwhelming. They're thrust into this community all at once and they're expected to just quickly adapt but we don't, yes, they do have opportunities to go for counselling, they have opportunities to heal, but we've just thrust them where they might not be good at English, they have to quickly find a way to communicate. They may not understand how to adapt within the culture and we just expected them, "Well, you wanted to come here so you have to understand". I don't think it gets that much better.

And the fact that I'm an immigrant; I have experienced all of those emotions. I have experienced loss. I lost support systems. I don't have that much extended family here. So if I'm not home I have no-one else to talk to, well, I mean, besides some friends and stuff. But I can't go to an uncle. I can't go to my grandfather. I can't go to specific people that I had strong relationships with. That's a loss. I grieve. I grieve the person that I lost when I moved here in the sense that I can't act African in an Australian culture. I'm persecuted for that. An example of that would be, and I know this may seem odd, but I can't freely speak of my life in the public transport here without having stares. I understand where people are coming from. "How dare you speak your language in our country? You're in Australia. You better speak English. How dare you." And maybe I would feel the same if someone else lived in my country. And I think people have the right to feel that way in a way. I'm also acknowledging that maybe if I was in there shoes I would have the same feeling. I don't know. Religion is another thing. We have certain things that we accept and things that I could never express outwardly without the fear of being judged, or the fear of being called backward or the fear of being called too conservative. I'd rather not give an example of that. So in a way, I mean, I understand why it's done. I understand that sometimes people's beliefs that things have to be a certain way could be validated. But people seem to forget that my beliefs and my realities, this is who I am. I know it's idealistic to think that people could agree to disagree. One person has to take the dominatory role. And in this country I feel as if I have to suppress parts of me just to fit in. And that's what I grieve.

I arrived here at age 16. I did do Year 11 but I didn't want to do Year 12. I didn't feel, I didn't particularly enjoy going to school. People had already formed little friendships. And it's hard cracking those things in Year 11. So I thought, no, I was

unhappy. So my mum said "You can do foundation, year" which is an alternative, and then go straight to Uni, which is what I did, yep. I have one younger sister here. She's six years younger. So when we moved she was 10. She's fit in better than I have, maybe because at 10 you still can form your friendships.

SP work was an added bonus to my part time retail work. It was good that we got paid for it but I don't think I went into thinking "I'm going to get paid." I was curious, money wasn't the motivator. But I never looked at SP work as a job. No, it was more of an experience, I think. It's like volunteering. You get out of it more than you would say, something, like a job I'm paid to do something. I wasn't, I mean, I was paid to do it but I wasn't looking at it from the money perspective. It was more for what I got out of it or what I could give the students, yeah.

When I finish my degree I would like to work in child protection. I'm passionate about that. My parents were divorced at the age of nine. And I think some of the experiences or some of the emotions I faced during that time are things that can't be explored in an African culture. We don't acknowledge mental wellbeing as much as maybe the Western culture does. I think I had been saying I'm going to be working with kids since I was, I don't know, 10 or 11. I wasn't too sure about the social work part but I knew I'd be working with kids. I think because the parents don't appreciate what they go through. There is a lot of undiagnosed depression and that sort of stuff in the African community, particularly because we don't accept those diagnoses. So, and because kids do experience it, depression is a real thing. I speak of it from personal experience. I want to help these kids because I know how difficult it is to have a feeling, to understand that this is sadness but have your parents tell you it's not real when it is real in my mind. It's real. I'm experiencing it. Of course it's real. But I have no-one else acknowledge it. To be honest, they know about it but they think it's another excuse for, well, I hate to say this, but white kids to act silly or it's a way for white parents to be permissive on bad behaviours and that sort of thing. That's the perspective. My parents, I'm going to share a bit of personal details. I had a suicide attempt when I was a teenager. And I recall my dad saying "Oh, attention-seeking. Why? Why would you want to kill yourself?" But they didn't understand that the divorce took such a toll on me. I couldn't explain why I was so sad and why that feeling was so overwhelming. But, it was. And I did know about depression because I read about it back in Africa. But, having my parents tell me that it wasn't a real thing, was almost as hurtful as the experience itself.

It's a hard thing to try and improve your emotional intelligence when you're older as opposed to having the support you need when you're going through it.
It would be harder trying to work in Africa because the general population doesn't accept it. I think I would have more success if I worked with immigrant children in a setting where it is acknowledged. But I do feel as if Australia has enough children rights for me to work with those children. So the parents, working with the parents is something that would be challenging but it's definitely something that can be done because there are all these protective factors for the children because Australia does acknowledge mental illness.

The last thing I want to say is that a cultural sensitivity program shouldn't be just about being aware of people's cultures. I think it's just reminding people to be human, even if we were teaching Caucasian people to relate to Caucasian people, it wouldn't be different to teaching Caucasian people to relate to black people. I think its just reminding people to be human. We live a very busy, in a busy world, basically. I have to do this and we're selfish now. I think we're trying to teach people to be less selfish. That's the whole point of this. I mean, yes, we're talking about the different colours. Yes, we're talking about different backgrounds. But the key point there is just to remind you not to be selfish.

4.5 Conclusion

The three stories in this chapter are set in different eras. The participants arrived in Australia when the country was changing and yet each narrative has similarities.

Aleesia shows multiple identities, from shame of her heritage to pride alongside acceptance over time. Abida's story is perhaps the most memorable. It shows the suffering, resilience and gratitude for safety. It is topical, personal. It gives multiple examples of being different ('other'), moving from identity to identity to fit in. Kabill shows the persistence of otherness and allows the reader to see how this otherness is exposed as a SP then resolved in the simulation debrief.

Each of these stories touches me profoundly. I felt for a moment that I had walked a few steps in their shoes and vicariously experienced the life of a CALD SP. In the following chapter I will present the thematic analysis of all narratives along with the intersectional analysis of participants' identity positions at the time of data collection.

Chapter 5

Analysis of Narrative

The kitten was not his mother. The hen was not his mother. The dog was not his mother (Eastman, 1960).

5.1 Introduction

The narrative stories are the results of this study and each narrative speaks of ideas and concerns the individual held within their sociocultural context. The reader makes sense of and gains insight from each of the stories. The researcher, from the perspective of in-depth comprehension of the narrators, their context and stories achieved through the research process, is positioned to assist the reader to draw together this collection of narratives. This chapter seeks to thematically analyze the narratives across the collection and draw out commonalities for the reader to observe.

I seek an interactive and humanistic approach to an exploration of the perspectives of CALD SPs. As such I was interested in the way CALD SPs construct meaning. Using analysis of narrative the events as told convey individual meaning rather than decontextualized truths (Hardy, Gregory, & Ramjeet, 2009). Like Emden (1998a) I seek to hear, sensitively, what CALD SPs had to say about working as a SP and how this fitted in their lives. Polkinghorne (1995) summarizes these concepts by noting, "Narrative is the linguistic form uniquely suited for displaying human existence as situated action" (p. 5). This awareness is needed to inform comprehensive understanding of the CALD person acting as a SP and to inform intervention decisions with programs seeking to integrate CALD SPs who may recognize similarities in their context.

This chapter will demonstrate how the themes emerged and then, using both quotations and thick descriptions (Geertz, 1973) marked with the Arial font, relate the theme to the evidence in the narrative. Thick description speaks to context and meaning as well as behaviours and actions rather than just providing detail. Thick description also attempts to augment interpretation and lead to meaning from which verisimilitude can be experienced (Ponterotto, 2006). In choosing which thick descriptions to feature I was influenced by points of emphasis and body language of the participants. The context notes introducing each narrative are drawn from my field notes and reflective journal

and influence the information that is emphasized and foregrounded. The analytical technique used to discover the themes was described in detail in chapter 3 (section 3.7.3). As previously mentioned in chapter 3, the themes that emerged from the narratives were The SP Existence, The SP Imperative, Otherness, Learning and My Identity. Each of these themes will be discussed in turn.

5.2 The SP Existence

Through the information provided to participants as a part of the research recruitment process, and the conversations and explanations that followed that ensured each participant was adequately informed to give consent, the focus of the research was always on the perspectives each participant had of being a SP. As expected, each narrative addressed the perspective of being a SP through discussion of the reality of the work and about the experience generally.

Leyla began by talking about her recruitment as a SP three years earlier and related that at the time she had never heard of a simulated patient program. She felt that lack of understanding of the SP role was the likely major impediment to recruiting people from her community to SP work.

> First when I've been asked to be taking part in this program I was surprised there is something like that's happening because it gave us opportunity and the experience for us as well to have this kind of knowledge and then later on pass it on to the student. (Leyla)

> If they (*community members)* know about it and they benefit later on and the student benefits, they will, the whole community will come, just because of the programs limited fund that only needed this particular numbers. Probably when people don't join the program they're not clear about the role and what is the outcome from it. (Leyla)

Initial training as a SP was important for a number of the participants. Preparation, their understanding of the SP role and their relationship with SP educators were highlighted. SP training is not standardized, therefore most SPs would have experienced one or two days of initial training, which included some introduction to simulation, and some practice scenarios and sessions dealing with giving feedback to learners in the debrief. Onam was another person who didn't really have a mental conception of what a SP

might do and explained that the training provided that view. She also highlighted that the training was adequate for her needs using a range of learning styles.

> You know we got the training, which was helpful, and we do need the training. Well it was, like it was detailed and the way, there were PowerPoint presentations. It wasn't just talk, talk, talk and, or just listening and not having a clue. We were able to role-play as well, so get a feel of it. They had sort of examples of someone that had done simulated patient before so, we saw that example too. It also went, not just about the performance part, but then going back and giving, you know, criticism and feedback and stuff like that and the way to go about it, what's positive and what's not, so that was good too, that helped. (Onam)

Abida also reflected on her preparation but placed importance on her relationship with the SP program staff and trainers.

> In the training when the instructors talk, I feel it like, oh, this is easy. It's not that difficult to do it. The simulated patient instructor, when she interview us practice, I told my colleague I love to work with this lady, I love it. I love the work with her, with the school and with what we are doing, it's, we felt it's something will be benefit for everyone. This is what, what's my feeling was. When I hear different stories and different people, everyone start talking their feeling. Yeah, this is make me more understanding what to do when we do the simulated patient. (Abida)

Leyla also considered the importance of the program staff in her training and while recognizing that practicing scenarios with program instructors was a useful component of her training, she felt they were more inclined to provide positive feedback only. She noted that practice with others would be beneficial.

> …you know like I feel if I did wrong it's still like the instructor, want to support me, and want to give me great positive feedback. (Leyla)

Chenai's initial impression of simulated patient work was influenced by peer role-playing in her social work course. She felt anxious that learners would not believe the simulation. Most learners in simulation have undertaken some initial induction that covers such concepts as suspending disbelief, often referred to as a fiction contract, to enable learning.

> I thought it would be hard as in, I would get to meet a lot of professional people. I thought they would know what they had to do, they would be on point, so I thought it would be hard to convince them that I'm acting and this is

> what I have to be. But I have found it interesting because they have no idea. (Chenai)

In contrast Chinh didn't mention any concern that his portrayal would not be believed. He expected that the simulation would be viewed as authentic, even though his simulation was presented in a classroom.

> I think the feedback that I got was that they thought I was a patient from the hospital or from a mental health, you know, from a psych ward coming out to do this "sim", so even though the setting is in a classroom and isn't real but it's the closest they can get. (Chinh)

Khyath described being eager to know the learners' responses when they discovered he was acting. He was equally surprised at how effectively the fiction contract operated and how immersed the students could be. This surprise was tempered by relief. A number of SPs described feeling relieved that the simulation had proceeded as planned.

> So I would put all the effort to make them believe that, "Look I'm not simulating" but when they were told that I was simulating they would be just awestruck and I would be like "Wow, so it worked, I'm all right then" [laughing]. (Khyath)

As each participant experienced growing confidence in their role as a SP they described variations in student ability and modulating their own performance to match the students' abilities. This is not always clear-cut and Onam described her reliance on the simulation facilitator to know when to intervene if the student had a negative reaction in the scenario. At the most experienced end of the spectrum, Onam and Leyla working together described leading an unprepared facilitator through a simulation situation.

> I can tell how they are going from the questions, their body language, the questions they ask me, you know they would ask me a question I would reply and depends on how each individual session goes, that would be the outcome of how I play my role. (Chinh)

> You need to know why you're doing this and then what they're (*the students)* going to gain out of it. So you know sort of what to look out for and probably change the way, you know, you act or you come across. Because if they're first year students, for example, and that's why it's important to tell us what background? Are they professionals, or are they students, so you know to go easy, you know to make it a bit more challenging, because at the end of the day, you know that's what you are trying to achieve for them. (Onam)

> If I saw a student getting stressed or crying, for me, it's not my position to say stop. I think it would be the teacher. Because I don't know if I should continue or not. Maybe she does want something like this, you know, to happen or the students who come across something like that, because as I said, that's what they may deal with. (Onam)

> So the student doesn't know really know our role, why we are there. So being as, like the knowledge I have that the health assessment, so when the student was struggling they didn't know why we are there, and just like the teacher, she was there and I knew they are confused, so I just have to put my hand and I was saying again, "I work in the community health centre and I know the nurse will have this health assessment form." So I just want to give them confidence, so you don't have to know the questions. It's on the form, it's already provided to you and you just start. (Leyla)

> But then when we weren't getting anywhere, that's when the other simulated patient interrupted and said look. (Onam)

Lian chronicled her journey from bewildered real patient to a developing self -image as a professional SP. Throughout her narrative Lian, one of the most experienced SPs, demonstrated her commitment to and control in the SP role. She had moved beyond passively participating with a simulation facilitator and instead exhibited the hallmarks of professionalism. This is a moving insight into the extent to which Lian occupies and owns the SP role when compared with her experience as a real patient, who didn't feel able to take control and ask questions, but is now the instigator and controller.

> I didn't even understand the word like diagnosis. What's diagnosis? I didn't understand. But when I was diagnosed with cancer, so all those words I didn't know. Prognosis. I had to look at the word in the dictionary. When the doctor say, and then I just, when he said prognosis I just write P-G, something like that. And then I went home and look at the word in the dictionary. Because I also felt bad that I am asking so many questions, because for me it's a bit awkward.

> I think there is some like emotional things, parts of the role involved. Especially when I play the cancer role. You just couldn't help reflect it back to your, you know past, all that sort of thing you know when I was having (*pause)* because those things you never forget. You know when you've had cancer those things you never forget.

> I actually often like an opportunity to talk to the tutor before I went, like on the way to the classroom. Sometimes they will brief me, "This is the group like very shy group", and then sometimes they'll say "This is a very active group". If they don't say I will ask them. I will also ask "What sort of group is this?

> Are they first year or last year, active or shy?" and then I kind of know what I'm going to get. And I also ask them "How long do we have?"
>
> I regard simulated patient as a profession because you go there, you are not like, I'm not like a real patient, but I am presenting a real life scenario. So I'm not a real patient. And I am facilitating with the students and the teacher, and all these people working together to create a safe environment for the students. (Lian)

In keeping with a sense of growing professionalism and experience, many participants contemplated students or learners as they considered their own role as SPs. Gabir describes the students as innocents who have not had contact with refugees and the suffering they have endured except on television. He tells of questioning the students regarding the differences between migrants and asylum seekers and refugees with many unable to differentiate between the classifications. SPs have worked with students from year 1 of entry to practice health professional courses who may not have commenced discipline specific lessons all the way through to experienced practitioners undertaking ongoing professional development.

> …they are young and they didn't have that, you know opportunity to meet, they've probably seen on TV, they you know, probably they haven't met someone physically or they might not have had face to face with someone who've been so and active.
>
> Refugee, migrants, asylum seekers you know, because every journey of those people, different categories, have significant impact on the mental and the physical health of, you know. An economic migrant who wants to work here, you know coming from plan to plan, they wouldn't have the same mental health status from someone who travelled fully in a jungle from one country to another country with fear, frightened of animals at night, all of this. So sometimes you think, people would know but unfortunately, I actually asked initially I asked the students whether they know the difference between those and almost I think one student come very close out of 60 students, there's only one student or two students just come close, they know that they're not the same. (Gabir)

As well as observing the level of interest and baseline knowledge of learners SPs demonstrate empathy for the pressure the learners feel within the simulation environment. The concern for the student's feelings arises from recognition that the environment in a simulation is still artificial and that learners are being watched by a facilitator and often by student peers within and outside of the immediate simulation. Aleesia and Chinh both described this awareness and empathy.

> I felt sorry for them in a way, because they're still students in front of other students and they've got to put themselves out and some of them were you know a bit more shy and some of them came very natural but others were still a little bit nervous and I'm sure they were nervous because, I was role-playing, there was the facilitator or lecturer or whoever, the other students were listening in, so I'm sure that must be intimidating to some. Confronting to some. (Aleesia)

> Or even just that, the pressure of doing it, if everybody, people watching you so it's very real you know it might not be in the real environment but it's real for the student. You know added pressure so it's a good learning curve I believe. You have about what, twenty people watching them and they know that they are being assessed by it, whereas as that's a stepping-stone to going to a work environment where there will be more pressure. (Chinh)

Within the theme of "The SP existence" Khyath's experience represents the negative case. Khyath illuminates SP reality more through what he does not say. While others have spoken of increasing skill and modulation of performance Khyath relates a negative occurrence where he was not taken seriously. His impression of SP work lacks the sense of importance and effort in preparation and portrayal of the other participants.

> In the first couple of times itself I found it harder, I don't know why but after those couple of times it was cruisy.

> I was confronted by students who were not able to understand what my situation was or what I was acting as and they started questioning off the track and I was like, "Oh it's not in my script. What do I do now?" I just made up stories.

> I know that I'm simulating but you should understand that I'm not simulating so respect the part where I am in pain and not giggle and discuss questions. (Khyath)

Within this theme the transition from newly recruited SP through initial training and then work as a SP is reported. The participants shared a concern that they would not be believed, and a delight and relief in the observation that the scenarios they were presenting were deemed authentic. They shared concern for the students and actively modulated the complexity of their performance to suit the student's capability as their skill and professionalism grew.

5.3 The SP Imperative

As noted, the central premise of the research involved the participants' perceptions of SP work. The previous theme "The SP Existence" dealt with the logistics of that experience. While still immersed in the SP space, this theme titled "The SP Imperative" is concerned with the underpinning emotional obligation and duty to undertake this work. This theme speaks of a deep and strong need, almost evangelical for some, to spread the word about their culture.

Many participants linked their decision to become a SP to events in their past to help explain their motivations. For Lian, reflecting on her cancer diagnosis years later, the realization that a simulated patient could have saved her from insensitive student physical examinations was an important insight and driving force.

> I remember when I had cancer and I was in hospital, like the day I was diagnosed with thyroid cancer I had 10 students coming to, you know, touch my neck. To be honest I felt pretty bad, I was so anxious and yet the Doctor didn't come and the students all came to touch my neck and then they also talk to each other like you know, like oh "do you feel anything?" and stuff like that and I was there feeling anxious about my life because I didn't have much knowledge about cancer at the time. Then I really did feel if I were a simulated patient at the time that would be different and then I thought yeah there is a value for using simulated patients from my own experience. (Lian)

Gabir expresses the relief he feels sharing the weight of responsibility he perceives to unburden himself in a manner that assists his community, especially when undertaking scenarios that deal with mental health issues. For some cultures, including Ethiopian, mental illness is not commonly recognized and therefore opportunities to intervene and provide management to those with mental illnesses are delayed or missed. Gabir considers education the key to improving understanding of health professionals, especially when dealing with high-risk groups, such as Ethiopian refugees, who have experienced significant trauma. Gabir himself was a former refugee who had a traumatic flight to safety.

> And also it's a reflection of the issues within my own community and the community I work with so one of the, I think one of the things I've done was mental illness, mental health issue so it become, it reminds me, you know some of the mental health issues with my own community. But also I feel happy in the relief because I felt I shared my experience and those students

> will go to the field having you know, equipped with some of the basic knowledge so I think for me, I have, it's kind of I have done my responsibility, my duty to you know, share my experience to educate those young people who will be going to the field and then, and those people will assist the community I belong. So yeah, it can be both ways, number one I was happy I share my experience, you know shared some burden from my shoulder as it, but also I thought I make a difference to the knowledge of the young people who are students.
>
> So this kind of thing really it's about frustration and why people lose their life. So I think even if I think, I thought about the frustration and the emotional stuff but also I have a sense of pride and a sense of happiness at the end of the *(simulation)* session because I really, I feel like I have done well to see what it looks like as a worker, new graduates, what it looks like to be in that situation and they do observe that emotion also. They do observe that emotion because they can tell, they can read how I'm presenting myself, and they can read it's even if I am doing the role-play, the simulation, but they can see it's real. It's real, real story. So, and I feel also happy because, well, I have done, I think I have done, my job in terms of getting that message across. (Gabir)

The motivation to improve conditions in multiple ways for the community was frequently addressed. The relationship between the accumulation of new knowledge for the individual that could be transmitted to the community as well as improving health interventions was paramount. Leyla sums this up with pride.

> Now I'm sharing it around the community and saying, "I've been in this simulated patient," sometime I say to them, "I'm very proud to be taking part of this simulation patient in this university," and they *(the community)* say, "Oh, that's very good Leyla, that's wonderful experience. You will be able to share and get knowledge at the same time and share your experience with others and make a big impact on both, like me and them and the community and the student." So really, everyone say, and why they don't apply it in every single hospital, and university? That's stuff like that, it's very important. (Leyla)

Wages for SP work were often identified as adequate and more frequently as a bonus with a number of SPs suggesting they would work as a SP, even if they were not paid.

> It was good that we got paid for it but I don't think I went into thinking "I'm going to get paid." I was curious, money wasn't the motivator. (Kabill)
>
> I'm doing it because it's something that I really want to do. I find it satisfying I feel that I am contributing in this manner and okay the money is a real bonus but I would have done it if it wasn't for money. (Aleesia)

Many participants reflected on the cathartic effect of being able to express how they felt as a simulated patient. They often recognized this as relief and a positive motivator to continue as a SP. Kabill mentioned these sentiments more than once, and described the feeling as empowering initially and then reflected on the impact this had on her including the relief of sharing.

> Having a voice as a simulated patient is empowering. I know I've probably not made that much of a difference but in the small group that I have worked with, I feel that it's important because at least, even if it's 30 people that know, 30 people that are aware, it's better than zero. So, yeah, it's empowering.
>
> I didn't realize the impact it would have on me. I thought it was just sitting in front of a class and pretending to be someone else. I wasn't too sure how the students would feel about it. So I was surprised hearing some of the responses, how they thought it was possibly the best thing they could have ever done. That made me feel proud. But the fact that it evoked so many emotions in me, that was the biggest impact. Being able to say things that I probably wouldn't have been able to say in a different setting. I could tell people some of the stereotypes they, not say but some of the stereotypes that we experience, I would never tell a random stranger that. I suppose it's, in a way, relieving that I can actually say it out "This is how I feel about certain situations." (Kabill)

Gabir echoes the feeling of empowerment and explains that he answers his memories of trauma through educating others, to make a difference, for those who follow him.

> So even though it's emotional the empowerment is stronger for me. I think it's the most important pathways because that's why, because you know, when I, I think about any impact, after I finish I would say yes I have done, you know I educate people, I have that, it's not about the relief, it's not about I say what's inside me, but it is, I educate people. It's satisfaction because I would like a difference, I think this is my purpose of joining this simulated patient, it wasn't the employment side of it which really interests me, it's more about you know, that educational component. (Gabir)

These ideas of expressing oneself and feeling relief expand for many participants as they explain the "reality" in the simulation scenarios they perform in. Simulation programs utilise a number of methods to produce authentic scenarios including developing cases with real patients. The SP uses real experiences to portray the emotion when working as a method actor. The SPs draw on composite stories of their own and from people they have known to bring the personal authentic detail required in the simulation. Many participants believed that the scenarios could not be effectively portrayed without real

experience to inform the SP. The close bond between simulation and life is clear as discussed by Gabir, Chinh, Aleesia and Abida.

> I don't believe someone, unless they have that experience, will portray me in that context because this is where, when you're doing a role-play or simulation but you, sometimes you struggle with self to hold, "Hang on a second, I'm doing simulation I'm not talking about my real life." But without knowing it you are *(pause)* Yeah. Without knowing it that whole emotion just start to come. (Gabir)

> I think it's more authentic if the person has real experience and I think it's very hard to find someone who has actually been through it and if even if you can find a person who has been through it are they willing to do it because it might bring back some memories. (Chinh)

> A physical pain can be the experience from a specific physical pain can be drawn from something you have experienced. But a cultural portrayal is an emotional thing rather than a physical one. So providing feedback would be different for a person who hasn't been through that experience because once again it is a learnt thing rather than a heart felt thing, because I think in that respect you've also got to learn the answers rather than give a feeling of the response. (Aleesia)

> When we deal with the students the first time, it was really, I say "Oh, it's easy." It's not that hard for me. Because I'm talking what I have feeling. It's something I created from different story, something was inside me, and it's true. It's not acting. What the students ask was, I feel it in my life. (Abida)

Chinh was the only participant who related a story of needing to debrief in order to de-role from a character. Despite the connection to emotion that most participants made they did not recognize a lasting negative impact. It is usual to offer a SP the chance to debrief after participating in a simulation although this is not compulsory. In view of the emotional nature of some roles, simulation staff would recommend the SP debrief. Hwei-ru presents the most extreme account of managing her emotion after simulation.

> I went straight from the simulated patient straight from the Uni to work and I found myself talking a little bit like I, you know, I was still in role at work as well. So I recognized it and I try and stop it and then when I went home with my partner yeah I did it again but then that was it. (Chinh)

> I can control my emotion as a simulated patient. I think I am very strong. Afterward I can relax. I can forget something. Today I am playing a patient for mental. I am worried, anxious and things. But the finishes the class. I go back. No problem. Going out I'm feeling is happy, everything good? I forget this story.

> Just finish it today. And tomorrow morning I'm thinking again because I need to work again. You know what I'm saying if not able to forget then I am sad. At night nothing, I don't worry about the case. I think though I have good control. I get this control by thinking of the happy things, yeah, I finish the University job I'm going out and look at the blue sky and look at some things, making me happy. (Hwei-ru)

Rather than the expected or typical recognition of debriefing after an emotional simulation scenario, the participants spoke more of recognition and feedback within the simulation space. Several participants mentioned receiving applause when they were introduced out of character, while others spoke of the impact on the learners of their performance being recognition that their message had been internalized. Despite not focusing on debriefing, the idea of being made or kept safe through the performance aspect was identified by Leyla.

> I'm there to collect the feedback and to gain like a perspective that they understood our culture and maybe later on it will be like they know more about the Islam culture, or more about you know the different culture.
>
> So I was protected. It was something to do with me again, with, I didn't have to be shared, I felt like I am safe and the message will pass from the client to the student. So, I felt like the whole process, there is nothing that will hurt me culturally. (Leyla)

Whereas Gabir is more direct.

> Some people, they become very emotional about it, they cry and I say I win. So you know, inside me say yes that's, I win, so this is my emotion, so welcome to it. (Gabir)

The participants felt a strong bond between their work as a SP and their cultural heritage. While some said they would do this work regardless of whether their cultural needs were highlighted in the simulation scenarios or not, others said this was the driving force for their work as SPs. Lian, Hwei-ru and Aleesia exemplify the variety of perspectives.

> If the simulated patient work was not related to my culture I think I would still be interested. Because I'm interested in helping people. (Lian)
>
> If I look for some simulated patient job or work and I think I should be understand the work, if it is about medical sickness and not culture, I will do, what they ask me to do. (Hwei-ru)

> It wouldn't have been a priority to get involved if the purpose weren't cultural education. You know if I had absolutely nothing else to do and I'm into doing a lot of voluntary work so that's fine but it wouldn't have been one of the priority ones. It really touched me and touched right into my psyche. (Aleesia)

5.4 Otherness

As participants told stories of their life that related to their work as SPs the notion of difference and often being marked as different arose. This theme showed that all the participants recognized points of difference in their own and others' lives. Often they attributed difference to negative connotations of disadvantage and sometimes shame.

Variation within this theme was apparent as individuals moved through a continuum of positioning themselves at various times as an outsider and "other", through to regarding themselves amongst a collective of sameness with the prevailing group.

Examination of this theme begins from the standpoint of historical cultural observations of "otherness". Otherness is then observed from the viewpoint of the individual before widening the lens to view otherness from the perspective of CALD experience. Finally, otherness is viewed from the position of alignment with the majority. To experience otherness the person has to be aware of its opposite. Seeking sameness or likeness with others moves the person along the continuum and away from being "other".

Aleesia as the oldest participant observed the changes in society brought about by multiculturalism. She elects the Vietnamese community as an ethnic group previously vilified. Chinh as a member of the Vietnamese community makes a similar observation.

> Why can't they show, perhaps what it was like in the Vietnam war time you know, when the boats were coming in and just show the positive sides that we've got out of that? Sort of let, allow people to understand, I mean we're a country of migrants for goodness sake. (Aleesia)

> Being a refugee you know living in a refugee camp, just the hardship I guess you know I have to adapt to a totally new country you know and find my way around. I was eleven. I lived with my brother, brothers. I was born in a war torn country so my family was scattered everywhere. It's pretty normal you know when you are born in a war torn country that your family is scattered everywhere running away from the war and experiencing the racism and the prejudism {*sic}.* Because when I first arrived the Vietnamese was the newest

> ethnic group to arrive to Australia so we were the target so we had to put up with a lot of that. (Chinh)

Many participants related stories of individual difference originating from their culture or ethnicity or arrival mechanism in Australia. In particular, they told of how this difference manifested or impacted them in their lives. Lian begins by explaining that cultural difference can impact medical consultations and her experience with her father-in-law.

> And then also the doctor was asking him to do whatever test, and he didn't want to do it. And then I said "Then just tell the doctor you don't want to do it" and then he said "No, no, no, the doctor will get upset". But then he didn't want to do it. But then because he felt the doctor would get upset, and then he had to think, think, think, couldn't go to sleep, "What should I do?" He struggled, worried. Worried for a few nights, and then he still decided to do it because to make the doctor happy. Otherwise the doctor may not want to see me again. (Lian)

Chenai, relating to being assessed as a simulated patient, revealed how questioning and commenting on her journey to Australia can be alienating. The experience is significant to the person who has made the journey yet distant, to the assessor.

> But the personal questions are "so where did you come from, who do you live with, how did you leave?" You actually find someone to say "Oh it's really bad out there we watch the news" and you're like "Yeah you do. I know I've been there you've just watched it on the news" and they are telling you how horrible they have just heard it is there like "it's quite bad isn't it?" and you're sitting there thinking yeah it is! (Chenai)

Onam feels marked by difference in choosing to wear a hijab as part of her sense of identity. While Kabill also feels marked and labelled as "other".

> Well it just, because we're supposed to *(wear the hijab)* and then my dad was sort of strict anyway, so it's not an option. If I didn't cover he'd disown me. So yeah, like that's not an option for me. Yeah, and like my husband doesn't care. He tells me, do whatever you want, he doesn't care. Yeah. He tells me, if it bothers you take it off. But then I'm like, it's who I am, like I can't, I can't any more. (Onam)

> Being separate, recognisable, all the time, it's always there. All the time, I struggle with it day to day, every single day, it's a struggle. We talk about it, we do, yeah, like for me, when I was working at the bank, I used to work, and I used to say to myself, you know, if I wasn't (*wearing a hijab)* I probably would have been able to get up higher positions and stuff like that because I

> wouldn't always feel this way and so yeah, I feel that that affected me in work as well. (Onam)

> I describe myself as marginalised in Australia because, for starters, I have to assume the title of immigrant, or permanent resident or someone on a bridging visa. (Kabill)

> My skin colour's the minority in the country. (Kabill)

> I grieve the person that I lost when I moved here in the sense that I can't act African in an Australian culture. I'm persecuted for that. An example of that would be, and I know this may seem odd, but I can't freely speak of my life in the public transport here without having stares. I understand where people are coming from. "How dare you speak your language in our country? You're in Australia. You better speak English. How dare you." (Kabill)

Aleesia told many stories of individually standing out as "other" during her childhood and being ostracized and segregated.

> I was definitely ostracized by the class, by the kids in the classroom because you know it was only a few years after the war and these kids were saying my father shot their fathers in the war and all that sort of stuff so that was very prevalent within that community and I remember having fights after school. Physical fights after school with kids because well I didn't even understand at the time so there was a lot of prejudice. It was just about being different and not being able to communicate.

> Bringing food, of course my Mother couldn't eat anymore with all the chemo and stuff she was having. We were bringing the food and you know we felt a bit like we were doing the wrong thing, because we weren't made to feel that it was okay to do it you know "OK yeah if you want to do it, but there's food here, why can't she just eat this food?" (Aleesia)

Similar to the individual stories told of perceived otherness, participants also told stories in which they noted where their community or cultural group was perceived as other. This perception rested with the individual participant, that everybody with a given characteristic was positioned outside of the mainstream or part of a minority, often as a result of stereotyping. However, the participants themselves also expressed these ideas that separated them as a cultural or ethnic group and identified with or focused on difference. An example of this latter is the observations by both Kabill and Gabir about African cultural beliefs related to mental health. Relatedly Onam separates her community from the mainstream and stereotypes a position that suggests the community is "other" to mainstream as well.

> There is a lot of undiagnosed depression and that sort of stuff in the African community, particularly because we don't accept those diagnoses. So, and because kids do experience it, depression is a real thing. I speak of it from personal experience. I want to help these kids because I know how difficult it is to have a feeling, to understand that this is sadness but have your parents tell you it's not real when it is real in my mind. It's real. (Kabill)

> Because community, the different communities, particularly the new arrivals, people from Africa and probably Asia also, and the people I work with, mainly the African communities, we have a different way of looking at mental health and we have a different way of treating mental health, but in this modern country we've possibly got every facility, they're not accessed. (Gabir)

> You're never going to satisfy everyone, especially like from our community, as in they expect everything, you know, to get everything and everything should be like given to them you know, or, if something happens, that's it, they'll blame and go oh everyone's against us, or, it's not good enough or the government's like trying to do this, or whatever. (Onam)

Leyla is sensitive to the negative perceptions of Islam, and the ready recognition that women, such as her sister, who choose to wear a hijab endure. She is also aware that people who hold the Muslim faith are stereotyped. She classifies herself as a defender of her faith as she differentiates between bad people and believers in Islam. This awareness is echoed by Onam.

> I feel scared about my sisters because she is covered. You know I feel like if something goes wrong in the media for Islam and every time I feel like I have to be with her, I won't let her go by herself. Again the culture, again they have to be together walking. They feel against, there is you have to be supported by other, but we feel scared yes. It's not us if someone bad, we don't want them to label all of Muslim, all of that.

> Every time. If I hear stories someone murdered someone I say, "Tell me what nationality?" If by example he's Asian or something I feel relaxed. Even though it's bad, but I feel relaxed. All the time. Yeah so really sometime I don't watch the news. I don't hear news. When they tell me something shocking, so I don't want to have this feeling, negative feeling. I want to feel people love us, we all love each other. I want to have this feeling. Like when sometime they say oh this, like even like with work and everyone they say a Muslim and that, you that. I say "It's not Muslim." I say, "Don't label the Muslim. This is bad people." So I'm living my life to defend my religion and my culture. (Leyla)

> That's why I say, it's so hard on like the girls. Like the guys, they don't care, they can blend in and, you know what I mean? It's the hardest for us, it's, yeah, you know, we always have to cop it and deal with it and then sometimes they say why most people are bitter or are trying not to fit in. Well obviously if you don't give us the opportunity, well then that's the way they're going to feel. (Onam)

Abida recognizes a similar stereotype for people who arrive in Australia as refugees. Often asylum seekers and refugees who arrive by boat are smuggled into Australia and treated as criminals. The process of refugee internment is strongly akin to prison and reinforces this belief.

> It's important for me to share my story, because I want to let the Australian people how the refugee coming to Australia. Eagerly not illegally, legally. Yes. This is what's good to make them know, how much we suffered. It's not like they are born here, they didn't see anything. They don't know what's happening around them. But when they live, know about us, maybe they will change their mind. (Abida)

Aleesia also spoke with passion in her story considering the prevailing attitude to migrants and refugees in Australia. The otherness directed at refugees was objectionable and failed to consider their plight.

> And THEM *(refugees)* they're always talking about THEM. They don't humanize it they don't talk about the people, the children, it's so negative. (Aleesia)

Khyath's stories while displaying the theme of otherness have an alternate perspective. Rather than cast himself as "other", he implies that students from other backgrounds have inferior attributes as students and will not perform according to plan in a simulation. He also relates a story of using his knowledge of different sects to deflect a difficult question in a simulation. This is the only story of manipulating otherness to advantage that was told.

> When I stepped into that class there was a lot of students of very different backgrounds and because they didn't know that I was not a real patient, I knew that they would not stick to the script. I knew it definitely before I actually stepped in and started acting.
>
> And then I had to make a story about it. I think I had to say that I was belonging to a certain sect where I can't really talk about it much because I didn't have an answer for it. (Khyath)

Whereas otherness communicates understanding of difference, several stories made reference to a perception or desire to be a part of the majority. Chinh moves across the continuum from outsider to a sense of belonging as he summarizes his adolescence. He readily identifies as other in his youth as a Vietnamese refugee but then relates to himself as a typical teenager growing up.

> School was difficult and you know I think that was, given my experience that's how we started to form gangs and it's not even gangs we would just get into groups just to protect our self. I think that's a lot of how gangs start, you get together with the people with the same experience and then the groups form gangs, stuff like that. Over time I wouldn't say it got better I would just say over time people find somebody else that's newer to target. If you look at it now it's the Africans or Sudanese or Indians. So yeah I don't think you can ever wipe racism or predjudism {sic} its human nature to have. I think so, people need to be educated but it's funny how you know I remember when I was in Vietnam we were very racist towards the Chinese and other people that come into Vietnam so its human nature. I think you know racism and prejudism, stereotyping all that I think it comes from the fear of difference and even fear that someone is better than you, you know? So I don't think we can ever get rid of it as much as we want to. It would be a perfect world [Laughs] if we can. We can do something about it you know but I don't think we can ever ever get completely out. But when I think back to that time I was very happy, I was oblivious I was just your typical teenager growing up. (Chinh)

Onam told two distinct stories of occasions when her actions suggested she was working to be recognized as more "same" and less "other". In the first example she was a part of a formal program that sought to demystify cultural and religious difference by recognizing points of similarity. Conversely, in the second story Onam demonstrates that she is aware of the apparent contradiction in her action as a recognizably Muslim woman, but puts aside her difference to participate in a mainstream activity.

> I've also worked with the city council. (*Named program)*. So they chose five people from different backgrounds, and I represented the Muslim community. And then pretty much they had, four dot points about what we are. So with me it was professional accountant, doting Mum, likes a girl's night out, and then all of the above. And that pretty much had that's for everyone. And then it shows that we are all the same, no matter, don't judge us.
>
> It's like, you know, on a few days ago I took the girls, to take photos with Santa, I do it every year. And he *(Santa)* was so happy, he goes oh, like I'm so happy and good on you, and I know you don't celebrate Christmas but it's very nice to see. I go no, I do it every year. Yeah. And for me you know, it's

> just a celebration, I love it. You know, it's a happy time and it doesn't necessarily, like you don't have to believe in it, but celebrating, why not? And it's nice, like, as in because everyone complains oh, you know, they're in our country, and they don't follow our ways and all that stuff and as in they're trying to, but like that's what I mean. (Onam)

Finally, Kabill takes the perspective that even when one feature recognizes differences it is still possible to see similarities. Despite being aware of otherness she seeks empathy that constructs a link that can unite experience.

> You look past the person's colour; you look past the person's presenting problem. You might recognise something that's similar to you; they've had a similar trauma, they've had a similar emotion. So look past that and I know, because it's the health profession. We focus on fixing a problem so we don't always show empathy. (Kabill)

5.5 Learning

The theme of learning had contributions from all participants. There was differentiation of what had been learned and recognition of that learning. Some people were consciously aware of what they had gained and how they had learned it, whilst others were not. Some features recognized as learned were related to outcomes of SP training while other learning was unintentional and could be attributed to the new experience of being a SP. The third category of learning was the unanticipated insight that some people gained.

Intended learning recognized by the participants included how they performed in their SP role as well as how they delivered feedback to learners. All SPs had undergone training to perform the various roles they had been allocated and all had been trained to provide feedback to learners in the debrief. Not all learning situations require feedback from the SP. Some people were more experienced with feedback than others, yet they had all been trained in techniques to use for performance and feedback to learners. Onam, Leyla and Lian explain what they have learned from training.

No matter how much you prepare it's never the same as when you, when you're actually doing the role. But it was good enough to be able to actually do it good, as in getting the positive feedback obviously the training was beneficial and I learned from, it. It was the second training, the one when we met at the venue. That was where I was able to ask all the questions, get all the answers I needed, just verify and make sure I was all right. (Onam)

And then to find out if the students gave good feedback I asked the program staff to give me a call. The students said it, it was like a bit more detailed, as in they found it important, useful, and I was very convincing and stuff like that. (Onam)

I get knowledge like when someone make a mistake and the *simulated patient instructor* pointed that you don't straight away tell them the negative things in the beginning, you just give them their positive things and then later on break it down like you know, it will be this way rather than, "Oh, that's wrong, that shouldn't be like that." I have definitely used this feedback lesson. I will think about it first, maybe like in our culture we could say, "Oh, this is wrong," but it's like when we learn from the expert, and then every time something happening and, or even it applied to my family and apply to the community, I have to think first of the word, like the instructor says, because again if we make it sound like this is no good, again it will break there, you know, confident, but you know, I use a lot of the technique that I learn during the training. (Leyla)

It's a lot to think about it. And then when thinking about it you don't want to let people know you are thinking. You can't stop acting. You must be doing simulated patient and then you actually, I don't have much time to organize my final feedback thing, because a lot of time they just run out of time. So I keep it all in your mind how many students and who you want to say, and then give a general audit sort of thing. Yeah, and I always open up with the positive thing. (Lian)

The learning achieved through unintended mechanisms was diverse. Personal development included knowledge that was useful in the SPs substantive employment or vocational education as well as general learning that could be shared with the community. Khyath, Chenai, Hwei-ru and Kabill all share examples of this type of learning.

I got to learn about mental health because I was acting as a depression patient. I always thought depression like someone was being sad. (Khyath)

When I say educative I mean I sat in on one simulated activity where there was nursing students I think it was a whole group of allied health students

and I saw those with a strict medical background sort of like struggling with how to actually build the rapport and seeing the ones from much more social backgrounds also show education. Yeah they were quite good but it was interesting to actually make the distinction, before this person actually introduced themselves or after they introduced themselves and you sort of listen to their questions and you're like they are very much just interested of how my temperature has been and what is going on. (Chenai)

During the simulation you try to say, you try to talk to the interviewer to say yes and look at her (*the client).* You're trying to say look at her, try looking at the patient and they will still look at you *(interpreting)* so that's really the only feedback that I give them to say try looking at the patient and not me, I don't matter. It will be fine in my practice as a social worker because now I know never to look at the interpreter. [Laughs] (Chenai)

You know I learn the aged care, the course. Finish it. I should go to the aged care facility people. They, the course asks the people to pay respect to different beliefs. I understand the different beliefs because of the work with the simulated patient. (Hwei-ru)

I did think – well, considering that Australia has so many cultures, yes, I did need cultural competence education. I assumed that, being African, I would just, I don't know, all I'd need to know is being African. But then I had to learn to respect and understand the different cultures, the different religions. I had to learn more because it's easy to think that I'll go into a certain area with my set of values. I also have to acknowledge other people's sets of values and because we have so many of them in the Australian community, I had to learn. (Kabill)

The final area of learning that participants told stories about related to unanticipated learning or insight that was gained through SP experience. Gabir told of the importance of his own education in moving forward after arriving in Australia as a refugee. The opportunity to participate as a SP became his contribution to the education of others.

I was the only black person in about 30 students. So I was a stranger. But I don't present myself as a stranger and they accept that as I'm one of them, and that's really I was unique and that uniqueness really helped me a lot. People put more attention towards my welfare and my education, and every single student in that group for two years has really, they want to make sure I am at the right level in my education and they commit. Yeah. I am one of them. I receive my lecturers, my teachers, my students, they were standing with me. They really support me. They help me to walk and run, and that's critical. So the message is if you really understand someone and try to help them they can achieve a lot. (Gabir)

> Education, that's an opportunity. I think that's, to me that's once probably in, opportunity to make a difference because to educate the community, as I say, you start from zero and it's a hard way, it's a really hard way, but to educate the professionals, particularly at this early stage of their education, I think that's, I thought that's quite important. (Gabir)

Kabill's narrative details her feelings of living a life labelled as other. She talks of viewing herself in comparison to others in the world. Her insight came in the form of exposure to the needs of refugees and asylum seekers, from which she has developed a new interest in people with these backgrounds. However, her real insight was that despite feeling she was from a minority, this did not give her knowledge of other tyrannies.

> I couldn't say I could relate to refugees and asylum seekers. I'd never lived that life. But doing the program, the simulated program, because I had to put myself in character, I suppose I was more aware of the emotions and what they go through. And it just, it made me realize that maybe I am actually as ignorant as the rest. That's confronting. (Kabill)

Several of Onam's stories relate her concern for identification as a Muslim woman. She feels this separates her and she provides a number of examples of efforts she makes to be understood and accepted. Her insight relates to a belief that people were judging her.

> Simulated patient work has changed the way I feel too. Because then, I actually know, you know what these people are not really judging me. Because I was under the impression that I was, the people were saying oh look at her blah blah blah, you don't know what they're thinking, so of course you think the worse. But then when I meet new people and I meet all, from being a simulated patient. These people actually don't care and are trying to make the effort of learning different cultures and are not judging you because of the way you look, or come from or, and all that, so it makes me more confident. (Onam)

5.6 My Identity

The theme of "My Identity" deals with the constructs by which the participants defined themselves. Throughout their narratives people spoke of the multiple meanings they held about themselves and their relationships to identity categories and groups. Membership of identity groups was not static for most people but seemed to influence their thoughts and perceptions. This theme represented a continuum of acceptance of identity. At some point participants accepted identity and labelled themselves, while at

other points they resisted an identity and were keen to be seen divested of a characteristic. Many of the identities mentioned are acquired during simulation.

Chenai, as previously noted, identifies strongly as a social worker and is pleased with the psychosocial approach to patient assessment she witnesses in simulation. In developing a simulation character Chenai explained that she borrowed background from others and incorporated her own as well, to form a composite character.

> I'm obviously going to combine my experience and all the other experiences that I have had from people that are here and people that are back home going "Oh yeah going up the road you meet this and this and this", it's interesting. I'm not going to tell them any names or going to say this is what happened to someone. (Chenai)

Nevertheless, she reveals insecurity in this character and relief to be revealed with a different identity. This is despite the fact that the characterization she has developed is made from aspects of her own background.

> I thought it would be really bad to say okay fine they look at you, and obviously when you are in the character role they think that it is real. And who knows even when you do get out of character someone might still have that lingering saying "that was probably, is her life story" and they would still hold that against you. It's fictitious and it probably has been a bit dramatized. So you're, it's not something that would bother me. I'm not going to see them again and when you do get out of character, they obviously show relief on their faces to go "Oh yeah that's interesting, but you?" I was worried to say oh my goodness what if they just hold that thought "that is her!" Well it's obviously because of the whole race because they are going to look at you and go like "oh yeah she is African we have heard things like that". (Chenai)

Chenai's stated relief at reverting to her whole identity suggests she feels some risk or discomfort in the sympathy that learners show for that character. Her relief at divesting this identity is visible.

> Some of the character roles are confronting. I've had to listen to my friend sort of like talk about the background of where we came from our country and something like that even from interpreting for her and you look at the person you are telling and how they sort of feel sorry for you, makes me stand back and say okay this actually has a tiny bit, like it affects me just a little bit but the whole getting out of character and introducing yourself to say "No I'm not that, my name is Chenai and I was just you know I was playing", so yeah it just relaxes you. (Chenai)

Hwei-ru's stories of identity suggest that occupying a role affiliated with a university provides a positive status she is content to inhabit.

> In China I was a university lecturer in management. My friends, I don't think they can understand *(About the SP role)*. I just say I am working here, I have the very interesting job. Yeah. I don't explain. Some things they don't understand, I say I am an assistant to the class. Too hard to explain. I understand these things now, but I don't want to spend a lot of time to explain to them when they don't understand. I just say I assist in the class, at university, and it's a very interesting job. (Hwei-ru)

Lian recognizes that her identity was irrevocably changed by her cancer diagnosis.

> Before I had cancer I was so busy, I was so so so so so busy first I came to Australia as an overseas student, I was just totally absorbed by the learning, the English all that sort of thing. I was so busy with my studies to catch up with language all that sort of thing and then I straight away I got a job, a full-time job, I really didn't have much time. [Laughs] After cancer I think my, how to say, my attitude towards life has changed a bit. Like I no longer view making money as the most important thing. I find that you know life has a meaning. I sometimes, I think having cancer is a good thing for me. I didn't die a) and b) I think I maybe my caring nature started to show. (Lian)

Abida presented a complex mix of identities and loss of identities as she recounted her story of life in Iraq. Fleeing her home with no papers after it was burned, she initially could not prove that she was a citizen. Later in her birth country she faced a negative allegiance with America, and also as a Christian that threatened her claim to her own citizenship and identity as an Iraqi.

> We left to Bagdad. We moved there like only my mum, she was the one take care of us, and she took me to school, to public school to enrol me. They say, "You don't have any ID. How we don't know you are not Iraqi." And she said, "Yeah, we are Iraqi, but everything is burned, they burned our village and everything is gone." They say, "No, we can't accept your daughter." (Abida)

> I stand in the queue to get bread, I was wearing a cross and one of the Muslim ladies, she just turned like this on me and she said, "You are Christian. Why you are standing here to get the bread. Let Bush give you bread." At that time America was bombing Iraq, and I look at her, I say, "Oh

> my God, what's wrong with these people?" I scared, I thought, "Oh my God, she will kill me now." In my own home, in my own country, and living there at the time. (Abida)

Both Kabill and Onam examined the contradictions of identity that they experience in real life as well as in simulation. Each acknowledged competing spaces they occupy in different ways. Onam recognized that the simulations feel real and have negative energy but suggests separating real experience from the simulated environment, thereby creating two identities.

> I think, simply put, I live in a country where I have two identities. So I can't be – in a sense, I can't be African in an Australian culture. I have to assume one in different situations and the other in a different situation. (Kabill)

> My number one hint for others? Trying to be as real as you can, for each situation, get yourself away, your personal experiences. If you have gone through stuff like that, keep it separate. Because I know it can affect the students, because I know somewhere, some do cry, and then they get scared whether it is an act or, is that really what they go through? So it puts stress on the students as well. And just to remember, at the end of the day you're only acting. Basically for training purposes and to deal with others. (Onam)

Aleesia is the only person who mentioned a resolved identity. Her narrative told of her adaptation in Australia and denying her ethnic identity. Eventually, she moved past this state to reclaim her ethnic identity and to find peace within herself.

> As time went by and as I came to learn the language and then because I was able to communicate and then things turned. Although, I must say I was well and truly in my 20's and maybe even a little older when I really became very comfortable with myself that I was of ethnic background. I have just gone through my drawers and trying to get rid of a lot of junk and you know you get little receipts for something or another and my name on those receipts is (*shortened and Anglicized)* rather than *(original Italian name)* just so I could sound more Anglo. It was very strong, very strong to try and fit in. I was very embarrassed by my name. (Aleesia)

5.7 Conclusion

This chapter has explored the themes arising from analysis across all of the narratives. Participants have contributed to the themes in different ways or from different perspectives. At other times some participants have exhibited remarkably similar ways of considering the points examined.

The narratives of this group of SPs, working in simulation and using method acting techniques that draw on past experience, give rise to the aforementioned themes: The SP existence, The SP imperative, Otherness, Learning and Identity.

The SP existence and The SP imperative have shown how this group of SPs relates to SP work and provide some insight into their motivations for being involved in health professional education. The Learning theme demonstrates some of the intentional and unintentional learning that has taken place as a result of working with health professional learners in simulation. The themes Otherness and Learning and Identity explore the way these SPs perceive themselves in life and in simulation. In the next chapter an understanding of how the subjects of identity and otherness interplay in the lives of SPs, as they move in and out of simulated environments, will be explored in more detail.

Chapter 6

Discussion

Now the baby bird did not walk. He ran! Then he saw a car. Could that old thing be his mother? No, it could not. The baby bird did not stop. He ran on and on (Eastman, 1960).

6.1 Introduction

The themes identified in chapter 5 are considered here, in light of the theoretical construct of intersectionality. In this chapter I have advanced from the information presented in the findings and analysis chapters, to establish new knowledge (Evans, Gruba, & Zobel, 2011). By exploring the way in which the narratives of CALD SPs demonstrated the participants' vision of their world, a new model of CALD SPs is presented.

The opportunity to perform as a SP was not something any of the participants had previously sought. Indeed, most admitted to not understanding what the role was until they had accepted the challenge to become a SP, and had either begun to be trained, or for others, participated in their first simulations. Yet from a perspective of unfamiliarity, many participants had become fervent supporters of the role that CALD SPs could potentially play in health professional education. From anxious novice to fervent supporter and in some instances, expert SP, the stories accumulated and re-told portrayed similarities related to the experience. And each participant's sense of self expressed through the themes were outlined from the narrative analysis.

The intersectional identity of each participant was explored in order to understand the categories of self that were revealed through multiple references within their narratives, and in turn were inferred as important to them. As described in the intersectional analysis method, the narratives gave rise to identity constructions that may have been reflected in symbolic representations and were relevant to social structures. Where categories of identity were expressed, more often these were conceived as prominent or prevailing for that participant.

Using those prevailing intersectional identities, examination across the 11 narratives revealed four distinct intersectional groups (Winker & Degele, 2011). The process of this analysis is described in detail in chapter 3 (see section 3.7.4). These groups are outlined as follows:

1. Shielding emotion – For some SPs the potential to be injured emotionally through vulnerability was a central identity characteristic. The influence of past trauma lived and remembered was part of their everyday experience. Inevitably they shared some part of this as SPs as well as in other aspects of their life.

2. Taming stigma – Responsibility toward their community and the concerns of the community were paramount for some. Stigma could be derived from being a minority and emphasized in the simulation. But powerfully it was also experienced as a within-group issue, particularly concerning recognition and appropriate management of mental health.

3. Influencing image – the primary point of focus for some SPs was the perception that others had of them. In society this included recognizable difference and feeling like an outsider. Image was also asserted in the SP performance, as participants grappled with real and simulated.

4. Overcoming ignorance – The emphasis of this category was educational and addressed communication, understanding and changing the perceptions of others. It also concerned the appreciation of new knowledge and understanding that the participants valued as part of their own personal development as SPs.

These four intersectional groups provide insight through a deeper dimension than the thematic narrative analysis. The intersectional identity groups demonstrate the positional perspective of identities that this group of participants brought to the research with their narrative accounts. These group identities provide the framework for discussion in this chapter against which the stories and literature can be contrasted.

6.2 Shielding emotion

The context, story and situation portrayed within a simulation will give rise to an individual SP identifying with their own intersectional identity points. If a person is

portraying a difficult life event, such as remembering or responding to the effects of the journey to Australia as a refugee, then the recollection of their own experience will be influential.

> It's because the experience, you present yourself as a migrant, a refugee, how you have been through and because some of the questions you've been asked as a simulated patient, perhaps you'll ask me how my experience affects my health and that. So you know, when I share all of this, a lot of them they don't really know what migration showed me, you know walking on foot for about a year on the jungle, what that might look like and how that impact on the physical and mental health like when I say that was my experience, that was my experience clearly you know, walking from one country to another country on foot. (Gabir)

An individual's experience may extend beyond their own experience to encapsulate that of friends and peers. Gabir spoke of the many people he knew who were scarred by the trauma of their refugee experience and unable to recover from this. Therefore, when undertaking a mental health simulation he is thinking about those people and the emotion that evokes in him.

> One of the scenarios was about you know, mental health issues and so it reminds me a lot of the people with the community I belong who really suffer silently and when I, because there was also discussions and suicide was a question that students ask, all the practitioners ask, you know I, it reminds me what is happening with my own community. (Gabir)

> It reminds me how a lot of people do struggle to get through those experiences and I become emotional because I witness a couple of friends, close friends I know, have committed suicide because no one has really noticed about what happened. So when I think about this, being a person with mental health and doing that simulation, all this really comes to your mind. It's not really role-play. (Gabir)

Even in a simulation in which the scenario content is not related specifically to a past experience the SP can make a connection to a past event. Taylor (2011) investigates the aesthetic of emotionally affecting performances by SPs. In Taylor's (2011) view the role of the SP is to mobilize emotion from the past and present those emotions without reactivating themselves in the present. Taylor questions exactly how the SP is to avoid reactivating themselves but does not provide a solution (Taylor, 2011).

In keeping with a social constructionist perspective the memories of our past are collected, edited and replayed for meaning as we organize our lives. According to Sacks (1985 cited in Freund, 1990) our sense of selves as people is influenced by our memories and the emotions that accompany them. Our sense of self is validated through interactions that express emotion and create new memories (Freund, 1990). However, as emotions are the response to individual and cultural appraisal of a given context, then no two responses will be identical (Freund, 1990). While this may impact on the ability of a SP to truly standardize a performance, it also corresponds with Taylor's (2011) position that embedded social reality of SP cases impact authenticity. Effectively we rely on the SP being able to use their individual, context specific, knowledge as well as associated emotion within the simulation.

A further important factor to consider is the assertion by Freund (1990) that the more powerless an individual's social status, the more likely they are to experience unpleasant emotional modes of being. Additionally, the individual is more vulnerable to unpleasant emotionality during psychophysical openness or transition (Freund, 1990). My field notes reveal an example of the emotionality of memory from my first meeting with Chenai.

Chenai's demeanor changed and she became very serious and I wondered if her eyes changed when we were talking about estrangement from her family and her failed immigration attempts to England. She didn't have tears but her eyes became really dark. It was interesting juxtaposition of work as a SP, teaching students to form rapport before asking painful background questions whilst in this research I'm doing just that. Clearly she didn't want to have a focus on the past and was much more comfortable with future focused questions and thoughts.

I argue that simulation is a time of psychophysical openness as described by Freund (1990) for the SP, where they expose themselves emotionally as they leverage from unique past experience. However, I would extend the effect beyond psychophysical openness to acknowledge social, cultural and spiritual openness as well. Simulation is also a period of transition; learners and participants undertake an experience to learn and practice and are inherently changed by the experience. Hoffman (2006) likens simulation to a priming event where the participants use the simulation to try out future roles, techniques and behaviour that can be used at a later time. In reducing risk

simulations "limit or suspend formal metrics and long-term consequences of failure" (Hoffman, 2006). Woodward (1998) adds that role-playing facilitated change in a SPs construct system through newly understood experiences, further citing Bannister and Fransella (1986) who argue that emotion is a sign of actual or impending change.

When a SP performs as a character they can be said to have assumed an identity. When a CALD person talks of their race, ethnicity or culture they are expressing their ethnic identity. In my discussion of intersectionality (section 2.13) I note the various identity categorizations used to position people in context and time. When a health care provider dons their uniform and enters the health care context, they may be embodying a professional identity. Fearon (1999) asks "What is identity?" in his language analysis, and goes on to explain that despite the word identity forming part of everyday discourse it is difficult to summarize the range of meaning (Fearon, 1999, p.1). Most social identity authors describe a pattern of personal and socially constructed identity or collective identity as the constructs by which we define ourselves (Beech, 2010; Chaitin, 2004; Pifer & Baker, 2014). In other words, the meanings we hold for ourselves of who we are, are characterized by our thoughts about ourselves as role occupants and as group members.

Chaitin (2004) stresses that our identity is not static but changes over time and is influenced by others we interact with. Beech (2010) affirms this assertion, naming it 'co-construction'. "The co-construction is enacted in the interplay between an individual's 'self-identity' (their own notion of who they are) and their 'social identity' (the notion of that person in external discourses, institutions and culture)" (Beech, 2010, p. 285). Identity transitions are often provoked by changes in role or major life events and each of us can expect to undergo a range of work and non-work transitions (Ladge, Clair, & Greenberg, 2012).

People move through life, experiencing a range of personal and social interactions that result in an evolutionary change to the way they define themselves (Ladge, Clair, & Greenberg, 2012). Beech (2010) suggests that change may be to a sought after aspirational identity, or to dis-identify from a work imposed identity.

Ethnic identity is considered an aspect of social identity. Ethnic identity is influenced by one's membership of a social group and acceptance of the value and emotional significance attached to that membership (Phinney & Ong, 2007). Phinney and Ong

(2007) examine the aspects of ethnic identity providing insight into the adoption and maintenance of ethnic identity. They discuss the complexity of ethnically mixed people suggesting that self-reporting will enable the individual to choose a label they feel fits the context. Some individuals may change their self-label depending upon the circumstances. Eventually through exploration a person may develop a stable sense of self, called an achieved identity (Phinney & Ong, 2007).

Similar to the suggestion Hoffman (2006) makes regarding simulation enabling experimentation for future roles, Lucas (2015) suggests that liminal spaces are those in which previous positions are unsustainable and participants develop new identities. As SPs undertake simulation, presenting an identity that is socially constructed and defined, and respond to the input of the learners both within the simulation and later in the reflective period of debriefing, they are changed by the experience. They are transmitted from the pre- to post-simulation state with change attributable to learning, insight and feedback that occurs during simulation.

Liminality refers to the process of "passing through a phase of social evolution involving three stages" (Lit, 2015, p.123). First described by Van Gennep in 1909, the rites of passage work by Turner (1987) was based on the earlier work of Van Gennep. Turner understood the liminal process to describe the change in any "stable or recurrent condition that is culturally recognized" (p.4). The first phase of separation signals the transition and is followed by the liminal stage. This stage is ambiguous. It is neither easy nor difficult. It is characterized by being socially invisible. Using the example Turner (1987) provides of this invisibility and ambiguity that he has related to the period of male puberty "not-boy-not-man", it parodies the SP experience in a simulation of patient-not-patient. The liminal person contemplates their relationship to society and arrives at a new identity, passing through this area to emerge on the aggregation pathway (Turner, 1987). Turner goes on to note that this process is not confined to life crises. The CALD SP talks about and relives some of their major liminal experiences within simulation scenarios using cultural content. However, the liminal process is not only purposive in the recall of the CALD SP, but also in the process of the simulation experience. I pause in this discussion to pursue this argument.

The similarities between the process of liminality and the process of simulation are, I contend, extant. While classically, liminality is a sacred space in anthropological study, the similarities are so striking that they have impressed the comparison on me. In

keeping with the postmodern influence of my research the move from the traditional view of liminality to that presented here, is I believe, fitting.

Liminality is ritualistic; simulation is a ritual of pre-briefing, scenario and debriefing. The liminal process is defined by rules of conduct. Simulation is defined by rules of conduct. The individual is socially invisible while liminal (Turner, 1987), while the CALD SP has a fictional existence. Liminality is a place of paradox. The CALD SP is a patient yet not a patient, remembering previous pain yet *not* in pain (Taylor, 2011). They are following a characterization yet in control of the unfolding scenario. The rules of daily reality are suspended within the simulation.

The liminal period is regarded as unclean or prohibited (Beech, 2010). The CALD SP is separated from the learners and isolated from socialization lest they are seen out of character before the simulation; this is a preparation for the rite in the liminal period. The main difference that arises here is that the SP in the simulation joins with the learners, all of whom could be argued to be experiencing a liminal change. Rather than isolated, the SP and learners are together. Each group could be said to be transitioning through a separate liminal period during simulation. The inputs and outcomes from the liminal state are different for each group, so these could be argued to be two different rites of passage occurring concurrently. Sharing of a liminal space by individuals transitioning from one identity to another is known to occur such as women sharing the puerperal period together. The shared aspect of the liminal space is beyond the scope of this research.

Few rights and a requirement to obey characterize the liminal period (Beech, 2010). The CALD SP must follow the scenario and, in some instances, deliver a standardized performance. The liminal period of reflection results in arrival at a new identity (Turner, 1987). The completion of the simulation scenario creates an opportunity for the CALD SP to debrief and de-role. Stepping out of the SP role and casting off the simulated identity the SP could be said to assume their new identity which is mediated and formed by the experience of the simulation itself. Simulations are designed to give rise to learning and changed perception through sharing judgments and reflection (Rudolph, Simon, Dufresne, & Raemer, 2006). Reflection comprises self-questioning and self-change and is inherently part of the process of liminality (Beech, 2010).

The simulation is intimately entwined with the liminal experience and bears many of the same hallmarks. Table 6.1 summarizes the comparative hallmarks of liminality and simulation. The SP, using the emotion of the liminal state, as method acting requires, relives rather than revisits the pre-liminal or liminal state when they are portraying a condition from which they have moved. Beech (2010), discussing performance genres and liminality, suggests that this is identity work through the inclusion of experimentation, reflection and recognition of an identity that is projected onto a performer.

Table 6.1: Summary of some of the characteristics of liminality and simulation

Hallmarks of liminal process	***Corresponding hallmarks of simulation process***
Ritualistic	Ritual of pre-briefing, scenario and debriefing
Rules of conduct	Rules of conduct such as confidentiality, fiction contract
Socially invisible while liminal	SP has fictional existence in simulation
Place of paradox	Simulated patient but not a patient
Unclean or prohibited while liminal	Sharing liminal state with others who are also liminal
Few rights – required to obey	Must follow the scenario, may need to standardize performance
Reflection results in new identity	Debrief and resume simulation mediated (changed) identity
Incomplete aggregation leads to stress	Incomplete de-roling leads to stress

Ladge, Clair and Greenberg (2012) explore the two schools of thought related to identity change. One is that identity is perceived as relatively stable and enduring while the other sees identity as evolving and context sensitive. Chaitin (2004) points out that multiple concurrent social groups, such as race, gender and class, distinguish an individual and each may prevail in different circumstances. And this is in keeping with the fluid nature of identity construction. In certain contexts an individual will reveal different identity aspects that influence the way they think and behave (Ladge, Clair, & Greenberg, 2012). Similarly, in a simulation where the context focuses on the diversity

of the patient character, the SPs performance is likely to be influenced by those diverse characteristics. The extent to which one identifies with a given social category is influenced by their internalization of the social category's goals, values, norms and traits, as well as commitment to the group (Chaitin, 2004). As identified in section 2.9 most SPs are trained through method acting techniques. This requires the SP to use their experiences to identify with the character.

Finally, stress develops where aggregation of the liminal state is incomplete (Beech 2010). Ladge, Clair and Greenberg (2012), observe that triggers in liminal states, may lead to self-questioning and re-visioning. Closing the scenario and de-roling are vital to the health and wellbeing of the CALD SP (Bosek, Li & Hicks 2007). Banks (2008) suggests that strong attachments to identity groups, such as those of race religion and ethnicity, can lead to divisions and conflicts in society. While Ladge, Clair and Greenberg (2012) note that all identities are not accepted and an individual may reject an identity or delay working through a new identity. These ideas demonstrate that some identity characteristics have risks for the individual. The social pressure to identify with or reject a characteristic may be an issue, if deemed positive or negative in a given context. When discussing stigma management for men with gay identities; Cain (1991) found that the men could be overtly gay in some circumstances, but not in others. He goes on to note that social influences of identity formation are an important determinant. Kaufman and Johnson (2004) support Cain's (1991) view, observing that people are highly perceptive to interpreting the appraisal of those around them. Individuals want others around them to conform to their self-view, even when that self-view is negative (Kaufman & Johnson, 2004).

Kaufman and Johnson (2004), discussing stigma and identity, declare that stigma management techniques depend upon whether the stigma is obvious or known versus unknown and invisible. They suggest individuals may attempt to pass as mainstream, or try to correct, hide or remove the stigma or manage information about themselves, as well as build up other features of their life, such as develop mastery, in another area. Another important strategy is to build a network of those who share the stigma or are sympathetic while restricting access with other non-accepting members of society (Kaufman & Johnson, 2004). In undertaking these strategies the person is attempting to develop and maintain positive conceptions of their stigma in order to find positive appraisal that supports their identity (Kaufman & Johnson, 2004).

In the intersectional group of shielding emotion Hwei-ru and Chinh spoke of the need to de-role and the potential for the mood and behaviour portrayed during a simulation to remain at the end of the simulation.

> You know sometimes the mood can continue, yeah, continue sometimes in the, when I sleep I wake up, I can thinking about the case, yeah, what I have to do something. I think of some of the happy things and forget this. I have to, yeah. (Hwei-ru)

> I remember, I went straight from the simulated patient straight from the Uni to work and I found myself talking a little bit like I you know I was still in role at work as well. So I recognized it and I try and stop it and then when I went home with my partner yeah I did it again but then that was it. It's just a matter of recognizing it and talking to myself and then talking to my co-worker just like a debrief. I didn't feel at that time that I needed a debrief. Having a debrief might have been a way to stop me taking that character with me but like I said I didn't feel that I needed it. I didn't realize I was doing that till I got to work and started talking to other people. (Chinh)

These findings are congruent with those from Bokken, Van Dalen and Rethans (2006) whose study SPs also reported that they sometimes continued to act and feel like the patients they had been simulating (p. 783). Boerjan et al's (2008) SP interviews revealed that SP life experiences are used to enhance performances and were helpful, provided they did not come too close to reality. The link between the performance authenticities achieved through real emotion was recognized along with the protective concept of keeping sufficient distance from real life. While the warning to maintain distance is heard again, the mechanism is not explicit or reliably described.

Shielding emotion therefore is an impulse to protect one from potential injury caused by a simulation, where paradoxically the need to draw on the emotion of situations previously experienced is necessary to perform faithfully. CALD SPs providing culturally acquired content within simulations seem driven to share experiences to improve understanding for themselves and their communities. Leyla grasps the paradox and the difference of approaches when telling the story of her acting experience and contrasting this with SP work. In the acting example she provides, her ability to shield emotion and avoid the stress of the liminal stage was non-existent, whereas her simulation experiences let her revisit with an understanding of emotional shielding and the mechanisms available to protect herself.

> I am comfortable because the way, like the instructor say, they train us if something personal or hurt you don't have to answer that. So it's again from the training, we get this knowledge like if something will hurt us we could say no, or yeah, so from the beginning we know it's not going to be something going to hurt us or damage us later on. I will go back again to my play at the Women's Theatre, I have to feel and live the moment that someone hurt my sister and my sister injured, and my mum trying to save her, the same moment I have to live and I was crying every single play, day and night about it, and then this is, I felt in the end it's damaging me actually. So that's why I withdraw from them because the support I didn't get, and to them, they just want me to play on this particular one, like I like to play on the laugh bit and that, but not on this particular hurtful, and I have to beg on the soldier's knee because this is why my mum, she had to do that when my sister had been injured, so she had to beg him and tell him, "Please, can you let me save my daughter. Let me go to the hospital," and he said to her, "No, you go to hell, you and your daughter. You deserve to die," because we have, we are from different belief. This happened in Lebanon. So when I was telling my story she only want this particular very painful moment. This was awful. (Leyla)

6.3 Taming stigma

During simulation scenarios the CALD SP presents a personification characterized according to the scenario they have learned. This performance often focuses attention on an issue of culture, illness or other inequality creating situation. Many CALD SPs have experienced first- or secondhand these issues, or a likeness to these issues. They revive the pre-liminal state and movement through the liminal phase. Bokken, Van Dalen and Rethans (2004) describe method acting as a technique where the actor draws on personal experience. At Maastricht medical school the SPs are trained using method acting techniques, as these are thought to provide more credible performances, although it is also acknowledged that more stress symptoms are seen amongst those using method acting techniques (Bokken et al., 2004). In Naftulin and Andrew's (1975) study of effects on professional actors who were simulating, the extent of real-life conflict with the simulation scenario content was also conceded. The potential to affect a vulnerable aspect of the actor's personality was determined to be the actors choice and whether this would be injurious was said to be equivocal (Naftulin & Andrew, 1975).

The difficulty of the liminal process is influenced by the intersectionality of the context. Woodward (1998), describing a SP portraying an incest victim, suggested this experience could be threatening to the SPs core role and identity constructs. For the SP,

reliving a stigmatized stage is likely to be difficult. Focus group data with CALD people uncovered healthcare experiences that were both poor as well as positive from a cultural perspective (Rutledge, Garzon, Scott, & Karlowicz, 2004). Revisiting or remembering a privileged or inclusionary liminal experience, is likely to be easy. A liminal experience that results in a person feeling included in an identity group they embrace results in a positive recollection. Leyla recounts a negative cultural experience after an accident where she felt disadvantaged. Abida however recounts a transitional experience of relief and care upon arrival in Australia.

> …when I had the accident and I felt all the nurse, all male, and they all come to me, I wanted to go to do a urine, and then, like everyone come and on top of me and I'm trying to say, "I just want if, it just" I'm trying and no one heard me, just no one hear, it's just like, "Come and lift," so again I was very, very hurt and because they didn't respect my belief and they didn't, doesn't have to be believe, or just like, my wishes. I wouldn't be, I wasn't comfortable to expose myself because they take off all my clothes and then they put me to do like the urine. But it was, this is uncomfortable. I'm trying to say, and they have a, like I've got the collar so I couldn't move and it's just like it was a horrible shocking.
>
> It's not because I have the pain, it's just like the way they treat me, it was in the hospital and I say, "I can't, I don't want you to touch me, I don't want you," it's already they, I am exposed, already I am that, and the whole experience, like not from the accident, I was thinking, "Oh, I was exposed," even that's their job. And even it's traumatic. And even like when I was staying and one nurse later come and I say, "I'm not comfortable doing that," and she say, "But this is their job, even this is their job." To me it's like when you are exposed, like this part, especially it was horrible experience. So I wish that they did listen to me rather because I couldn't talk well, like and I say, "I don't want you, please," and because I am lie, you know, and then they are concerned more for me if I have a break in neck or my back or that, so there wasn't listening to my need. (Leyla)
>
> In Australia, I don't know what to say, because when we arrived here they welcoming us, and carry us on their hand, when I arrived here, like this. First thing they done for us was take us to check their eyes, their, it mean the healthy thing, they done test for the kids, everything they do it for, from the time we arrived, 2nd week, they took us, health issues, they took us there and check eyes, teeth, and we do blood test, everything. (Abida)

The SP reconstructs their identity after a simulation but with the knowledge of bias attached to that confluence of identities. The SP has seen the reaction of the learners,

uncovering their thoughts and attitudes during the simulation process. SPs examine not only their own behaviour but that of the people they encounter in the simulation (Woodward, 1998). In this way reflected appraisal influences the CALD SPs identity (Kaufman & Johnson, 2004). For those individuals whose reflected appraisal suggests they are different from the majority the issue becomes more particular. Socialization and identity are conceived as two concepts that give rise to the view of otherness (Pifer & Baker, 2014). Johnson et al. (2004) observed that othering has been used by scholars to consider issues of racism, identity and difference and therefore to examine unequal relationships in society.

Othering is defined as a process that marks and names an individual as different from oneself (Canales, 2000; Grove & Zwi, 2006; Johnson et al., 2004). By labelling another person as different, we distance ourselves from them and stigmatize that person. This process allows us to reinforce our membership of the "normal" group (Grove & Zwi, 2006). Being labelled as a point of deviance from the prevailing norm is described as having a range of negative outcomes for the othered individual. These are variously described as marginalized, disempowered, excluded, devalued, dismissed and devastating to self-esteem (Grove & Zwi, 2006; Johnson et al., 2004; Johnsrud & Sadao, 1998; Pifer & Baker, 2014). Rutledge et al. (2004) recognize that bias, prejudice and stereotyping may contribute to disparities in health care and can be unconsciously reproduced by practitioners or learners. Lian tells a story where she accepts that doctors respond to minority status of some clients.

> For example, it is very interesting, I've had friends going to a private doctor, and then the doctor say "You have cancer, blah, blah, blah, blah, blah" and then the doctor will not, a lot of times, the patients tell me, the friends tell me, the doctor will not give them choice about, there is a new drug that has no government support, PBS drug support, but because the doctor know they are receiving Centrelink support or disability or whatever support then the doctor just assume you can't afford it. So the doctor will not tell them you actually have a choice of accessing that drug, it's just that you have to pay this amount out of pocket. The doctor will assume they cannot afford it, so maybe it's out of the good heart of the doctor "I shouldn't mention it because they can't afford it. I think it's a judgment implied there, that the doctor judges, they can't afford it and then just say, you get, that's all the, and then later on they went to see another doctor and then they asked, the patient has to ask, "If I pay do I have another choice?" So we were talking, and then I said yes, and then the patient say "Why didn't", the patient actually didn't challenge the doctor, "Why didn't you tell me?" the patient was thinking "Why didn't you tell

> me? Because you thought I couldn't afford it?" So things like that. So that it's like income or things like that. (Lian)

The CALD SPs concern for stigmatizing events is expressed as a desire to be accepted. Amongst the consensus of negative reactions to othering, Canales (2000) stands out as distinctly different. Her view includes both positive and negative impacts of othering that she calls 'exclusionary' and 'inclusionary' othering, reflecting the two dynamics. While Canales (2000) agrees with the prevailing opinion of exclusionary othering having devastating impacts, she augments this view by describing inclusionary othering as a process that uses "power within relationships for transformation and coalition building" to create outcomes of inclusion, shared power and consciousness raising (p. 19).

Relating otherness to the healthcare context Johnson et al. (2004) argue that issues such as barriers to accessing healthcare are often attributed to culture. In making this attribution, the underlying issues of stigma and otherness are not addressed or problematized. Patients, Johnson et al. (2004) claim, are held up as being reluctant to accept Western medicine because of their culture, thereby overlooking the alienation and marginalization they feel through exclusionary othering.
Cain (1991), discussing stigma management, says homosexual men engage in lifelong information management that changes over time and from context to context. Concealment of sexual identity rather than revealing maladjustment may instead be indicative of a desire to avoid hostility. CALD SPs in taming stigma reveal multiple lived examples of hostility and assumptions. Gabir and Kabill provide examples.

> Why should I get upset with a drunken person who yell me at an intersection or roundabout? (Gabir)

> Is it hard to think that, when people see me, the first thing they acknowledge is my skin colour, before they ask for my name, before even when someone looks at me, they've already made assumptions based on just how I look. (Kabill)

Where the SP is representing their culture or ethnicity they can be said to have more of a collective orientation. Depending on the situation the participant may be stressing a personal identity attribute, or at other times a collective one. "When the group replaces the individual as the centre of concern, however this does not disrupt the discourse of

individuality. The group like the individual is perceived as being imbued with good and evil intent, held blameworthy, deemed worthy of rights, and so on" (Chaitin, 2004, p.5). At the same time the individual can be perceived as excluded other but when considered within the community is simultaneously included other. Integrated identities intersect one another blurring the sense of self and potentially giving rise to discord (Ladge, Clair, & Greenberg 2012). Thus the dialogically constituted self is dynamic.

6.4 Influencing Image

The intersectional position, influencing image, resists the stereotypes that the CALD SPs are aware of and live with. For many, performing as a SP is an opportunity to address the misinformation that comes with cultural assumptions and stereotypes. The range of individual responses to this intersectional position is dialogic. Some participants spoke of difference, prejudice and weakness while others spoke of strength. Everett et al's (2005) study of African American and Latino SPs revealed those SPs sought cases that dealt with cross-cultural communication but avoided stereotyping social, cultural, and economic dimensions of their minority status. They were interested in scenarios with real-life problems affecting their community rather than those focused on prevalence of disease (Everett et al., 2005).

The opportunity to control one's image presents the possibility to fit in to the mainstream, provided the point of difference is invisible. Aleesia speaks of this as she reconciles her own experience as a new migrant against the importance of heritage for her children and grandchildren.

> One thing that really stands out is a lot of people kind of say "Well these people come into our country, they should learn the way we live, and do the way we do things why should we put ourselves out to them?", I experienced that as a child growing up here when we first migrated here. I overcame that beautifully, that's not a problem with me now, but I hear other people constantly talking that way. I'd like to hear the experience of the latest generation of migrants and think about our black friends that come from Africa, they can't even hide because physically that's how they look. Our children are so proud of their background and they are bringing up their own children knowing they have this different background as well. I can think about my life and I can talk about it and I do refer this to my children just so they can understand it. You don't forget but you do get over it. (Aleesia)

Onam was also conscious of breaking down the image of difference. Having referred to her choice to wear a hijab, as a covered young Muslim woman, she contrasted this with a story of commonality with other young women.

> There isn't any difference between us and other women, no, in fact if they come and see us, we're more crazy and, we have such a good time and you know, and they look at us, like a lot of, when we have parties and things and like we get a lot of Australian friends and whatever and they look at us, like my God, you guys can, you know, have such a great time and you know, we didn't know that you guys do that. And I'm like, we're not different. There's nothing different apart from this. Apart from that, nothing. Music, oh I love music, I'm dancing all day. You know, parties, yeah, we go off. Go wow, always with my friends, you know, like our husbands are beautiful, let us go, and I can come back at three o'clock, four o'clock, he doesn't care. You know? Obviously, and then I think in all religions and in all cultures you'll get some that are like that, and then some that are the opposite. It just depends on their personality, not what they believe in or where they come from. Yeah. And then I'm just hoping people understand. Whatever you believe in is between you and what you believe in. And that's it; it should not affect anyone else. (Onam)

Onam's story of sameness was reinforced when I visited her house for each of the interviews. Up until this time we had only ever interacted at simulation venues and she had always presented wearing a feminine, lace overlaid, hijab. When undertaking the depression scenario, she was specifically asked to wear dark clothing and avoid the pretty embellishment of the lace, and this was the only time I had seen her wear entirely black. The following excerpt from my field notes from the first interview marks the contrast of finding her without her hijab in contemporary summer clothing.

Onam is uncovered and opens the door by opening it a crack and ushering me in. I am struck by how different she looks today. She is wearing a fitted maxi skirt with a split to mid thigh and a short cropped t-shirt. Her hair is dyed red and mid length. I wonder if this represents her ordinary home choice of clothes or is influenced by my visit as it seems so revealing and not conservative.

Feeling different or "excessive individualization" can be associated with discomfort and diminished self-esteem (Pifer & Baker, 2014). Pifer and Baker (2014) suggest that individuals are aware of their differences and consider difference as an explanation for failure or inequitable access. Being able to hide or disguise difference can reduce the

negative consequences of being other (Canales, 2000). But, performing as a CALD SP brings attention to difference. In the simulation CALD SPs cannot influence their image, but after the simulation and in other interactions this consciousness of image and attention to difference is more explicit.

Othering, Canales (2000) observes, is rarely recognized as having positive inclusive elements. Inclusionary "othering" she says uses power to transform and build coalition. Difference can be a tool for connecting when we examine how our lives and experiences are linked (Canales, 2000, p. 26). Participants' examples of influencing image were associated with moving from points of otherness, both exclusionary and inclusionary, to points resembling sameness. Aleesia captures the way her image was managed with awareness of her otherness within the household and attempts to appear same outside of the household.

> …we have suffered we had to be Italians inside the home and then something else outside. (Aleesia)

Chenai describes a movement from exclusionary other to inclusionary as the scenario concludes, and she joins in the laughter and release of tension with the learners.

> In the end it felt really separate to say this is the script and this is me and getting out of character right in front of them and actually laughing and telling them "oh yeah this is what I do". (Chenai)

Khyath describes inclusionary othering as he outlines the collective of simulated patients sharing scheduling and class allocation information, acknowledging that this creates a special coterie of interest amongst the group.

> Me and my friends were also because some of the patients, simulated patients were from my circle and they would always, when we will meet outside and they will always talk about this, when this is happening and "Are you going there next week or if you're not then you should" and stuff like that. They were excited as well. I could sense that, because those people are really new in Australia and this kind of experience was making them feel special as well and I could sense the building up of confidence just because they were confronting people in a very different way. (Khyath)

Sameness does not always reflect the position or identity of the mainstream population. Gabir positions his image and identity as part of a collective sameness. This sense of belonging, characterized by strong attachment and personal investment in the group, is a vital component of ethnic identity (Phinney & Ong, 2007).

> My experience more or less reflects all Ethiopians, almost all Ethiopians and some other refugees so it's that reflection, when I speak, I speak on behalf of me, you know it's a voice of you know, many of the refugees who've been through, you know difficult journey. (Gabir)

The influence of image intersectional position is dynamic. While the participants were often unable to control the influence of their image within simulations they were aware of the way they were positioned as insiders or outsiders. At different times and in different contexts they moved from an exclusionary othered position to an inclusionary othered position and to a position of sameness.

6.5 Overcoming ignorance

The intersectional position of overcoming ignorance is akin to the theme learning, demonstrated through thematic analysis of the narratives. This position instills the importance of change and influence. The desire to influence includes the learners and more generally the public, the health care providers of the future and CALD communities. The individual participants recognized their own ignorance and learning in a range of ways in addition to those discussed under the theme of learning in chapter 5 (see section 5.5).

The experience of working as a SP has previously been reported to change the way SPs regarded their own health care and health care providers. SPs were said to be more discerning about the performance of that provider, as well as better prepared to communicate with that provider (Blake & Greaven, 1999; Boerjan, et al., 2008; Hanson et al., 2002; Wallach et al., 2001). Although several CALD participants mentioned their own health provision, this was an area where they differed markedly from previous SP studies. Chinh and Khyath both considered their own health provision in light of their SP experience. Chinh reaffirmed a previously held view whereas Khyath's learning related to the significance of the doctor's experience to reach a point more advanced that that seen with students in simulation.

> Even sometimes today I refuse to go to see a Vietnamese doctor, I much rather go and see a Anglo doctor. Because they are more open they are more professional, my experience and not saying all Vietnamese doctors, don't take it the wrong way, but the ones I've had contact with, they are very closed minded. Look to put it in a nutshell it wasn't a pleasant experience for me. (Chinh)

> I do actually think differently when I go to the doctor now because then I get to know how many patients that would have gone through and how many of them would have been just simulated to actually to get to that point where they fire just whole questions and get to the conclusion instead of asking questions for hours. So I have a better impression of them now. If it's a polite doctor. (Khyath)

The difference between the reactions of participants and those reported in the literature for SPs was probably related to the focus of the simulations in which they had participated. The participants in this research had mainly worked in simulations with a strong focus on communication skills and cultural competency. They had presented to a wide variety of learner groups including medicine, nursing, physiotherapy, social work and paramedicine. While they had worked with graduate staff the vast majority of simulation they had been involved with was in entry to practice courses. They were therefore seeing very junior students through to senior students in the main. Hwei-ru equated her newly developed knowledge of the students to qualified staff she was working with in an aged care course she was undertaking. This learning, while different to that reflected in the literature, still involved insight into the practitioners one has contact with.

> I worked with, the nursing and medicine. You know in the aged care facility there are a lot of nursing and medicine people. And now maybe the student later is in this role. I think the nurse in the aged care, before they are students. So I contact with the student so I can know what they think. It is similar to nursing and the medical worker in the facility. You know in the facility I have to work through the nurse, the nurse and the doctor, yeah. Most of these is a nurse, yeah. Before I never had contact with the nurse. Yeah I don't seem to know what they think, what are they like but I contact the student and I know they will be the nurse, what they think, and they are very careful, they're very kindly, yeah, same as the facility nurse. (Hwei-ru)

For Chenai the realization of the level of cultural competence of the learners positioned her to reassess her previously held belief that health care providers would be skilled in this area. She learned that this education was useful for health care providers.

> Being a simulated patient, well besides showing me that people are actually ignorant, like people barge into hospitals and they actually don't know what is going on in someone's life. (Chenai)

> It's also shown me that it's important for people to learn, it was, it's an important subject to be taught to people *(culturally competent communication)*. Because I'm sure if its, if it's forgotten then people will just go out there, they won't know what to do, they won't know what to say because I can imagine all the people that we work with now, have that knowledge to say "I have to be careful, I have to be sensitive, I just don't have to go in there and ask them about their age, how their travel was, what happened, where they are living now, what's going on in their life, what did they have to eat?", you take a more gentler approach to finding out things about someone obviously. (Chenai)

Many participants related to learning new information about specific illnesses presented in simulations. This opportunity to learn was a positive motivator according to McNaughton, Tiberius and Hodges (1999), who also reported SPs learning about specific disease presentations.

> And also I feel that sometimes, when I was preparing I was able to communicate with an educator, ask, clarify a few things. But say in the diabetic case, the first one that I did, I was able to ask, because I'm skinny, I am like maybe, because I'm skinny can I put like the question, I don't understand why I have diabetes? Because my understanding is that people are fat, overweight, get diabetes so why do I get diabetes? This was a very genuine question from a friend of mine who's been diagnosed from diabetes, who's very slim. (Lian)

While Woodward (1998) observed that SPs in her study learned about themselves and how they reacted in given situations the participants in this study were less aware of changing. That is not to say they did not learn and change, rather they did not tell their stories in that way. This may reflect the way the stories unfolded or a cultural determinant. Leyla, as previously highlighted, learned to give feedback to her family and community in the manner she was taught as a SP, while Abida went from being shy to being able to present in front of a group of learners in English, and Lian learned to assert herself and assist others to do so in health consultations when she initially felt unable to ask questions when she herself was diagnosed with cancer. As Woodward (1998) attests, as a constructionist theorist would anticipate, the participants inevitably learn

through their work. They are transformed as a result of simulation experiences and emerge as changed identities. In the following section I present the model of liminal experience that reflects the various factors and responses identified in this research.

6.6 BLOSSOM – A model for CALD SPs in simulation

Blossom provides one possible explanation for the experience of CALD SPs.
The model is named because Blossom represents a new identity for the plant on which it emerges, and because the model is represented by a dried flower arrangement mounted onto a background for artistic representation (Figure 6.1).

Blossom also represents an acronym of important components to the model:

B Background of the CALD SPs
L Learning
O Otherness
S Sameness
S Simulation
O Ontogenesis
M Multicultural

The acronym components summarize some of the important elements of this study that have contributed to the ideas within the model. The **Background of the CALD SPs** is vitally important. Their heritage and culture is the point of difference between CALD SPs and those who identify with the prevailing majority of the culture in which the SP teaching is located. The SPs from CALD backgrounds similarly to other SPs draw significantly upon their background when utilizing method-acting techniques.

Learning draws on the theme of learning which encapsulated the manner in which the CALD SPs developed new skills including English language and negotiation through participating as a SP. **Learning** also described the process whereby the SPs in simulation could explicitly see the way the simulation participants "viewed" them and how this in turn positioned the CALD SPs as Inclusionary or Exclusionary other. **Learning** was closely related to the intersectional group of overcoming ignorance. The important aspects related to the opportunity to influence others and elicit change in their knowledge and attitude for the betterment of the community group from which the CALD SP most identified.

Otherness and **Sameness** describe the contrasting positions that the CALD SPs inhabited at different times in their lives, including when depicting characters within simulations. Whilst not always consciously aware of these swinging and dynamic positions the CALD SP narratives revealed many stories and sub-stories describing themselves variously as alike or being positioned as minority and other.

Simulation provides the context for both the study and the work of simulated patients. The 'take away message' for the understanding of CALD SPs relates to the transferability and verisimilitude of the study. The context of the study in simulation is relative to the perspective and interpretation that a reader would adopt when considering the narratives and the analysis of these. Simulation is the lynchpin.

Ontogenesis is the sequence of events involved in the development of an individual (McLeod, 1982). The arguments leading to the development of this model stem from the narratives outlining change and development of the CALD SPs. Whether through the theme of learning or the reliving of liminal events or the change that occurred through simulation exercises, the common result was development of the individual.

Finally, **Multicultural** represents the multiple intersectional identities of the CALD SPs. Culture is an all-encompassing term to describe the variants of characteristics that delineate the individual. This term takes in differences of age, gender, ethnicity, religion, sexual orientation, ability, generation, and migration source. This term is deliberately non-specific to encompass within group (intragroup) difference.

The distinct elements of the model are the epicentre of the flower divided into three concentric circles. Emanating from the epicentre are the stamens. The petals emerge around the central disc and the whole is mounted onto a solid backdrop.
To retain consistency the interpretive scheme of significance, value and intention has been applied as a lens overseeing that experience. The following model shows the relationship of each of the elements studied, with a detailed explanation of the dynamic interconnectedness of each separate part.

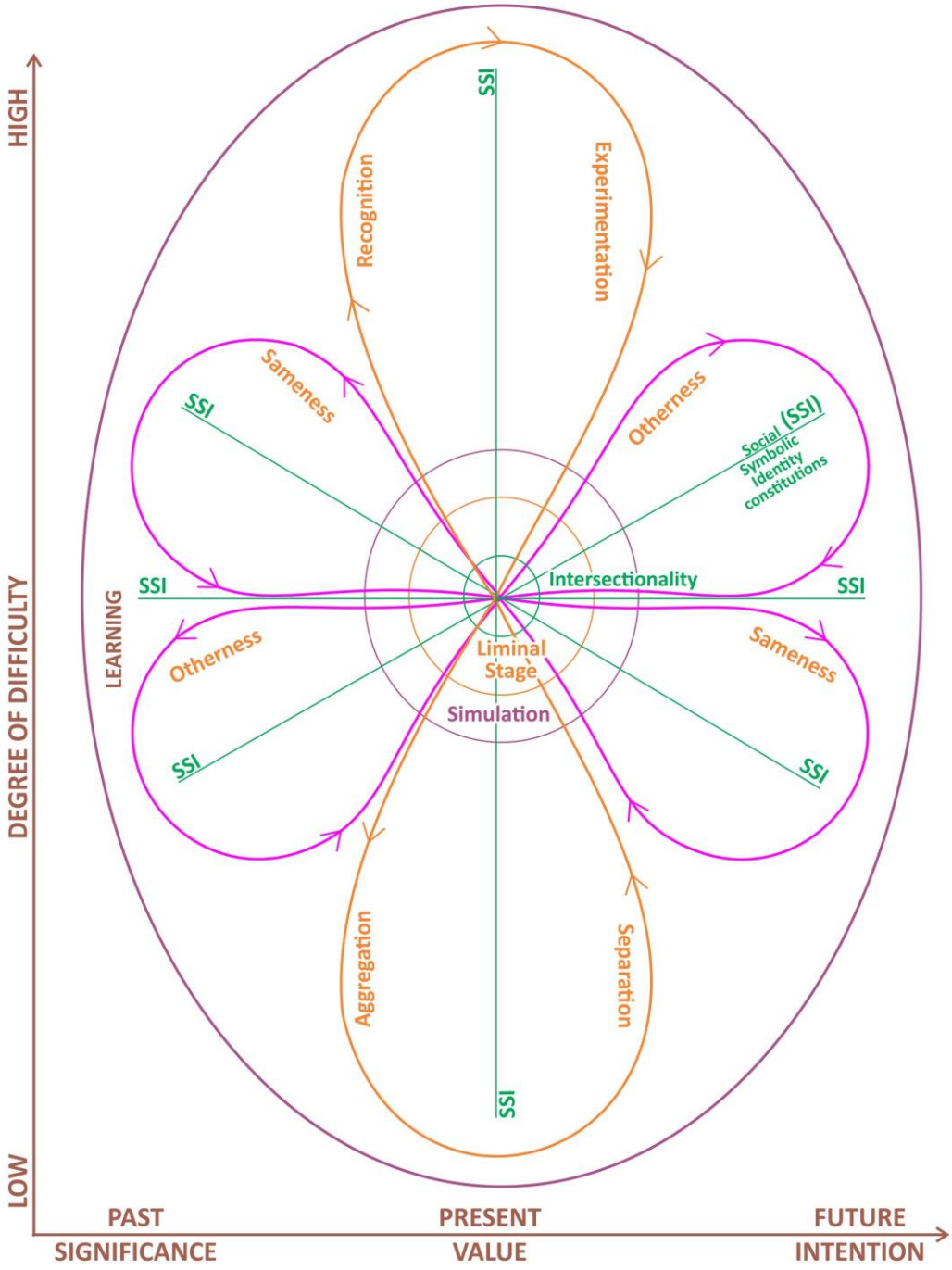

Figure 6.1: BLOSSOM – A model for CALD SPs in simulation

6.7 Intersectionality

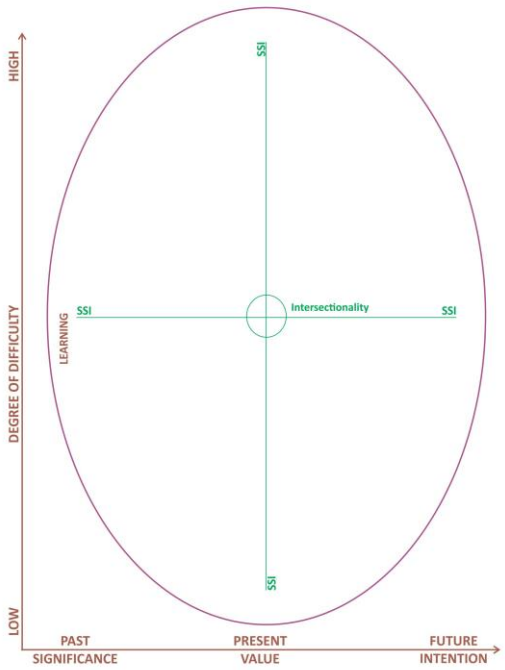

Figure 6.2: Intersectionality component

The centremost disc represents the intersection of the individual CALD SPs identities. The intersection is relevant to the individual and the context and thus changes according to the situation. Each stamen represents the possible social, symbolic and identity constructions of the individual. They intersect at the centre disc, which is the point of intersectionality. The influence of each of the intersectional points will be prompted by the context of the simulation or life situation. Winker and Degele (2011) understand intersectionality to be the "interactions between inequality-creating social structures, symbolic representations and identity constructions that are context-specific, topic-orientated, and inextricably linked to social praxis" (p. 54). Identity is one of the themes that emerged from the analysis of narrative stage.

Simulation should reflect the multiple intersecting identities of the CALD SP rather than present a single characteristic, identity or stereotype.

6.8 Liminal stage

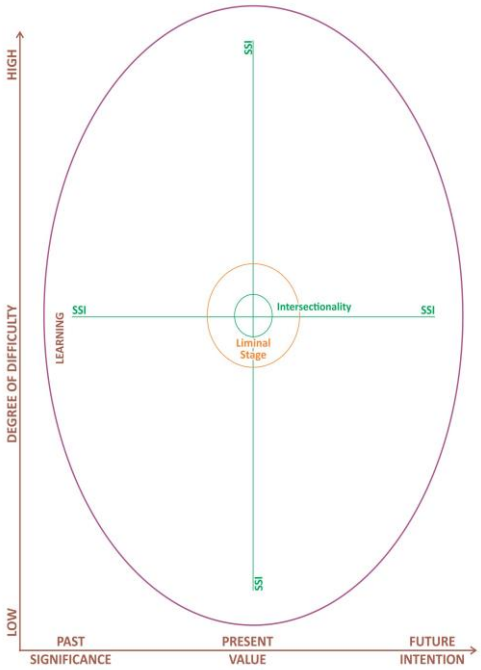

Figure 6.3: Liminal component

The second concentric disc is the liminal stage representing the middle or separation phase of transmission from one social state to another, described by Van Gennep in 1909, which in turn informed the seminal work of Victor Turner (1987). Within a simulation the CALD SP moves through this stage either revisiting a previous transmission from one social state to another or because they are changed by the practice of the simulation. The liminal state sits within the simulation disc to mark the space in which the change of identity occurs. Through simulation the CALD SP is changed with the change attributable to the process of the simulation. During the simulation the SP has a fictional existence as a patient. All of the SPs told stories of enlightenment that changed their perspectives, which were achieved through the process of participation in simulation.

6.9 Simulation

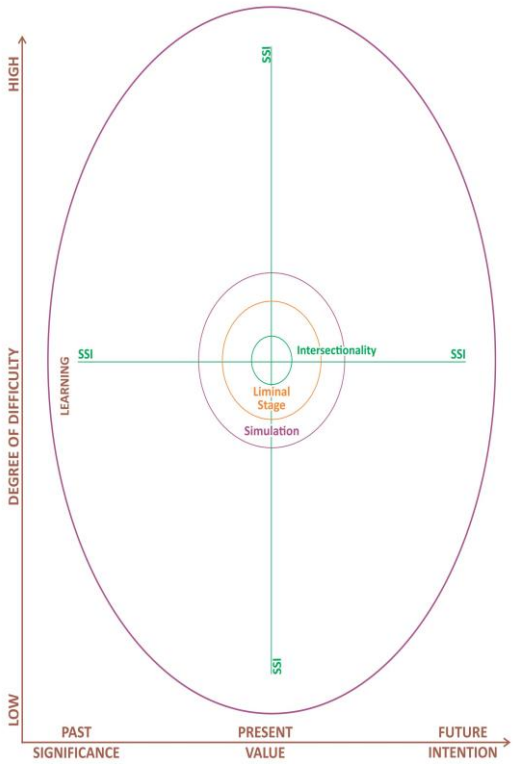

Figure 6.4: Simulation component

The third and outermost concentric circle therefore represents simulation and encompasses both the liminal state and point of intersectionality. Drawing on Gaba's (2004) definition of simulation, the technique of simulation attempts to reflect or amplify the important elements of an experience for the purpose of knowledge and learning. The simulation disc is therefore a microcosm of the learning circle on which the image is mounted. Simulation surrounds and incorporates the disc of liminality and the disc of intersectionality.

Each of the petals of the flower represents an infinity symbol that crosses the central disc. The infinity symbol conceptualizes a cycle that can be repeated uni-directionally. As an infinite shape it deliberately symbolizes animation and movement. This embodies the idea that identity is shaped by context (Lucas, 2014). In the ever-changing context of life and the infinite different contexts of simulation the movement through a cycle can occur any number of times. Grunenfelder and Schurr (2015) describe identities as "relational, fluid, multiple and always in the process of making" (p.772).

6.10 Process of liminality – Separation to Aggregation

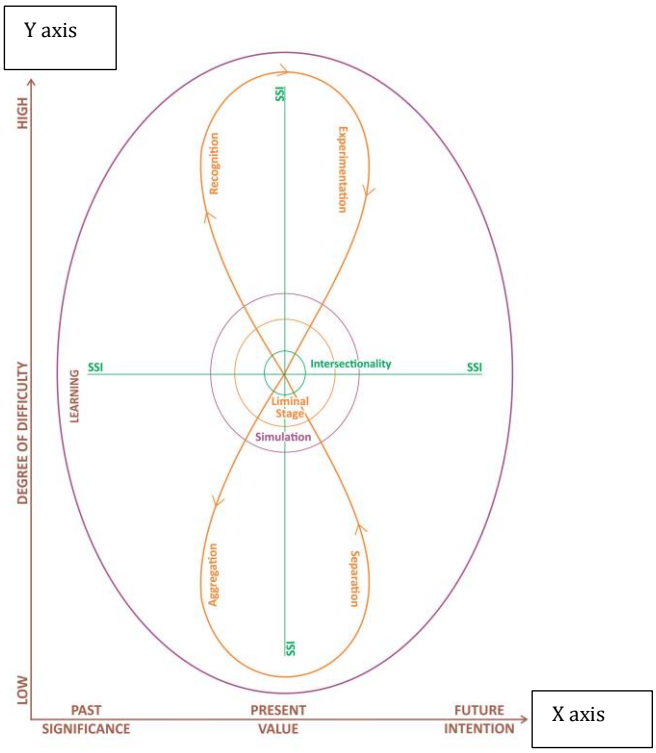

Figure 6.5: Separation to Aggregation component

The vertical infinity symbol making up the two largest petals represents the process of liminality. The crossing point at the centre disc represents the liminal stage. The sweep into the liminal stage top and bottom are labelled separation and experimentation. These represent the pre-liminal stage and characteristic (Beech, 2010). On one petal the separation stage is moving down the Y axis and is relatively effortless; on the other petal the separation stage is moving up the Y axis and represents more difficulty or effort. The opposite side of the same two petals represents the aggregation stage with the characteristic of this stage being recognition (Beech, 2010). The direction line emerges after the liminal stage yet still reflects two opposing levels of effort. People move through an unknown number of significant liminal stages in their life. All the SPs told stories about liminal events within their narratives. All the narratives have a commonality of changed identity and multiple different identities during the narrative analysis. In simulation the CALD SPs are frequently re-enacting pre-liminal and liminal stages in their lives: many of these memories are unpleasant and painful. Acting as a CALD SP cycles the individual back through the infinity complex. Sometimes re-enacting the pre-liminal and liminal stages requires effort and is difficult, while at other times this is less so. On each occasion aggregation is required to recognize their new identity.

After simulation the participants as well as the learners are influenced by the simulation and debriefing and their identity is changed through learning and reflection. The aggregation stage is not necessarily stable (Beech, 2010), giving rise to the ethical imperative to de-role successfully and well.

6.11 Otherness and sameness

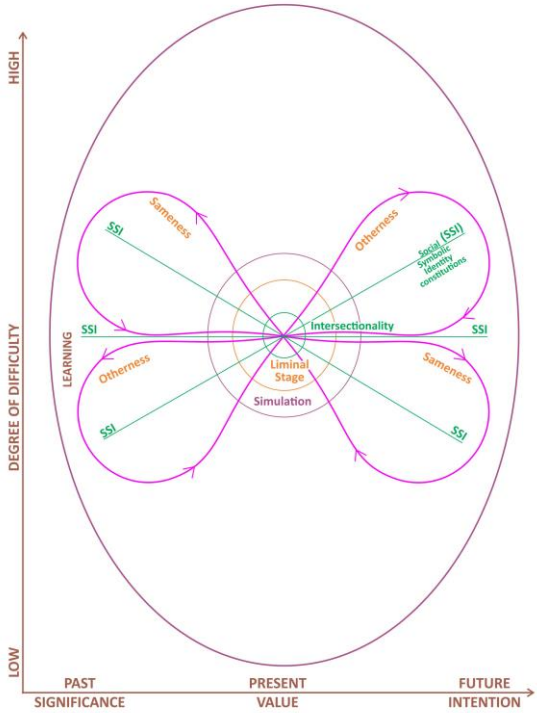

Figure 6.6: Otherness and sameness component

The four other petals also formed as infinity symbols represent otherness and its opposite: sameness. Each of the states of otherness rests in the difficult and easy zones of the Y access. While otherness is generally problematized as creating boundaries and perceived as negative, the shifting nature of identities in developing relationships may be mutually recognized and therefore gives rise to recognition of similarity (Norris, 2015).

Sameness and otherness are not binary. Both can exist together depending on the intersectionality of the context (Norris, 2015) and therefore these petals represent the opposition to single or simple categorization. Intersectionality manifestations can recognize infinite identity categories which shift identity away from binary choices such

as black or white (Koehn, Neysmith, Kobayashi, & Khamisa, 2013). Amid the infinite possibilities are opportunities for relational points of sameness at the same time as other axes of intersectionality that epitomize otherness. Otherness is another theme emerging from the narrative analysis.

6.12 Learning

The outside of the image or the mounting on which the flower rests represents learning. Simulation is a process supporting learning. Learning is one of the themes that emerged from the analysis of the SPs narratives, and is woven in at this point. Learning encompasses the entire model as it represents the purpose for the experience. The imperative to inform and the drive to overcome ignorance are also inherent in the representation of learning.

The X access is horizontal and represents past, present and future or significance value and intention. Intersectionality, liminality and simulation occur in the present and are reflections of value. The past or significance is drawn upon to create simulations and inform reflection in the liminal state. Intention denotes the future aggregated identity and also the state from which a CALD SP leaves to resume a new identity after simulation.

The Y access is a continuum vertically indicating the level of ease or difficulty with which the various movements within the model can be undertaken. While the label for states of otherness and some liminal experiences is often painful or difficult, it must be recognized that these are not universal outcomes. In some situations both positive and negative effects may be encountered. The release from terror may begin with a frightening difficult ordeal but ultimately be liberating to form a new identity (Apfelbaum, 2001). Canales (2000) notes that the consequences of exclusionary othering can fluctuate depending upon the context and conditions that cast the person as other. When difference is used positively as a catalyst for exploration, creativity and empowerment the outcome is affirmative.

6.13 Conclusion

The stories of the participants in this study reveal the complexity of overlapping identities depending upon the context and position they occupy. Despite the complexity of their lived experience they share four intersectional identity positions that encompass the milieu of their experience.

Day to day the participants negotiate their identity within various social contexts, recognizing the prejudice and bias they feel directed toward various minority status categories they occupy. For many SPs work encompasses an opportunity to be heard and understood and gives rise to the drive and motivation to be involved in health education.

Within a simulation the SP exposes their difference and the attached emotionality to provide an authentic performance. They revisit those periods of liminal change and experience new identity perspectives as they emerge from the simulation experience. At times the simulation experience gives rise to otherness while at other times it assists the participant to experience commonality with the other simulation attendees, whether staff or learners. Blossom – a model for CALD SPs in simulation reveals the various forces at play in the dynamic of CALD SPs in simulation. The model maps the movement and dynamic experienced by the SP through the simulation and debriefing episodes as the various identity constructions portrayed and emphasized are highlighted.

In the final chapter I will draw recommendations from this research and explore the ramifications of this study for others who work with simulated patients.

Chapter 7

Conclusion

Just then the mother bird came back to the tree. “Do you know who I am?” she said to her baby (Eastman, 1960).

7.1 Introduction

The unnamed baby bird recognized his mother despite passing her by at the beginning of his quest to find her. Through a process of discovery, trial and error he was finally able to distinguish his end point. The research process is somewhat synonymous. The journey is a requirement in order to distinguish the important concluding elements. Examination of the findings allows the reader to reach the conclusions drawn by the researcher. Through an understanding of the research problem, familiarization with the background literature and rationale of the study, the reader can appreciate the methodology. Comprehending the methodology, the findings and analysis can be considered and the reader is well positioned to reflect on the discussion. Only through the sum of all stages are we prepared to consider the limitations of the study, and think about the implications and recommendations.

This study sought deep contextual understanding of the research participants as a group of CALD SPs. The influence of post modernism and feminism reiterates the call to question our previous thinking and be open to consider the world in new ways. Listening to the way CALD SPs perceived their world and acknowledging the dialectic of multiple perspectives across narratives and within individual narratives enabled the witnessing of life in the moment and within context. Exploring the meaning of the participants’ narratives provided an avenue to advocate attention and responsiveness to the needs and claims of the CALD SP participants (Scuzzarello, 2015).

7.2 Summarizing and fulfilling the research aim

This research commenced with a single broad aim. The aim was necessarily broad because the research was centred in an area where little previous knowledge was documented. As such, an exploration of experience was conceived to cast a wide net

through the experience of being a CALD SP. This net however aimed to be wide ranging and to be deep and meaningful in order to generate genuine understanding.

The research aim was to explore the experience of CALD people who have worked as simulated patients.

In response to this aim, the outcomes demonstrated that CALD SPs were concerned with five themes that emerged from their narratives. **The SP Existence** described the logistic involvement of SP work. Similar to previous research with SPs, the CALD SPs were focused on the process of working as a SP. Beginning from a position of unawareness; the SPs undertook training and rehearsal for their roles. The fact that learners were immersed in the simulation experience and accepted their portrayal as authentic was pleasing and a source of relief for many SPs. They provided stories that demonstrated increasing confidence and competence in their SP role. Eventually some showed professionalism and proficiency coupled with an ability to support the learners and less experienced facilitators. Never far from their consciousness was the stress and emotion the learners experienced during simulation, such that empathy for the learners was often a focus of recollections.

The SP Imperative was a theme wrought with duty, emotion and a stunning drive to participate in programs that better the experience for community members: in this instance those seeking health care. By sharing knowledge about their culture many SPs felt they could improve the way health providers interacted with people from their cultural background. The individual stories that prompted the drive to share cultural knowledge were diverse and impacted by prevailing cultural norms at the time the experiences occurred.

Mental health issues were identified by many SPs. Mental health issues are often associated with trauma experienced as a refugee or migrant (Kirmayer et al., 2011). Cultural, ethnic and health belief systems related to mental health were also exposed and demonstrated significant variation in understanding. Consequent approaches to recognition and management of mental illness alongside acceptance of mental illness as a physiological problem, as opposed to a behavioural issue, were also highlighted for some. For those SPs aware of health beliefs that denied mental illness, their participation as a SP was a strategy to bridge the divide between belief systems and

practice in health settings. Acting as the bridge for understanding and knowledge to flow in both directions was an influential imperative to be involved as a SP.

The cathartic impact of unloading emotionally vibrant recollections was another strongly expressed imperative. Being heard resulted in a sense of relief by many participants. Augmenting relief was the desire to influence the learners to consider the plight of others from the relevant community more empathically.

The theme of **Otherness** was demonstrated through stories recognizing the positionality of insider and outsider in various contexts. Often the CALD SP participants compared themselves to the prevailing and dominant societal group, and expressed points where they considered themselves as included or excluded depending on points of otherness and sameness. Ultimately, as a CALD individual, the societal position as part of a minority culture was experienced and described.

Positioning oneself outside of the mainstream prevailing culture as "other" gave rise to recognition of stereotypes and generalizations that cultural groups are afforded and, for some, feeling the threat associated with those stereotypes. None of the CALD SPs cast themselves statically in any group but rather dynamically changed depending upon the situation being described, moving up and down a continuum from otherness to sameness.

Operating as a CALD SP enabled **Learning** for most of the participants. New skills were associated with training as a SP as well as the development of important new insights. Insights were permitted through seeing behind the curtain of other people's beliefs and views in simulation. Exposure to the learner's unique unfiltered perspective resulted in diverse insights such as the hardships others endured and awareness that others were not judging.

The theme of **My Identity** explored the identity groups to which CALD SPs ascribed. Similar to the changing status of feeling other or same, the categories of identity were also fluid. Working in simulated settings the CALD SPs took on and displayed identity characteristics that were sometimes real and at other times simulated.

Linked closely to preconceptions and self-labelling evident as "other" or "alike" was the insecurity and stigma associated with some identity categories. SPs were discomforted

by the sympathy or empathy they perceived from learners in simulation. The individual identity characteristics of each participant were considered in the stories told as part of the thematic narrative analysis. However, identity has been considered in this research from an intersectional perspective as well.

The identity of each participant as a dynamic, socially constructed and contextual characteristic was contemplated for the multiple different intersectional positions experienced. The analysis of each individual participant's intersectional position gave rise to four distinct intersectional groups relevant to the research participants. Through this deeper level of analysis, shielding emotion, taming stigma, influencing image and overcoming ignorance were identified.

The need to **shield emotion** emphasized this aspect of CALD SP performance. The SPs used a composite of their own real experience augmented and complemented by experiences of others to create a complex characterization. Employing method acting techniques the CALD SP was exposed to a mix of real, empathic and sympathetic elicitations of the emotions associated with the simulated event. While protecting oneself from emotionally injurious exposure was recognized, the function of simulation as a priming event for impending change was not. The importance of de-roling and debriefing was foregrounded through those SPs who recognized hangover effects from performances after the simulation.

Taming stigma related to the way the SPs were sometimes positioned in their life and those situations that were recalled in simulation scenarios. The difficult exclusionary events that had emphasized minority status and judgment were relived or recalled in simulation. Through mental health simulation scenarios CALD SPs felt the stigma attached to a diagnosis that, for many, was poorly understood or recognized.

While not all events are stigmatizing the desire to avoid the stigma or at least achieve acceptance was a related concept. The CALD SPs responded to the appraisal of learners in simulation and sought to divest themselves of stigmatized characterizations with the learner's acknowledgement.

In resisting stereotypes and generalizations about cultural and ethnic attributes CALD SPs attempted to manage the way they were perceived and **influence image.** The outcome of influencing image provided another layer of understanding to the theme of

otherness as the CALD SPs at times positioned themselves through their stories within groups and at other times opposed groupings.

Overcoming ignorance was closely associated with the theme Learning. Although the SPs acknowledged learning it was not confined to their own learning. Their new knowledge related to illness symptoms was acknowledged through the stories told, as were the communication skills gained through provision of feedback after simulations. A desire for others to learn about culture and culturally competent communication and healthcare was also paramount.

Review of the themes and shared intersectional perspectives of the participants has provided genuine insight into the experience of CALD people working as SPs. Insight is a mechanism to understand another person's experience and demonstrates that the research aim has been achieved. The research questions "What experiences influence CALD people to become and continue as simulated patients?' and "What is their experience of the simulated patient role?" are answered specifically in each of the individual narratives. Through the opportunities for introspection and internal dialogue the reader is challenged to think about the experiences of the participants and answer the research questions. The analysis assists the reader by drawing together the collection of narratives to provide an understanding of the CALD SP. The thematic and intersectional analyses as summarized here have identified the commonalities of influence to become and remain a SP as well as identified the cohesive elements of experience.

7.3 Implications and recommendations

The SP Experience demonstrated that CALD SPs react similarly to SP training and performance in simulation scenarios to those outcomes documented from previous SP studies. While the SP narratives did not discuss any language or cultural modifications that may have been made to accommodate their needs in recruitment, training or deployment this may still need to be considered. All of the research participants were able to communicate in English to undertake SP work.

Diversity of SPs is largely unknown and unreported in the literature. Nonetheless the demographic composition of populations that SPs represent is becoming multiethnic and pluralistic (Yancey, Ortega, & Kumanyika, 2006).

The following recommendations have emerged from the analysis and discussion:

1. Purposively recruit SPs from diverse backgrounds so that SP demographics resemble population demographics.

CALD SPs reasoned that many people from their various communities would be interested in working as a SP. The major barrier the participants perceived was that potential new CALD SPs may not know what a simulated patient was or did. Anecdotally this would reflect a whole of population perspective rather than one only relevant to CALD people.

2. Establish journal standards for the reporting of SP interventions to include the demographic composition of the group.

It is not acceptable to assume that the sample in SP studies is white or from the dominant cultural group unless stated otherwise. While a small number of studies provided information about the ethnic racial or cultural diversity within their group this was not common (Escott, Lucas, & Pearson, 2009; Everett, May, Tressler Nowels, & Main, 2005; Long-Bellil et al., 2011).

This recommendation strengthens and expands the study of simulated patients by advocating for accurate reporting of relevant data associated with simulated patient groups. This would make the information on diversity explicit and draw attention to authentic SP diversity. Ultimately this outcome will serve the simulation education population and the academy in our efforts to understand evaluations of SP interventions, and replicate SP work in various countries and districts considering the demographic makeup of the SP groups with which we work.

3. Recruitment of CALD people should reflect the motivators that speak to their individual needs.

CALD SPs were highly motivated to work as SPs where they felt doing so brought advantage to the perception of their community. This was significantly displayed in the SP Imperative theme. Many were altruistically motivated to work towards improved

understanding between health care provider and patient to ultimately improve care and reduce disparity. The emotional release and satisfaction associated with sharing their perspectives and having a voice that was experienced during simulation, especially during feedback, was highly regarded.

The SP Imperative linked strongly the experience many participants had lived through feeling misunderstood and disadvantaged. The emancipation experienced sharing their composite stories in simulation was an unanticipated benefit they accrued working as a SP. The injustices they felt in previous experience were also strongly storied. Therefore emphasis on the potential to influence the experience of community members or work towards an improved level of understanding is likely to resonate with potential applicants.

Diversity advocacy groups often operate in competition for limited funding. As their issues are often similar, potential exists for a more unified approach. Otherwise the result is that different groups compete against one another. They should work in unison whenever possible, support one another's causes, and recognize their common stakeholders in the intersectionality paradigm, according to Gopaldas (2013). Recruiting CALD SPs to a simulation program recognizes the commonalities and allows advocacy across groups. Potential SPs interested in diversity advocacy may find the unified approach appealing.

Learning opportunities were also conceptualized as a positive outcome for the CALD SPs in their narratives. Many participants recognized they had developed new skills through SP work. For those who lacked confidence in their English language ability the opportunity to practice in simulation was beneficial. Similarly, several participants recognized increased confidence that came through simulation experience and the benefits in understanding aspects of the health system that newly arrived people may accrue through simulation. Marketing these benefits may assist SP program staff to identify potential SPs and demonstrate additional value in participation to potential new CALD SPs.

4. Minority SPs will have more than one dimension of diversity and this should be considered in scenario design.

The theme of Otherness along with the four intersectional identity groups recognized amongst the participant CALD SPs amply identified that each participant had multiple different dimensions of diversity. Scenarios should be designed for CALD people that embrace a multitude of identity characteristics.

Narratives demonstrated that CALD SPs often identified themselves as outsiders and "excluded other" when compared to mainstream characteristic determinants and they were uncomfortable with the emphasis on these issues. Scenario design that includes issues that isolate inclusionary othering as well as exclusionary may assist the CALD SP to feel less stigmatized.

The recommended dialectic of diversity, including aspects of otherness and sameness, is required for authentic scenario design with CALD SPs. The narratives demonstrated that none of the people represented a single position, but more authentically represented multiple identity positions that moved them through a cycle of sameness and otherness depending upon the context and setting.

Regardless of whether the learning outcome of a simulation incorporates culturally competent care components, it is recognized that authenticity of simulations is a desired state. Learners who work with clients who represent a range of dynamic identity constructions related to culture and belief will give rise to comprehensive characterizations in keeping with authenticity. Inclusion of cultural variation not only reflects reality but normalizes the interaction between learners and care recipients from diverse backgrounds. Exposure to difference alongside practice opportunities that include feedback will accelerate skill development and enhance practice readiness for real and diverse client interaction.

5. Scenario design should conceptualize issues of oppression and privilege that are not specific to a given diversity characteristic.

The intersectional position of a SP gives rise to issues of privilege or oppression. Using an ethnic characteristic to demonstrate a scenario situation rests the pretext of the simulation in a stereotype. CALD SPs were keen to avoid scenarios that stereotyped

their race ethnicity or cultural characteristics. “Stereotypes are shared perspectives of the dominant majority that are produced and sustained through primarily dominant-controlled communication channels – verbal, visual and technological” (Canales, 2000, p.22). Rather than perpetuate these stereotypes, working with the SPs will enable them to assist with individual cultural content. All of the CALD SP participants used method acting techniques and drew heavily on experiences they were aware of, from both their own experience as well as that of friends and associates. Including the SP in scenario design is an effective example of inclusionary othering that positions the individual to determine how they declare their difference. Facilitating this sets the scope to equal the power relationship and assists the SP to offset stigma (Canales, 2000).

The strong thematic association between participants suggests that many SPs would be able to fill authentic content for scenarios, if created from the perspective of aims of demonstrating oppression or privilege. Any CALD SP who is bilingual can show the complexity of rapport building and establishing trust between health provider and patient while reliant on an interpreter. The privileged position of communication that excludes the health professional can be showcased. Conversely, the communication that limits the patient’s understanding or assumes their willingness to participate in patient-centred care decisions, could demonstrate oppression. In this way many CALD SPs can undertake the same scenario and programs do not recruit for specific stereotyped diversity.

6. Consider working identity in scenario design.

This recommendation, dealing with Identity and Otherness, implores simulation scenario designers to consider the differentiation of categorizations. The narrative analysis demonstrated that each participant saw themselves as belonging to a cultural or ethnic group, but not having all of the same qualities as other people within the group. Onam, for example, did not equate with other Muslim women who covered completely in a burqua and could not drive a car, adopting a hijab herself. While Leyla, also a Muslim women, chose not to cover at all.

Carbado and Gulati (2013) raise the concept of intra-group differentiation where people feel an incentive to demonstrate that they do not embody stigmatized stereotypical traits associated with a social category. In response to this an individual may accentuate or diminish those qualities associated with the stereotype, a process Carbado and Gulati

(2013) call "working their identity" (p. 530). They use an example of two black women with the same intersectional identity. One has a working identity that looks very white (i.e. dress sense, hairstyle, name, residence) while the other has a black name, lives in a black neighbourhood, wears ethnic jewellery and has a black hairstyle (Carbado & Gulati, 2013).

Aleesia's example of Anglicizing her name as a younger woman and then including her ethnic name in later years, while teaching Italian language to improve credibility, is an example of working one's image.

Image must be considered as we create characters in simulation. The worked image may alter the feelings of the SP if they are more or less stigmatized and this may affect the way they present themselves for the simulation, for example, choice of clothing or hairstyle. Designers should also consider learners' reactions to the simulated patient. For those programs augmenting manikin based simulation with ethnic artifacts, the embodied revelation could strike a different cord with a SP or real client. A SP could be more vulnerable to negative racial stereotypes based on working identity depending on whether a characteristic is accentuated or minimized.

Considering health professional learners with different cultural beliefs, and recalling Foisy-Doll's (2013) example of Qatar and white women's dress (Foisy-Doll, 2013) provides another example of intragroup differentiation. For example, a SP who is a white women in conservative dress versus a SP who is a white women coming home from a nightclub. Both are young, white, professional women with health insurance, employment and married. They are intersectionally equivalent in terms of oppression or advantage but may evoke different responses from health professionals that could be usefully examined in simulation.

7. The importance of de-roling and completing aggregation.

I have argued that simulation is akin to a liminal event through which the SP passes and emerges changed as a result of the new knowledge, understanding and insight gained. Several of the narratives and previous literature have recognized that SPs report continuing after a simulation in a state influenced by the characterization they have portrayed (see for example Bokken, van Dalen, & Rethans, 2006). While the importance of de-roling has been widely recognized, this needs to be extended and considered in

light of the social construction of identity. It is important that the new identity successfully de-roled is identified after the simulation in order to achieve complete aggregation and resolve the liminal state (Ladge, Clair, & Greenberg, 2012). The SP needs to be seen by the learners and program staff and recognized as the new identity in order to avoid the stress of poorly resolved liminality.

Liminal spaces are ambiguous and within these spaces the taboo and conflicted social roles remain distinct and highlighted (Jackson, 2005). These spaces disturb one's sense of order and control, and so are bordered off as a special space or category to relieve the anxiety associated with the lack of order. A poorly resolved liminal state is analogous to boundary straddling and exposes the SP to confusion and conflict (Jackson, 2005). Similarly, where the SP is not adequately de-roled and continues to feel or portray some of the mannerisms of the characterization, they could be said to be out of their classificatory space or betwixt and between. In the same way, a long-term liminal state is argued for people with a cancer diagnosis where the existential state is maintained.

Actions to support the recognition of the new identity could include allowing the SP the opportunity to control and manage their image. By providing the opportunity to separate themselves from their character and be seen to de-role at the conclusion of the simulation the SP can reassert how they are seen and perceived. In the debrief, consider debriefing the SP not just for feedback to the learners, but to ascertain what they themselves learned and insights into the perceptions of others gleaned.

8. Use of BLOSSOM –A model for CALD SPs in simulation

BLOSSOM is designed to assist the SP educator to think through the writing and development of SP scenarios. I envisaged the model as a tool that a SP scenario designer could refer to each time. The model leads the educator to reflect on the following:

- What are the points of change for this SP?
- Within this scenario where are the points of character development?
- Am I creating liminal experiences or re-enacting liminal experiences this person has previously experienced?
- How does my scenario position this person's identity?
- What are the points in this scenario that position the SP as other or same?

The model provides a method to think through the concepts in scenario development, to review existing scenarios and reflect upon their effectiveness, and to consider the possible implications of the SP experience on the SPs portraying that scenario.

Thinking through CALD SP scenarios in this manner encourages atypical use of presenting problems outside of the disease prevalence or generalized epidemiology for the ethnic group or race. The scenario can be developed and driven from the learning outcome rather than the ethnicity or language ability of the character with a mindful approach guided by BLOSSOM. The intersectional positions occupied by participants enhance intra-group recognition of difference and steer simulation away from stereotypes, generalizations and token culturally diverse scenarios.

7.4 Strengths of the research

The greatest strength of this research is its contribution to the body of knowledge associated with simulated patient methods in the unique area of CALD people working as simulated patients. While some programs report the diversity of their simulated patient teams, most do not and therefore CALD SPs are invisible. As an unrecognized group, nothing can be known of their experience and perspectives. This research recognizes and foregrounds CALD simulated patients.

Through the philosophical influences of social constructionism, postmodernism, feminism and dialectic theory, an avenue to hear the variety of perspectives and opinions was created. Social constructionism offers a conceptual space that facilitates the exploration of the way people construct and perceive phenomena (McLean, Johnson, Sargeant, & Green, 2015). The combination and influence of the various approaches in this study were necessary to eschew power imbalance between participants, or between the participants and researcher, associated with ethnicity, gender, English language ability or any other determinant that could lead to disadvantage. Each of the philosophical influences added cumulatively to the opportunities for the variety of stories and voices to be heard, and for a diversity of experiences and opinions to be shared.

Narrative methodology provided the freedom for the content important to participants to be shared with limited structure, directing each participant. This enabled them to tell their stories in a manner that was important to them, and befitting to a study that sought their perspectives and experience. A more structured interview guide may have corralled the participants to talk about other ideas and concepts and not really reflected those they would have freely chosen. As a cultural outsider to the study, the narrative methods paid homage to the participants as those with experience to share.

Intersectionality married the philosophical stance to the methodology whereby the individual identity positions of the participants could be considered along with the narrative stories. This approach plumbed greater depth and provided broad contextual richness to maximize thick description. The study design was therefore strengthened by the congruity with the aim.

The method was also a strength of this study. Interviewing the participants twice enabled the opportunity to ensure mutually constructed understanding and probe the participants for more detailed responses. The richness of the eventual narratives was an outcome of this process that aided thick description and ultimately transferability. The interview method also afforded the participants the opportunity to speak and be heard and could also be considered a strength.

7.5 Limitations of the research

The small scale of this study may be perceived as a limitation in that only 11 participants' narratives were gathered. However, the study sought depth and detail and this could only be achieved within the available resources with a study of this size. All SPs belonged to one program and had focused on working in simulations with specific cultural content embedded in scenarios. Of the 11 participants, four had undertaken significant SP work that did not include cultural content. These experiences, both the selective simulations and more generalized simulations, would have influenced the experience of the participants. The patterns of SP work may also have influenced perceptions. Those SPs with other work commitments tend to be available for shorter time periods to accept SP roles and therefore would have experienced limited opportunity to repeat the same simulation performance multiple times. Others may have undergone sessions where a role was repeated up to four times. Studies have

linked the prevalence of stress symptoms associated with emotional role portrayal to the number of times a role is repeated in a single sitting (Bokken, van Dalen, & Rethans, 2004, 2006).

Other differences between the participant SPs that could have limited the study include past experience of acting. Two had worked as professional actors and undertaken training as actors. Given the implications of method acting upon retention of behaviour after the role and emotionality within the role this could have impacted the themes in which this acting technique was relevant.

The ethnic origins of the SPs were described in chapter 3 (see section 3.7.1). While ethnic and cultural diversity amongst participants was achieved, this group does not represent all diversity. Indeed, the absence of an Indigenous Australian SP is acknowledged. While three Indigenous Australians were part of the SP group, only one met the inclusion criteria of six months' experience as a SP and was invited to participate. This person chose not to be involved. So while the sample was diverse it did not represent all ethnicities and cultures, nor include Indigenous people. Considering intersectionality theory it is not realistic to represent all diversity, as this is the product of the various dynamic identity categories to which participants could belong.

The results of this study are not automatically transferable but follow the emphasis of naturalistic generalizations to achieve transferability. The thick descriptions need to be detailed enough for the reader to recognize familiar concepts within distinct contexts (Connelly & Clandinin, 1990). Having recognized the particular in the new context, associations can then be made (Houghton, Casey, Shaw, & Murphy, 2013).

My relationship with some of the participants spanned several years in which we had trained and worked in simulation together. At several points in my field notes I questioned the extent to which the participants were behaving in ways that were designed to please me, although this was not always so. I offer the following examples from my field notes of different observations.

I bought coffee for us both and it did seem to relax the atmosphere. She was reluctant to have a drink until I said I was having one and then she agreed to it, but this might have been to seem polite because she never really drank with much enthusiasm and didn't finish it. Chenai interview 1 in a café.

When I offer her coffee this time she says she doesn't drink coffee and orders a hot chocolate. This is odd, as I know I bought us both coffee last time but I don't think she drank it all. So this reminds me that people I am meeting might be trying to please me, maybe about power imbalance, maybe about culture. Chenai interview 2 in the same café.

I wonder if she knows anything about narrative technique because she seemed to make an effort to fill the anecdotes with detailed stories. Aleesia interview 1.

She has slept in and my call woke her. She got a taxi to our interview to save time but she isn't ready to start straight away either. First she wants to order breakfast. I ask if we can start while we are waiting but she would rather eat first. Wing interview 2 after 40-minute delay in arrival.

The chance that some narratives were modified to reflect more socially desirable stories is possible but improbable, given that narratives were formed across multiple interviews and participants demonstrated independent behaviour.

7.6 Recommendations for further research

This body of work although suitable to meet the aim intended for this research has several opportunities to be expanded. This research has provided a preliminary albeit deep view of CALD SPs. Future studies with a larger number of SPs with different ethnic backgrounds may yield different results. Ideally, an understanding of the extent of diversity within existing SP groups worldwide would be advantageous, potentially extending the work of Abe et al. (2011). This understanding may itself give rise to deliberate and focused attempts to broaden diversity within SP groups.

A narrative study with simulated patients from the dominant cultural group would also be interesting, to contrast whether the needs and concerns of CALD SPs differ markedly or marginally from those experiences told by SPs more generally. In a related way, an intersectionality analysis of the non CALD SPs would determine the extent that those people occupy positions of oppression and privilege. This could ultimately inform other ways to work with SPs to create a broader understanding of identity features of all patients. Ultimately this would be fitting to the patient-centred care focus dominant in Western cultures.

Other somewhat related questions arising from this research include investigation of whether a framework of diversity could be developed. I questioned whether some diversity attributes are dominant and other passive as I considered the intersectional attributes of the CALD SPs. I believe work in this area could assist SP scenario writers to consider the attributes that should be foregrounded in simulation.

Following an assessment of CALD SPs in existing SP groups, I anticipate a push to recruit more diverse SPs would be an outcome. While literature documents recruitment of diverse populations for SP work as problematic; little work has been done to move the agenda forward. Therefore further research that examines the challenges to minority recruitment and makes recommendations for their redress is suggested (Yancey et al., 2006).

As acknowledged in the discussion of limitations to the research, no Indigenous people participated in this study. In retrospect, this was a fitting outcome. Indigenous people are not appropriately labelled culturally and linguistically diverse, but rather acknowledged as first nation peoples of this country; all those who have come after them are CALD. Thus this study should be replicated with Indigenous people working as simulated patients in order to understand their perceptions and experiences. Indigenous knowing is unique to Indigenous people. Research using the vehicle of narrative would provide a mechanism for that unique knowing to be shared with the simulation community and potentially health educators more generally.

Finally, as noted in chapter 6, sharing the liminal space with learners undergoing their own separate and different liminal experience was beyond the scope of this research. However, further research investigating whether rite of passage theories have an application for students in simulation would be a natural extension. Lit (2015) describes the community present in liminal situations as spontaneous communitas. It is this group that would be the focus of further investigation.

7.7 Closure

Beginning from a desire to work with CALD people in simulation this research represents a metamorphosis of thought, understanding and new knowledge and

simulation practice for me. I knew that simulation was an effective method for student learning. I also knew that it needs to be authentic. In an effort to provide authentic practice experience the CALD SP was introduced.

Realizing that so little was documented in the literature about CALD SPs was the spark that lit the flame for this research. Yet as the research process developed, my expertise in simulation became silenced. It was replaced by a cacophony of new information related to research generally and this research specifically, and it deafened me.

I was consciously incompetent according to Howell's communication theory (Campinha-Bacote, 2002; Morell, Sharp, & Crandall, 2002). As the process unfolded and pieces fell into place like a game of Tetris ™, my pathway started to clear. Now my eyes were able to compensate for my hearing. I saw the CALD SPs who were my participants in a different way. I examined their words and considered what they were saying. I learned more and more about them. Along the way I learned about the research process and continued to marvel at the neat fit, as pieces fell together and new information was consumed.

I was indeed unconsciously competent. I started to anticipate additional work that was required. I looked for new avenues to read and was more certain of my decisions. I encountered problems and identified possible solutions, not always the correct solutions, but thought provoking and necessary, as I grew.

Am I consciously competent now? Sometimes. Is the journey over? Probably not. This research area has such scope and presents infinite opportunities. I think I will stay here a while and foster my commitment to diversity for authentic simulation.

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APPENDICES

APPENDIX 1

Narratives

A1.1 Lian

A1.1.2 Setting the scene

Lian is a tall, willowy Chinese woman in her early forties. She smiles and laughs readily and is flamboyant and extroverted, seeming to enjoy being the centre of attention. Lian would stand and do Tai Chi exercises in a break during SP training, signaling early on her individuality and eccentricity. Her first interview was undertaken while she was between simulation classes. She was booked for an entire day and had a two-hour break in the middle. I recorded the following field note:

Lian was very animated suggesting we hold the interview between classes. I noted that Lian didn't have anything to do to entertain herself between classes. Most SPs bring a book, Ipad etc but she didn't have anything with her not even a handbag. I asked her what she had done to fill in time? She said tai chi.

Lian was much more quiet when I arrived and less animated. She had been waiting for me and I offered her did she want anything before we started the interview. She asked me to get her water. This felt a bit strange and "needy" because there is a water fountain right outside the room and Lian had the run of the place since 0800 and it was now 2 o'clock.

Lian seems younger and child like during the interview like she enjoys the attention and being able to talk and be listened to. She gets excited as she talks and laughs very loud and for long periods despite laughing alone.

A1.1.3. Lian's narrative

I will always remember how I came to be a simulated patient. I was actually volunteering for (*nominated health centre)* at the time, and I was on the committee it's called consumer engaging advisory committee, so on that committee we meet every month and then we talk about issues, its like a bit of advocacy and a bit of a consulting role and then one day after the meeting they hand out like a flyer, say like you know someone from the University is looking for simulated patients. Well I didn't really understand what it is and then they explained to me, they say they would like the people to have like a cultural background, non-English speaking C.A.L.D *(Culturally and Linguistically Diverse)* background and then the lady said I think you're a good candidate because at the time I was already performing as a consumer actor for the health centre. So they knew I have, I had a bit of experience like performing, acting so they say you give it a go and then I went home and I really had a good look at it, yeah and then I felt I was really interested in it and I started to draw on my own experience.

I remember when I had cancer and I was in hospital, like the day I was diagnosed with thyroid cancer I had 10 students coming to you know touch my neck. To be honest I felt pretty bad, I was so anxious and yet the Doctor didn't come and the students all came to touch my neck and then they also talk to each other like you know, like oh "do you feel anything?" And stuff like that and I was there feeling anxious about my life because I didn't have much knowledge about cancer at the time. Then I really did feel if I were a simulated patient at the time that would be different and then I thought yeah there is a value for using simulated patients from my own experience. And I also thought I'm a suitable candidate because not just because I have cancer! That's one part of that and I think it's after I had cancer I started to explore a lot of things you know in the healthcare area and I started to help people with the language difficulties, started to go to doctors with them, all that sort of thing so I thought I had a bit of knowledge and a caring attitude.

Before I had cancer I was so busy, I was so so so so so busy first I came to Australia as an overseas student, I was just totally absorbed by the learning, the English all that sort of thing. I was so busy with my studies to catch up with language all that sort of thing and then I straight got a job, a full time job, I really didn't have much time. [laughs]

After cancer I think my, how to say, my attitude towards life has changed a bit. Like I no longer view making money as the most important thing. I find that you know life has a meaning. I sometimes, I think having cancer is a good thing for me. I didn't die a) and b) I think I maybe my caring nature started to show.

Before cancer I didn't have time. I was just you know pushing myself to the corner you know? Do this, do that, study, you know make money, buy a house all that sort of thing just didn't have time to help other people. The way I learned the English is that I learn as I go. I didn't even understand the word like diagnosis. What's diagnosis? I didn't understand. But when I was diagnosed with cancer. so all those words I didn't know. Prognosis. I had to look at the word in the dictionary. When the doctor say, and then I just, when he said prognosis I just write P-G, something like that. And then I went home and look at the word in the dictionary.

Because I also felt bad that I am asking so many questions, because for me it's a bit awkward. I understand a lot of those and there are also some of those that I don't understand. So for me, and also I think it's also like an ego thing, that I didn't want to ask so many questions. But further down the track I was able to feel free to ask questions, all that sort of thing. Yeah. So for me the journey to learn English is I learn as I go. So I learned a lot of English about health.

First I help one friend and then they say this girl is pretty good and then you know referring like self-referral and I also started to volunteer for a charity: a not-for-profit charity supporting people with cancer. It just happened naturally because when I got cancer that was like 11 years ago, 2002. And I was young and I didn't know many friends or people who had had cancer, I was feeling very scared, that sort of feeling. And then my mother-in-law gave me a book. She said "That might be helpful for you". And then I had a look at the book, there's a phone number and then that's actually how I knew the *(named organization)*. I didn't know they existed. Yeah. They have actually been there since 1996, so they had been there for six years but I wasn't aware of that. So I joined the Society and I initially joined as a cancer sufferer, and then I was like a survivor, and then I started to volunteer, get involved in all that sort of thing, helping people. Yes I also started to volunteer and then I had a bit of training and I started to do a visiting patient role. It's basically how do you talk to patients. Specifically how you talk to cancer patients, yeah cancer patients. So it's just happened naturally. I didn't think "Oh I want to do for the Chinese people only", no, it's not the case. Initially I didn't join any other volunteering for cancer patients apart

from the *(identified organization)*. But a few years down the track I also joined like a mainstream one. It's like advocate for people having cancer, their carers and the friends and family, so I joined that committee. That's a volunteer thing as well. That's the mainstream one. But I was there for three years, joined the committee. Then my very good friend she died. She and I knew each other from that committee, and then I just felt like was a really grieving thing, and I felt I needed a break. And then that committee also and then they also merged with another committee group. So I didn't join the new group.

Then as a separate volunteer thing I joined the community health centre. For that I think also that's also related to my how to say my health history. I really felt the need to advocate not only on myself for myself but also on behalf of other people. Because that role that's a special volunteering role it's a, it involves a bit of advocacy yeah in it.

I just feel the need to advocate, I don't know. Sometimes I feel that its like there's a bridge, maybe the word bridge is not the most appropriate word but if I can just borrow that word to use for the moment, I think you know, I don't know how to say its like if a patient just comes from patient view :I want this I want that why can't I get this and get that" and if Doctors just come from Doctors view you know "I want you to do this I want you to do that" and I feel you know both sides just need to build up, build first the you know the trust, and understanding and a bit of non-judgmental. Doctors not judge the patients and patients not judge the Doctors. For example, it is very interesting, I've had friends going to a private doctor, and then the doctor say "You have cancer, blah, blah, blah, blah, blah" and then the doctor will not, a lot of times, the patients tell
me, the friends tell me, the doctor will not give them choice about, there is a new drug that has no government support, PBS drug support, but because the doctor know they are receiving Centrelink support or disability or whatever support then the doctor just assume you can't afford it. So the doctor will not tell them you actually have a choice of accessing that drug, it's just that you have to pay this amount out of pocket.

The doctor will assume they cannot afford it, so maybe it's out of the good heart of the doctor "I shouldn't mention it because they can't afford it. I think it's a judgment implied there, that the doctor judges, they can't afford it and then just say, you get, that's all the, and then later on they went to see another doctor and then they asked,

the patient has to ask, “If I pay do I have another choice?” So we were talking, and then I said yes, and then the patient say “Why didn’t”, the patient actually didn’t challenge the doctor, “Why didn’t you tell me?” the patient was thinking “Why didn’t you tell me? Because you thought I couldn’t afford it?” So things like that. So it’s like income or things like that. It’s like say the doctor’s judged me because I have cancer, they judge me that I will always be fearful of cancer coming back, and then they started to say, when I was complaining whatever pain or whatever they have, and then they say “Oh don’t worry it’s not cancer” but I wasn’t thinking that way. I was not thinking that way. So I’ve actually moved on but my GP thought I was still, you know scared.

Then the patient judges the doctor when the patient go and see, the doctor’s so young, must be very inexperienced. [Laughing] And I even did the same thing. I as a patient myself I made the same judgment myself. I went to see my IVF doctor, that was highly recommended by a number of GPs, and I was sitting there waiting and the doctor came out, and I had a look at the doctor, wow, she just so beautifully, like she was so stylish, and I thought “Would she be good at treating me or is she just so focused on her?” She was so beautiful. So I’d never seen a doctor like that. So I just feel over the years, I’ve had cancer for eleven years now, I just feel if that you know if that gap yes that gap can be you know and I felt that advocacy is something that I can work on because I haven’t got a doctors [sic] degree I can’t be a Doctor. [Laughing]

For us we don’t actually go out and say we should do this and that. I think it’s a very organized committee we are just in the committee and we really work together like the health centre say they want to develop say they are designing a new website and they want the input from us, so we just gave them input and all that. For example a complaint form and then we think you’ve got to have this and that and the language has got to be simple and where you put it and how accessible it is and also that sort of thing we have a voice. And a lot of the times they just listen to us they’re very very good. I’m still in that group. So it was my Mother in laws referral that got me started not because I was really looking for something.

On the other side of the story is that I actually felt that people coming from a background, non-English speaking background, I actually felt that there are two things that really affects their access to the health system: (a) is the language, and (b) is really the cultural thing. For example, from a Chinese background, it would be

hard for them to gain knowledge about the health system, how the health system works. If you don't know there's social workers, if you don't know there's help, how can you access help? And also the systems, and the system in China and here they are so different. In China if I have a heart attack and I got sent to the hospital I would be required to, if I'm the mum then my daughter and my son or my relatives, or husband or whatever, will be required to pay upfront. Before they can save me because I have a heart attack. Or if I have cancer. Too bad if you're by yourself, and or if I have cancer. So a lot of people would not go to the hospital because they couldn't afford it. So the system is just totally different. And then also, it's the cultural thing, that doctors are like authorities, you can't challenge them. It's not like, you can't use the word communicate. They are the boss. And then if they prescribe you a whatever medication and you don't want to take it, you are so fearful if you tell them you don't take their drug they will get angry.

So all those things that we said in the simulated patient, all those things I said to the students that, because I remember like in one scenario I was telling the student taking herbal things, but please don't tell my GP. GP will get upset. And I find that a few students were laughing. Smiling hahah. They find it very interesting. But it was so real. They are so real, because we do believe, and even I, as a migrant myself, initially I do believe that my doctor will get upset. Because the doctor would get upset. Yeah. I think this is all so genuine, and even nowadays my in laws and a lot of Chinese friends that I have they still believe it. When a doctor prescribes like, my Father-in-law the doctor prescribed, what's it called? The drug you put under the tongue? Anginine, that the doctor say in case you need it, and then because I went with him to see the doctor, the doctor actually can speak Chinese. And there's no language issue, but it's a doctor. It's a specialist. And then he went and said he's not going to take it and then I say "Oh next time we talk to the doctor", he said "No, no, no, no, the doctor will get angry". Here it's still the same. And then also the doctor was asking him to do whatever test, and he didn't want to do it. And then I said "Then just tell the doctor you don't want to do it" and then he said "No, no, no, the doctor will get upset". But then he didn't want to do it. But then because he felt the doctor would get upset, and then he had to think, think, think, couldn't go to sleep, "What should I do?" He struggled, worried. Worried for a few nights, and then he still decided to do it because to make the doctor happy. Otherwise the doctor may not want to see me again.

So all these things I really felt, and then I think it actually initially happened naturally, that I volunteer for the ethnic community, and then I really felt that these are the communities they're really vulnerable, they're really vulnerable. They don't know.

If the simulated patient work was not related to my culture I think I would still be interested. Because I'm interested in helping people. I believe the best therapy to me, having been through a few health scares, I believe the best therapy is to help other people, and then it's just therapeutic. But I would be more interested, much, much more interested when you put the cultural part in. It was a driver for me. I felt a strong interest because it had that, and then I was, as a migrant I often have a lot of appreciation, really appreciate the help, the support, the money, the funding, this lucky beautiful country give us. I often have a lot of appreciation, like that. And then I thought wow, but it's a funded by the government, cultural and everything. I said how could I not apply? And then the lady at the health centre also said "I think you would be very good at it". Yeah. I thought how could I not apply? This is the job for me.

Then as I continued as a simulated patient the cultural part was still important but I think it's like a case by case. It depends on what the scenario was. That's what the situation is. It's sometimes, I think some things happen in all cultures, regardless. When you have a life threatening diagnosis regardless of what culture you come from, you go through all those emotions regardless. And then and culture might play a role in terms of, like I just mentioned, your attitudes towards how do you communicate with your health care professionals, can you ask questions, all that sort of thing. Or when you decide to make your own decision how comfortable are you? So that sort of thing. Then culture plays a role. For example, like a lot of Chinese people would try to seek herbal remedies all that sort of thing, and then in one scenario I acted as a patient with asthma and then when got the mum to come in, and so all those things: are you comfortable to talk to the doctor, what will they think.

So some of my Chinese friends say "No, no, they don't understand" and then they, "I won't tell them" all that sort of thing. But others, and I also see some other people are starting to ask, tell the doctor "I am also taking Chinese herbal medicine. Can I take Chinese herbal medicine when I have chemo?" And then we starting to see the doctors say "Oh I would prefer you just to focus on the, just not to take the Chinese herbal medicine when you are doing chemo. After chemo you can do whatever you prefer". And that's like there's a compromise there. And then people are starting to,

you can see some younger people starting to negotiate their health care. So I think further down the track I felt like they're equally important. So on the one hand we are aware of the culture sensitivity but on the other hand there's some things that are equally the same.

So I find that further down the track. But maybe for some cases, for some scenarios, culture does play a very important role. For example, when your elderly mum or dad experience end of life stage, and maybe from a Chinese culture perspective the parents are expecting that you as my children, you should take full responsibility of looking after me. If you go out and seek support from a health, like social worker or you get someone, if you don't come to my house and clean up for me and then you get someone from council to do the cleaning or that sort of thing, then you're not a loyal responsible kid. So maybe in that case culture plays a very important role in their belief system.

So I think the attitude and how you deal with the health care your choice, it is affected by culture. It's like a case like this. I think further down the track I was aware of the cultural thing but I was also feeling like comfortable when there's no cultural issue. It is just different. Because when I was working with the cultural one I felt I had a bit of personal input. (a) my look is Chinese look, I don't need to pretend. And (b) I have the personal experience to put it in.

I've been working as a simulated patient for about a year now. [Laughs] How to say I've done, I've done different cases done a patient with depression, I think that patient has severe depression she lost her son when the son was three or four years old to asthma, in her arms, she's so depressed. And then I've done end of life stage cancer patient. And I've done international students with abdominal pain, very painful in the right side of the stomach and I've, today I've done asthma patient with severe asthma and I've also done diabetic patient. So I really like the fact that the facilitators allow us to have our own input in it. But at the same time there is a script so its very flexible its not that I'm not like an actor and remember all the lines I have to say because students can ask any question like a real life situation. Yeah. But at the same time allow us to have our own input like for the diabetes case I put in my own input like "I'm so skinny" because I do look a bit skinny. "I'm so skinny how come I have diabetes?" And this is not an uncommon question you know for people skinny diagnosed with diabetes to ask. Yeah so I really like it and I think its also to some extent also I felt my knowledge of all those diseases did you know increase through

the training and my own preparation and the interaction with students it's always very encouraging.

I think I've worked with paramedics, and like nursing and I probably worked with social work student. Its very interesting even though like today even though today they are all nursing students they can have totally different ideas and pose different questions and different approaches. Some are very nervous and others are you know okay and I think they can be. I think one of the most interesting cases I worked with was I did a large group with paramedics and that's just after I had a car accident. [laughing] That was a very interesting case because after I presented the case as a simulated patient I then was asked by the facilitator to present my own case in a few minutes.

I think we do have scripts, I think if I have to stick to the script, I can still do that. I can well you just remember all your lines and you can still do that, but I think by just doing that, strictly to the script you just lose the, I don't know how to say it the spontaneous things and you know all that part loses your individual identity because you then just all follow the line and it becomes just like a standard thing. So I do think the benefit of having that flexibility outweighs the potential risk, because the potential risk can be, I can go as a simulated patient I can go sideways maybe you know if you don't have like, I don't know how to say like a, like a very strict script you might fall into the danger zone of going you know somewhere else, but I think as long as we all pay attention to that we know there's a danger there's a risk there then we can skillfully avoid that risk and the danger and pull ourselves back to the to the simulated patient role.

Acting is like you have a script. I think you just need to follow your script so your personal input and your flexibility, because a lot of things just happened, you can never predict what the student's going to ask you. Like I ask you once about the asthma case, the student will suddenly ask me "How many times have you had asthma attack?" For me I don't have asthma myself. I don't know what's an appropriate answer in that scenario. Because in my scenario my asthma was getting worse. So I don't know how many times is in that I say that is really worse, give an appropriate answer. So apparently this question if I was an actor this question is not in my script. Not in my acting script. Then I would say I wouldn't know what to say. You have to say take two. Also like when you don't see yourself as an actor, and I just totally sink myself into the role. So I'm, just like "my asthma just gets worse". So

just totally sink, and on the one hand you need to think about, on the other hand I just go with the flow. Actors also do that but you do it like, I don't know how to describe. I think it's a little bit different, and that actors do that. But also I don't know, because when the actors do that the other one is also an actor. When you're in an acting scenario you and I are both actors, but for us the student they are not actors. So you can't really do like equivalent to the acting. It's like a natural, it is a bit of acting, but it is also like a natural conversation. Yeah. So it's not like you are acting and I'm acting as well. So it is different.

And also I feel that sometimes, when I was preparing I was able to communicate with an educator, ask, clarify a few things. But say in the diabetic case, the first one that I did, I was able to ask, because I'm skinny, I am like maybe, because I'm skinny can I put like the question, I don't understand why I have diabetes? Because my understanding is that people are fat, overweight, get diabetes so why do I get diabetes? This was a very genuine question from a friend of mine who's been diagnosed from diabetes, who's very slim. She couldn't understand. Her husband couldn't understand. There's a lot of miss in the patients mind. So without a fixed script I think we have key points that you want to say about culture difference and whatever. The diagnosis, medication, all that sort of thing. We do have key points. It's not like I can go everywhere. But it's that we are able to add our personal input in it, and that just makes the case more real. That makes the case more real. If I'm overweight I wouldn't be asking that sort of questions.

There is a risk that the students can ask anything and I've had that risk. [Laughing] a few times and I think if I want to be perfect and of course that's not perfect but I think on the spot you just come up with, as if you are the real patient. Because once they've started to interview you, interview me I became the real patient. I forgot I was acting I just go with the flow. I was just immersed in the role so when you're in the role when they ask you for example today, today a lady asked me "From January till now how many asthma attacks have you had?" Well I haven't got asthma myself and I didn't prepare for that question so I just said "many times" and I think you know because I've got a bit of experience now I can come up with very quickly without them realizing that I just come up with something like just say something general.

The first session I did was with a large group I think it was diabetes and that was very successful. It just happened and we had so many interviewing me and that just

happened. I also believe I have I do have a bit of talent [Laughing] So I was very lucky I never had that sort of nervous thought, I was very lucky in fact I do enjoy it.

Some cases are not important like say the asthma case that's not important. Other cases like the diabetes case like putting the input I think putting my input of I'm so skinny why do I have diabetes that's very genuine its just according to the characters needs so some are important and some are okay. I think how to say like for some cases like for example the diabetes case you just imaging if I, if Lian because for my family history I might be actually quite vulnerable to diabetes you know later because my Dads got diabetes for a long time, my Mums blood sugar is high and that sort of thing so I was for some time, do think maybe I have diabetes. And I just can't help thinking if I'm so skinny why do I have diabetes? And also a lot of my friends have got that sort of you know question, I think it's genuine to ask that sort of question. If it makes it more real, then the input is important, otherwise it's just you know, yeah.

I think how do you say, I don't think there is a line the line there is a black and white it's not like a black and white thing what I'm saying is that you know that we are allowed as simulated patient that we are allowed just to go with the flow we don't have like a standard like say for example if that student asked me how many asthma attack have you had this year I don't have to follow like a standard because even if you have the script you can never anticipate fully or 100% what the student is going to ask. Like some scenarios I think are, well some scenarios I was able to put more like personal input in it because I've experienced that, or even like say for the diabetes because my Dad's got diabetes, and a number of people in my family's got it, I probably like, when you mention the word diabetes I straightaway have all those things in my mind. But for some other scenarios for example, asthma, I don't know anyone who's got asthma, so actually I need to do more homework. What I'm saying is that if I haven't got the personal experience, then I really need to investigate. So that's why I was saying, even though I'm very sad and still in grief of my miscarriage, I'm actually thinking if I need to in future have a simulated patient scenario about similar things, like miscarriage, all that sort of thing, then it's just I have a connection to it. So having a connection makes it a bit easier to do it. But on the other hand not having a connection you just need to do more homework, research, and it's equally, because then after I acted as the asthma patient for a few times for two days then I started to feel I have a connection to it.

I also felt that using simulated patient because I've done a few now different stuff, I also felt that as the interview goes on the students get more and more serious generally speaking as it goes on and goes on the first student might be nervous or whatever as it goes on and on towards the middle or the end it just becomes like a proper interview.

A student told me in one session "oh we used to do it with buddies you know students" and she goes "that's just not the same at all' because we are like a stranger going in. I also really like the way we do it. Because the way we are doing it we don't see the students before, we just go straight in, introduced as the simulated patients name, go straight in. We don't get to know the students before I really like that part that separation. That separation makes it very real. When you're working in a hospital you see a real patient do you get to check with the patient before you see them. Now I can see it is more realistic to have that separation. At the beginning I was thinking oh why, why we need to have that sort of distance before we start the simulation scene? At the beginning we were asked to do that and now I really understand and make sense of it I really appreciate that at the beginning I didn't really understand fully why we need to do that.

And the students, well ones were saying sometimes they laugh or whatever and I did learn that in a small scenario, often when they get stuck then the teacher will say stop and then I learned that I would, when they stopped and they had a discussion I would just look at the floor. And say and do nothing. Look at the floor, do nothing, whatever they say I would have no facial expression at all. And one day after the discussion the students said "How could you do that? How could you not laugh with us?" and then I said then I wouldn't be a simulated patient, if I laugh together with you. So all that, so the students did, they did observe you. If you seem to be not genuine they know. They pick it up and they are very smart. They're very smart young people. They are watching you.

I actually often like an opportunity to talk to the tutor before I went, like on the way to the classroom. Sometimes they will brief me, "This is the group like very shy group", and then sometimes they'll say "This is a very active group". If they don't say I will ask them. I will also ask "What sort of group is this? Are they first year or last year, active or shy?" and then I kind of know what I'm going to get. And I also ask them "How long do we have?" I think sometimes, some, because in some classes we have a lot of time to be. So if we have 20 minutes to do simulated patient role, as

compared to we only have 10 minutes. Because I've had a great variation of time keeping it realistic and then you need a bit of time to warm up, to build a bit of like relationship or bond with the, students. How confident are they? At the same time I don't want to scare them. If they are so, so timid, so scared, you don't want to straightaway give them all those difficult things, but at the same time you have to keep it real.

I think there is some like emotional things parts of the role involved. Especially when I play the cancer role. You just couldn't help reflect it back to your, you know past, all that sort of thing you know when I was having [pause] because those things you never forget. You know when you've had cancer those things you never forget. I just couldn't help myself go back to that. But that just happened when I did cancer patient the first time and then I just got over it. So also from that experience I think its not a bad thing that sometimes you just kind of upset yourself. You get personally involved but as long as you can you know withdraw from that involvement you don't get involved for two or three days. I think a short period of time because I had that similar experience I think that's acceptable and that's only natural. I think I made connection in two scenarios one is the cancer case that's connected me to my experience of me having cancer where to some extent that made the case real, real yeah that made the case very real I didn't have to pretend or whatever I did think of life and death all that sort of thing when I had cancer.

And in another case that also you know made me feel very emotional when I did the severe depression case that case I did it with a tutor at *(nominated)* university on that day there were a lot of simulated patients on that day a lot of them and then you know I think they were doing that had that sort of tutorial at the same time. So we just go to whatever room and I just went into the room and that day when I you know review my performance I just couldn't believe how that day went because the students started to ask about the "how are you blah blah blah" and then I just didn't know why when I started to say you know my son died and I just had a very sad feeling my son died and the students did enter it you know what happened and I just say he died in my arms had an asthma attack and I started to cry and I realized that from that moment on the classroom was silent. Apart from the student who was asking.

That case also touched my heart because then there was a mature age student came took over and he said something like I don't remember the exact words but he

said something really touching he said something like you know now when you are repeating your story you might have sad feelings because you have to repeat something really painful but then he said something that and then over time as you let it out it will help you in the process. It's something like you've got to experience this pain then so you can let go of your pain. He said something like that and I just looked at him I felt very touched that was a very memorable case that I did. At the end, I think we ran a little over time maybe because I cried or something and then the tutor said that's a difficult case because I did look so depressed that's a difficult case but we all handled it well so that's a very impressive case for me.

With experience you just get over those cases quicker and quicker the more you do it, the more professional you become. Actually the sense of satisfaction you know I think the reason why you get involved personally with the case it's sometimes to me not necessarily a bad thing as long as you can get over it because I felt and then I thought "Oh I did feel that" and then I just thought reflect on what just happened in the depression case and that part that really touched me was what the student said. There's no way I could expect a student to say that sort of thing. Also in the debrief I said thank you to that student in particular, I always thank all the students I also thanked him in particular and he also reflected he said he was feeling very emotional when I cried because he started to draw from his own personal experience. So he must have something really connected and he said that to me out of his own personal experience. So it's that sort of connection and I really felt I have contributed.

How I move on from each case depends on what case it is. Like say that asthma case, the debrief is just okay, it's just that's enough. Like say the depression case I had and the first cancer case I had where I need to put in a bit more effort myself but I think when I always when I felt that I was involved I always you know felt the satisfaction of I was able to, I don't know, how to say not to avoid my scars but just to go into it and I think that I can, I think the courage I had and I think the fact that I know the importance of being a simulated patient and I understand it is important because a lot of times it depends on how you present it because the facilitators can't on the spot when you're put on the spot nobody can help you. It's just you so it is so important and I always spend a lot of time to prepare and review my cases regardless of if I've done it before or if I haven't done it before. And I think I've got the right attitude because I really love doing it. Actually at that time I really if I could talk to someone after the case that would be great and then I just talked to myself. That was all right, yeah I think if I felt the need I would have emailed or contacted the

program organizer because I know I could do that but I just felt I was able to handle it.

I think the work of the working as a simulated patient has added a lot of color to my personal life. [laughs] It has like I was very proud to tell my Mother in law and Father in law I was doing this and they all “wah” “why the Government will spend money to hire simulated patient why can’t they go to the hospital and grab people?” [Laughs] And I started to explain then my Mother in law said “how can you be like a patient with diabetes you’ve got to remember all the medications and stuff like that” and I really feel proud of myself doing this and I also have a sense of appreciation like you know we have the funding to do this. I said to her just imagine if you were a real patient and you had students ask you two questions and then they don’t know what to ask and get another one and another one how would you feel she said “aaah”. She was just thinking about the money thing. [Laughing] When I was in hospital there was a team of doctors with all the student doctors came and they examined me and the student doctors said to me can I do this on you and I said no worries do whatever you want and then the doctor said what are you supposed to do today and I laughed and said I was supposed to do simulated patient today (Laughing+++) and he said “ahhh now you are a real patient!” [Laughing]

I think it helps one way or the other being a simulated patient helps the real patient experience and the real patient experience when I was in the Emergency department helps the simulated patient experience. Because I have done this simulated patient before I’ve had different cases and when I was so stressed in the Emergency department I was you know whether I had, I wasn’t very sure whether I had a fracture because I couldn’t move my leg at all they asked me can you raise your leg at all and I just couldn’t and I couldn’t move my neck at all and I just felt terrible it’s you know what’s going to happen to me? Then all of a sudden I thought woops that will help me, will help me you know for my simulated patient experience you know this experience and then I said to myself from now on I have got to observe everything. [Laughing] If I take in all the details, maybe that will help me one day. The distraction was good because then you, then in a real life scenario, I didn’t get too involved I began I was like observing things at the same time. I was also the patient myself that’s very interesting. Then they came back and say you didn’t have any fractures and I say that’s good I can be simulated patient very soon. [Laughing] It also helped my other work.

I work as a mental health worker and how I got this job was so interesting. I went to this interview and they said in mental health work sometimes it can be very stressful. When you're so stressed what would you do and I just came up with an answer. I couldn't believe what I said. I said I have another job that's not very stressful and they said what's that and I said simulated patient I've always enjoyed so when I'm stressed I can do that one [Laughing] and I thought that's not a very standard answer to say that. Does that mean I don't need your job? [Laughing while talking] So interesting but I just came up with that!

At the moment I'm working for two departments it's in the health centre, one department is actually helping to facilitate tai chi and a mindfulness program. So basically I'm just there and support the master trainer. Some of the clients are still experiencing mental health issues and others it's a mixture of kinds we have and we teach them mindfulness.

The other job is in a prevention and recovery centre, that's a rehabilitation centre for people with mental illness. You know when they are in acute phases you go to the hospital, psychiatric you know. And when you are not too bad you stay at home. Those people in between, it's the rehab centre. I'm a support worker but I haven't had I haven't finished the training for that part yet they are still training me. I just support the key worker, like you also talk to the clients because to me that's more stressful than the tai chi one. Because those ones are the people with generally speaking more severe mental illness. They can have anything, schizophrenia, bi-polar, they can have anything. You just connect with them check their medication and I did shopping with them one day. Mainly I just check on them, have meetings and organize activities for them. So they don't just go there and sleep all the time. The doctor will look after their medications and their support worker will also need to follow up whether they are taking their medications or not whether they had a good night's sleep that sort of thing, but for that role I am still in training.

Doing the simulations with the students, I did feel that the students their level is really a lot of times exceeded my expectations. They are better than I thought. Its not that I expected them not to cope, it's not like that it's like a lot of times I'm just amazed by their questions and answers, sometimes I think it's even better than the doctors I met in real life. A number of times they have come up with answers like today I had a lady who when I explored about my religion the Buddhism she totally respected it and I think a professional doctor over 20 years' experience could only do the same. It's

hard to exceed her level and yet she is just a year one student and I really can see the future of our country. [Laughs] I feel a sense of hope really can see the future of our country and that depression case, what that student came up with, so sensitive. It might be very painful at the time but over time by expressing your pain and whatever can actually help it to let it go, so sensitive. So sensitive a lot of time, my expectations, now when I go in I just have no expectations because I know they can be brilliant or they can be nervous or they can be nervous to start with then they can jump back and be really professional they really learn so quickly.

I find the students are pretty sensitive. Sometimes without the teachers knowing. I can see that they do feel, one young girl she was so nervous. She was the first one to ask me. She's so nervous. She kept asking for help, "What do I say?" blah, blah, blah. And then in my briefing that I opened up like that. I said "From my experience I felt that the first one is usually the hardest one to ask questions", and I said, "Well thank you so much for being the first". So she's straight away lightened up and so I think it's all those things. So it's not, so sometimes it's not just the script, it's also how you communicate and then you also you have to really, yeah, really see what's happening and then just do whatever's appropriate in that situation.

It's a lot to think about it. And then when thinking about it you don't want to let people know you are thinking. You can't stop acting. You must be doing simulated patient and then you actually, I don't have much time to organize my final feedback thing, because a lot of time they just run out of time. So I keep it all in your mind how many students and who you want to say, and then give a general audit sort of thing. Yeah, and I always open up with the positive thing.

I think my performance also exceeded my expectations. [Laughing] I did think I could do well, at the start I was nervous about some medical aspects because even though I had cancer I didn't have all that other conditions and even though I could do all the research of all the things in real life I was a bit worried about that. Now I'm pretty confident.

Student group size is a really interesting question because you can't just go in and say this is a small group I'll just get whatever, this is a large group I'll just get whatever you can't get anything. Like today I had a small group today with only four students and they were the best group. Only four students and then the answer from one of the ladies one student was the one that I said gave the brilliant answer in

terms of religious belief I would seriously say people with 20 years' experience would say exactly the same. You just can't exceed that standard, how can you exceed that?

I think I had high expectations when I first started I thought maybe I would get work once a week. But I didn't get that much so for that I was a little bit disappointed I think from when to when from about June July August I didn't get anything. I got nothing I was feeling pretty down for that three months I got nothing. I knew simulated patients wouldn't be used in teaching all through the year it's just I got a bit hungry about this job. [laughing] After I had a chat with another simulated patient lady and she reflected she thought we should get more work when we did the training I don't think we were told how many times we will be we will get, I think we sort of expected it ourselves because we thought oh we had two days training we must get blah blah blah job, that's our own expectation I don't think anyone said that. We had that expectation ourselves

The training was useful but I think one thing that I regret is that once you set out to do simulated patient role you don't get many opportunities to you know exchange ideas or reflect with your peers. I would like to have an opportunity to say once every six months or every nine months, however many months have a little get together to you know see how it's going for other people and we can all learn from each other and maybe have another you know like a meeting organized by the facilitator because I do think we can learn from each other. Sometimes I do feel a bit isolated.

I regard simulated patient as a profession because you go there, you are not like, I'm not like a real patient, but I am presenting a real life scenario. So I'm not a real patient. And I am facilitating with the students and the teacher, and all these people working together to create a safe environment for the students and I, I'm also learning as well, to learn together to, so sort of like practice, and learn. So that they can be more equipped when the actually go to a hospital, they go to do their placement and all that sort of thing. So it is definitely a profession and I also feel that I am contributing to the future.

A1.2 Chenai

A1.2.2 Setting the scene

Chenai is an attractive woman in her mid-twenties with an easy, wide smile and quick laugh. She is unfailingly polite in all of our interactions, almost to the point of formality, although her laughter debunks the formality aspect.

We meet in a shopping centre, close to where Chenai lives, at her suggestion. She sends me detailed instructions to find the small suburban shopping mall and the coffee shop within. The following entry from my field notes details our initial meeting.

> I find Chenai sitting in the plaza, not the café where we agreed to meet. Her hair is pulled back tight and she is all dressed in navy blue and white, very conservative dress, striped shirt, navy cardigan. I thought she looked like a nurse just off from work. (Interview 1).

At our second interview, at the same location, Chenai is late after waiting outside one of the multiple entrances to the shopping centre. One of the SP program staff had mentioned not long before our second interview that she had spoken to Chenai about the importance of punctuality for simulation. Reminding Chenai the learners are assembled and waiting and recapping the professional behaviour requirements. This seems so different from the formal, proper person I met for interview last time. But I reflect on this as I wait for her. She is more relaxed and casual as noted in my field notes.

> This time she does seem more relaxed. She is also dressed more casually. The interview goes well and we walk out together. Chenai drives a near new VW Beetle. It is such a fun looking car and reminds me of Chenai's youth.

A1.2.3 Chenai's narrative

I came to be a simulated patient after I got the email from a friend. She knew I was an immigrant and she knew what I had sort of gone through. Well the whole job description for the program sort of like described to say we want people with different backgrounds from being Australian. People who have preferably a refugee background. It's sort of like looking what the program was all about to say it's all about educating nursing students or allied health students. To sort of like embrace themselves, to know the differences or the changes that they might encounter whilst working with people in hospital conditions basically. So I am thinking okay, this is what, I sort of looked back, these are, these were my fears maybe, to say "okay fine you are going to encounter someone, they don't know anything about you, they don't know your boundaries. They are going to ask some things that may be like a 'no go' area, so part of that would you be interested to see? Oh yeah I would be interested to meet someone to say no you shouldn't really go there or stop here and having that experience as well it would be like, oh yeah it would be great to be heard with respect to all the allied health professions out there think we are really going in this field and we are conscious to say people are different in Australia".

By 'no go' zone with this professions, I have sort of noticed to say you need to build that trust, you need to know someone. From the first day obviously a lot of things would be a 'no go' area, a lot of personal questions or maybe just the general health would be okay. But the personal questions are "so where did you come from, who do you live with, how did you leave?" You actually find someone to say "Oh it's really bad out there we watch the news" and you're like "Yeah you do. I know I've been there you've just watched it on the news" and they are telling you how horrible they have just heard it is there like "it's quite bad isn't it?" and you're sitting there thinking yeah it is! So yeah just having had to build that relationship to say okay I know we have known each other for quite some time and we have built that relationship and you would respect that relationship with someone. So it's all about how well you know someone and what they are asking you and the approach they have taken. You can only open up to someone who has approached you in a very nice and compassionate way.

My friend said why don't you join this program? It will be fun for you and it will be educative for you, and you will get to understand things that people do not

understand and it will also open your eyes to sort of understand "Okay fine, so people don't get this, it's not their fault they actually have never learned about it". So it would be nice to teach them some of the things that are in this, that's how I came to be interested in simulated patients. She's a social worker at one of the youth organizations. I'm not sure of the name but I'm sure that's how she got the email invitation.

When I say educative I mean I sat in on one simulated activity where there was nursing students I think it was a whole group of allied health students and I saw those with a strict medical background sort of like struggling with how to actually build the rapport and seeing the ones from much more social backgrounds also show education. Yeah they were quite good but it was interesting to actually make the distinction, before this person actually introduced themselves or after they introduced themselves and you sort of listen to their questions and you're like they are very much just interested in how my temperature has been and what is going on. How I have been feeling physically, and you'd get a social worker and she would approach you know at a very different level and it would be easier to relate with her because she is not just going to walk in there and ask you so where is it painful, where is the pain, how is it going? I could really differentiate between the medical model and the social model. I was more comfortable with the social model, I think I had two social workers come down to interview and they were really good. They were all about oh yeah did you find your way okay here did you find the place okay? Can I get you something, before they just dived straight into so "how are you? Have you had anything to eat? Who are you living with?" So yeah there was quite a distinction.

I'm sure someone who is just sitting out on a hospital bed can tell the difference. To say I have had a lady who has come in here and she was really nice to me she asked me about all these things "how was I?", she didn't just come in here with a syringe to just come and get the blood *(laughing)* and then just get the blood and walk out. I'm not saying they do a bad job they do a really good job but I could just sort of pick up on the differences to say "Oh okay, this is quite different" and from someone who was in hospital I'm pretty sure if they are observant enough they would be able to say "Oh so what does she do because she was really nice?" Of course a lot of African backgrounds I don't think would be able to just tell from the beginning to say that is a social worker, we wouldn't. Because there is no social worker in a lot of African countries

Kabill is my friend we are from the same background so what I do I'm like "Oh so this looks interesting let's get involved together". I was thinking it was going to be hard, it was going to be really, really difficult to convince people (*in simulation)*. I thought it would be exciting too, for people to not know, to try to interview you, I have a social work background as I do social work and we do something similar to that, except we do it to other social workers, and not to simulated patients and I thought, Oh it would be nice to get someone from outside together in to interview someone they don't know they are in an acting profession and actually think it is real. It actually makes the whole situation real. I thought it would be hard as in I would get to meet a lot of professional people. I thought they would know what they have to do, they would be on point, so I thought it would be hard to convince them that I'm acting and this is what I have to be. But I have found it interesting because they have no idea. Very interesting because we could just sit there and they have a difficult time, they actually think it's real, they think you can't speak English they are having a hard time.

The nurses are most scared. *[Laughs]* The nurses were terrified they just were so scared out of their skins but the social workers were very good. They were so calm they would know what to ask, they would know what not to ask, because the nurses are probably more from a medical background so they just ask anything. The social workers so very much sensitive and know what just what to say.

I've been a simulated patient since last year in mid of last year I'm sure so that's about 6, 7 months I think. Oh yeah almost close to a year. *[Laughs]* I've found it to be fun, I've found it to be educative, I've found it to say after you get out of the acting role you actually say "Oh I didn't know about this, I didn't know about that" and now I know about this so I think it's helpful and I think it's something that's nice. It's fun to do as well because you just sit there and you are watching someone being confused and they are looking at the interpreter instead of the patient and you're like what about me? *[Laughs]* So it's fun, it's interesting! I've worked with, it's just the nurses and social workers and I'm sure there were, no it's just the nurses. I did a class at the hospital, there was social workers but the ones that stood out for me was the nurses, because they are the ones that just raised their hands and offered to interview so they were introduced themselves "I'm a nurse, I'm a social worker" I'm sure they are the ones that stood out for me.

The questions or some of the things that you are asked like you look at the script, sometimes you look at the script that you have to follow and if you get someone who

is really good at interviewing you, they will take the interview in a totally different way which is something good and new. So you are like “Oh yeah this person has taken me somewhere in a different way I can’t follow my script anymore” because to make room for what has come out, so you actually learn a lot of new things to say “Oh yeah they’ve ended up asking me about this, which is useful. Or you look at someone who gets stuck in an interview and you have someone who comes and picks it up and you’re like if I could have you sort of like relate, to say how was that person, I would probably be stuck in the same point but to see someone come out and pick it up and think “Oh yeah why didn’t I think of that?”

You can get stuck, to say it’s not exactly on the script, but definitely you can, it’s simulated patient, you can even just keep quiet and keep staring at them. At the end of the day you don’t understand English so they’ll think “Oh!” That would definitely be pulling from what’s not on the script but thinking back, to say I’ve been there, I need to borrow something from there, I’ve been there, I need to borrow something from there. So I am borrowing from my background or people I know. If my experience, that is on the script is not going to work I’m going to need to think or find or imagine I was someone else in a hospital bed and think what would I want them to know, what would I want them to come up with, how would I be most helpful to this person? I’m obviously going to combine my experience and all the other experiences that I have had from people that are here and people that are back home going “Oh yeah going up the road you meet this and this and this”, it’s interesting. I’m not going to tell them any names or going to say this is what happened to someone.

Being a simulated patient is good, it’s flexible because you only have to work when you can work which is a good thing. Which I try to put my availability down as much as possible and it’s good that you are actually re taught to do it before hand, you meet other people working in the same role, they give it their own perspective and you sort of like get to understand that. You role-play, you practice well, and that was a big help as well. I like meeting people but haven’t kept in contact with anyone particularly but surely if you meet at a simulated patient training then yes we would know each other.

The only negative that I can think about is that sometimes like you get a lot of places. Like one day you are at one University in a different building, the next day we are back at another University, though now at *(Named)* University we could probably find our way around because it’s always in the same buildings. But there is probably a

little anxiety around okay we have to find this. It's good in that you go there and practice before hand, so that's good you can say "okay I've been here, I'm going to do that tomorrow so that's okay" but the whole changing of buildings can be anxiety provoking sometimes. But it's definitely good in the sense that for me it's flexible you don't get to be there for like a long time and you actually meet people and the whole getting out of character, I'm sure is good for students as well. Because I have actually had most of them saying "You know what? We are genuinely scared here, we thought you didn't understand any English" so this is actually real so I think getting out of character and actually having them see the real you, is good as well.

The training was very much adequate you get to learn the, the theory and then you put it in practice and then you role-play and then practice, practice, practice and you know, you're told beforehand to say, next time we are going to meet you, you will be with this, this is your scenario, this is everything so I thought that was helpful.

I've played an interpreter most of the time so I haven't been in a position to give them *(the students)* a lot of feedback but surely my friend is the one who is the patient most of the time and she gives enough feedback and I thought that's good as well. I never want to say any more feedback than she has given. She's perfect, she's just perfect

During the simulation you try to say, you try to talk to the interviewer to say yes and look at her *(the client).* You're trying to say look at her, try looking at the patient and they will still look at you *(interpreting)* so that's really the only feedback that I give them to say try looking at the patient and not me, I don't matter. It will be fine in my practice as a worker because now I know never to look at the interpreter. *[Laughs]*

I think it's, it's just enlightening it's just that whole knowing that you're in power but the other person needs you to come down to their point. Needs you to actually understand where they are coming from. I think it takes away that whole "I'm in control, I'm the one interviewing you" and it actually gets you to say I'm trying to help you them. It sort of just takes away that whole trying to be professional thing and actually noticing this person doesn't need me to be professional he just needs my help. That's it, that's what it's done for me personally.

To say when I actually meet up with someone and I have an interview with someone I would try by all means not to show them that I'm the social worker here, go out

there and be their friend. Clients liked people talking about their talk, about the general stuff; don't just go all business on them. And don't go all medical, it's a definite no, no in something's that you can ask. So trying not to sew sensitive points. If you read someone's file beforehand you can sort of see where they have been and what they've gone through and you'd say, oh they'd obviously be sensitive about this they wouldn't want you talking about this. And if you look at someone's face the moment you ask something, you can tell whether they want to talk about it or not.

Being a simulated patient, well besides showing me that people are actually ignorant, like people barge into hospitals and they actually don't know what is going on in someone's life. I'd say it just made me consider that people have come, a lot of people have come a long way and you sort of look at everyone and you just put them at the same level and it's not that way. There might be someone out there having a very bad day, we've had a case like this where someone has just come out of a detention centre and you're like okay you look at someone and you just pass them and they don't mean anything to you. It's one of those things it just really opened my eyes to say look at people the way they are and just try to be sensitive.
It's also shown me that it's important for people to learn, it was, it's an important subject to be taught to people *(culturally competent communication)*. Because I'm sure if its, if it's forgotten then people will just go out there, they won't know what to do, they won't know what to say because I can imagine all the people that we work with now, have that knowledge to say "I have to be careful, I have to be sensitive, I just don't have to go in there and ask them about their age, how their travel was, what happened, where they are living now, what's going on in their life, what did they have to eat?", you take a more gentler approach to finding out things about someone obviously.

With school maybe through writing my assignments I can show that knowledge but not practically I haven't yet been in that position. But all the time it's come up in my assignments. *[Laughs]* It's very, very helpful. Just say you get an assignment about having to talk about aged people and the disabilities and the sicknesses that they have got. And I think I have used it to say, you really have to be careful to get an interpreter, try not to look at the interpreter, because I think I wrote in the assignment about immigrants, elderly immigrants who come here and the next thing they need nurses to come in but they don't have any English at all. It's very important to be sensitive with them. It's very important to sort of like try and look at the hand gestures. If you get an interpreter, they have someone at home, then it's very

important to talk to them, get to understand them and see if you can apply it with them.

Well hopefully its true to all the other health professionals because now I know that nurses learn about it, social workers learn about it, I don't know about the speech pathologists and all the other occupational health but if they do, then I think it will be very important, because at the end of the day they deal with people they deal with everyone.

I've always thought that other health professionals would be more aware, that there would be difficult questions in the simulation and I obviously thought there would be really big classes like in front of like 100 people and you're on a stage and you're putting that pressure and that's one thing that also scared me and its one of those you get to realize that these people have no idea, and I don't blame them as well, like I'm blaming them but it just, it just sort of like was comforting to say I thought they knew better. They don't. So it was something that I took into perspective to say these guys don't know anything, after the first simulated patient I was fine I knew I was going into people who have no idea. Obviously now that I know that they have learned about cultural competency, it's one of those things that I would just observe from afar to say okay they learned about it, I know they did so?

It is a bit hard on them, honestly it's not very nice to say, and at the end of the day we are human, and we have to allow for gaps. There is no way everyone is going to know. Even if we say okay fine we are providing simulated patient practice for them. It's just from my perspective they are going to encounter someone totally different and they can't use what they have learned from me on them because it's going to be totally different so maybe just allow for flexibility being in the field is a better way to say it and yes definitely a lot of gaps, would help if they are recognized.

Well with some of the professions, you actually have to be really cautious so I think it's just having that or working with that or maybe sitting with that risk to say this first point of contact has to be really important and if I lose them here I might just lose them forever, who knows what might happen when they walk out of here. So I think it's in the health profession you sit with a lot of risk which you have to be really mindful of to say if I don't get them now, then it might go wrong. If I say something wrong then that might be it, which is true for a lot of people. First impressions in these professions I think personally counts a lot so it's something that you really have

to be conscious of. Not saying that you should know everything I don't think that's possible, we can't know everyone we can't know every background but just being really careful and being really mindful that a lot has happened out there to people, a lot has happened to people, the worst that you could imagine has happened to people.

The role is a lot more relaxed, I thought it was going to be all, all professional and full on, with these great expectations but no it's a learning process. Because at the end of the day I have to be trained, I have to answer, I get told what to say sometimes, I'm given a script sometimes and I get told this is the script we are working with so go along with that. So I didn't need to do anything, I didn't need to be full on with knowing stuff and studying stuff it's just working with what I am given and it matches in. Where you are wrong, they will correct you and say why don't you try and take it this way I thought that was nice.

In the actual classes with students I've found it relaxed as well. Except for the students of course they're pretty tense, but yeah it's nice that you have, you can see the tutor standing there and they are sort of like interacting with their class, they are telling the next person to come, "this person has just got stuck," they give it up to the next person and you are just sitting there and you're like "oh right these people".

I thought the classes were going to be bigger, so that was something really nice. I thought the people sort of, would be really judgmental but no, they are curious and they want to know everything and want to practice what they have learned so. I thought it would be really bad to say okay fine they look at you, and obviously when you are in the character role they think that it is real. And who knows even when you do get out of character someone might still have that lingering saying "that was probably… is her life story" and they would still hold that against you. It's fictitious and it's probably has been a bit dramatized. So you're, it's not something that would bother me. I'm not going to see them again and when you do get out of character, they obviously show relief on their faces to go "Oh yeah that's interesting, but you?" I was worried to say oh my goodness what if they just hold that thought "that is her!" Well it's obviously because of the whole race because they are going to look at you and go like "oh yeah she is African we have heard things like that."

Maybe because it is still, as long as it's associated with something that people have or had in their minds as a stereotype to say "oh yeah so these people are like this"

You would obviously be thinking “oh maybe they still have that stereotype” even though you do get out of character you would still be thinking do they really take me out of the character or is my character still in there somewhere. In the end it felt really separate to say this is the script and this is me and getting out of character right in front of them and actually laughing and telling them “oh yeah this is what I do”.

It felt good and relieving to come out of character. You actually look at someone who was struggling to interview you and you have that whole “yes I’m sort of making that hard for you because I’m in character”. But it’s not like that it’s okay you can actually relax so you see a lot of sad faces and a lot of curious faces and when you get out of character they are like really why did you do that? *[Laughs]* The relief is theirs and mine too because I’m thinking oh come on relax guys. They do look very relieved to say “Oh wow we thought that was real”.

If the classes had been bigger I think I would have just adjusted because I was prepared for it. It was something I had in my mind and I had already prepared myself for it. I think it’s good that I've started on a smaller scale because now that I know it’s just a few more people what’s the difference it’s still the same script it’s still the same thing. I think all simulated patients should start with smaller classes because it’s one of those, you start with a class of 20 or 25 people, then sort of like relax you and you’re like oh okay, move it a bit to a bigger class, bigger class, bigger class and then yeah that would be good. The biggest group I’ve presented in front of ever is 50 people, social work classes are pretty small.

We get enough training we get a whole, almost a whole day and its helpful we get to meet other people. We get to see other people, we get to adjust the scripts, we get to, we get everything so I don’t think there is anything else. There’s not really any downside, I met a lot of nice people, it was helpful. You get all the help that you need really, at least that’s what I think.

The characters I have played haven’t had a lasting effect on me and I think if ever there were, the instructors say we could speak to someone to sort of like debrief and the whole helping to get feedback from the students I think is a debrief by itself, because you, you are out of that role you are laughing with the students, and you are telling them and they are like all surprised saying “Oh we didn’t think you could speak English” and everything. So that by itself sort of like gets you out of character and sort of like just gets out of it. Some of the character roles are confronting. I’ve had to

listen to my friend sort of like talk about the background of where we came from, our country and something like that even from interpreting you look at the person you are telling and how they sort of feel sorry for you is sort of like, makes me stand back and say okay this actually has a tiny bit, like it affects me just a little bit but the whole getting out of character and introducing yourself to say “No I’m not that, my name is Chenai and I was just you know I was playing”, so yeah it just relaxes you. When I am playing the interpreter, my friend is sort of like talking to me so I know exactly what she is talking about, even though I am interpreting I know what she is saying. I know what she means so I understand her and looking at the person you are interpreting to, sort of like makes it real because they actually think you are still in there, just been out of it, so just looking at their face and thinking “Okay it’s fine we’re fine”.

Afterward I don’t think about the character, but we talk about the students afterward. Like okay these guys, these people were no good, these people had no idea. It sort of like just gets you out of character completely. Also there’s the students, I still get to get out of character, just that action of getting out of character and laughing about it and having all the students being surprised and saying “Oh my goodness I thought that was so real”. That sort of like takes the whole script away and listening to the teacher and the teacher telling them to say okay fine I thought you could have asked about this and you I thought you should have stopped there [Laughs] thinking about that. I’ve had to listen to nurses sort of ask about how the journey was coming to Australia, something someone wants to talk about. To say okay fine so how are you finding it, that’s fine. What are you doing now, what I was sort of like trying to understand is that people with the refugee background or people with the not so good background just want to look at the future? So even if you are looking at Kabill and how she will be interviewed the moment they talk about “so what are your plans? What do you intend on doing? What can I do to help you move on?” that’s when she gets excited that’s when she lights up and says I want to learn English, I want to do this I want to have a career, I want to change my life. That moment of change is what excites people.

Focus on the past maybe when you actually have built that rapport. When you have got that persons trust and you’ve met probably two or three times and you say ‘oh now we are at that talking level’ I don’t think you can do that at the first interview. That’s appropriate for my culture. You get to know someone and see them regularly and say oh I’m meeting up with this person and look forward to meeting them not on

a once off, ‘I’m going to meet with Chenai and she’s going to ask me about all these things’. Too private. With time of course it’s helpful for someone to talk about what has happened, but you need to build a strong relationship. Someone needs to be comfortable with you, someone needs to know you a bit better and I think that whole, the person in the health profession sort of like discloses something about them, it gives you something, not a lot, definitely not a lot but if they said “oh yeah I’ve had a rough time with this as well”, it might not be as bad but just having that person being in the comforting position to say I’ve had something similar sort of like opens you up to trust someone better. Well sometimes, sometimes not. Sometimes self-disclosure I can only understand it because probably I wouldn’t have had it that worse, but thinking from somebody who has actually gone through worse than that could ever be imagined, but like what could you ever tell me? So self-disclosure from the health professions can help or not help sometimes and I think should be held to the minimum. Obviously it is comforting if they probably tell you the exact same things to say, maybe if you walk in and they’re like I’ve had headaches, I’ve had this happen to me, I’ve had this and this and they can sort of say yeah I know of someone or I probably went through the same thing can sort of like make you be on the same level and understand each other and they actually tell you symptoms like you haven’t talked about and they say and this happened to me and they sort of understand. But when it comes to the whole personal background if they defiantly are not from the same background or ethnic background and they try to normalize it, you’re just looking at them and thinking mmmm Really? [*laughs]* Maybe not! I think oh really? It would make me a bit curious to say okay, tell me about you, I’m curious to know what you think was the worst that could happen. So self -disclosure is good but could be a bit dangerous if someone is really curious because they could turn around and ask you to say why don’t you tell me what happened to you! Health professionals shouldn’t normalize what has happened to you, but still hold that, I am still sorry that has happened to you, not to say yeah yeah it’s okay it happens. Instead say, I really do feel sorry I can only imagine it probably would have affected you even worse than I can imagine, so still holding that empathy and that much risk to say okay fine it’s really something that is that big to you so I will hold it up there

I came to Australia as a student 4 years ago. If it works out well then I would want to stay, if I get the permission to stay I would want to stay and practice my social work I have no family here, it’s just me. I feel lonely sometimes, sometimes it just really sucks but yeah you live with it, for the future thing, you say when I get a career I’m going to build my own family and make it work. My Dad lives in Zimbabwe, my Mum

lives in England with my two sisters. I got to see my Dad last year last December that was good. I haven't seen my Mum in 14 years but we talk every day.

So it is like one of the simulated cases but it's not a good feeling it's one of those 'oh yeah, so I made this huge decision to move away from my family' and you don't think about it when you're doing it, it's only when you get here and you think 'oh right, I've just left and I'm by myself' so it's one of those it takes you back to think yes I have done that. You don't think about it when you leave it's when you actually get here and everything's changed that your life, yeah I have left.

I'm a nurse I do in home nursing as other work. I did Division 2 in Zimbabwe and then I came here. Then I did like my Cert II in aged and community care sort of to meet the Australian standard and so I'm registered as an enrolled nurse here. I work nights a lot and then I sometimes work during the day that would probably be 20 to 30 hours a week. You have to work hard, if you're going to keep up with the education on a student visa. The simulated patient work is just relaxing it's nothing compared to my normal day. I've always wanted to be a social worker and nursing is something I did while I was waiting for my social work. Social workers are not really that recognized you wouldn't work unless if you are volunteering in Zimbabwe. They are just starting to recognize it and I imagine it would be a bit hectic to have a profession that no one really knows about it that no one really cares about.

Well if Australia fails then I still have England and my sisters, have to try that. They have never allowed me to go there. They've never let me enter my visa has always been denied like more than 8 to 10 times. They give you feedback, you meet all the requirements all the documents you supply to tell then my family lives there they are quite established there they've jobs they even have houses, they've mortgages and everything they are able to take care of me but you know. Having a Zimbabwe background and having known about the politics that's gone on between them that's what I think maybe just helps me sleep better. Because I have no idea like I had to try applying back home and I failed and then I have to try applying from Australia but then I had to settle in Australia. Settling in Australia, it will work out and if this works everything will work out, it's all connected, hopefully.

A1.3 Chinh

A1.3.2 Setting the scene

Chinh has been a relaxed affable simulated patient since I first met him at training. He was one of the first CALD simulated patients I had trained. I recall his willingness to practice and participate in that first day of training, where others in the group were more reticent.

We met at a technical school where Chinh was studying in a room in the library. He had texted my mobile and called me twice to ensure I could find the place, was still coming and then to warn me that parking may be difficult when I arrived.

Chinh is a man of contradictions. At once he is helpful and willing, at SP training and prior to the interview he appeared to be extra cooperative and helpful. However, at the interview, despite spending some time establishing rapport, it was difficult to draw him out. The following field notes record my impression at the time.

My overall impression is that Chinh doesn't really understand the concept of his opinion having relevance outside of his context. I have found it very difficult to get him to elaborate, as he seems more comfortable in the abstract rather than the specific. At one point he used an example of a cultural stereotype and didn't elaborate with a specific example but was at pains to claim the stereotype was applicable to all Vietnamese people.
Sometimes he would start a sentence by saying something like, "I remember" but wouldn't really tell what I would recognise as a story.

A1.3.3 Chinh's narrative

Oh I can't remember how long I have been a simulated patient for now I think I first, I first got recruited in, it must have been early this year. So it's been on and off was it, on and off since the beginning of the year but don't quote me on it because I honestly, I can't remember. I've found it great In terms of for me it's just, the way I see it, is that it's work and I just go there and do what I have to do and that's pretty much it and that's on a personal level.
From my experiences, experiences in doing it, I can see the benefit that it, that it will help the students in terms of giving them, even though it's you know simulated, but it can be as real as it possibly can I reckon. I remember when I used to go to school we did not have the chance you know, to get the practice, so I think it's really good for the students to have some sort of, just a feel of what it's like, you know around making it as real as I possibly could playing the role. So I think giving them that actual experience is a good thing. I would encourage it, it gives the students a chance, a taste of what it's like to be out in the workforce or just to go on placement. It gives them a taste of what it's about, it sort of prepares them otherwise it would be a bad experience walking into a working environment could be a bit daunting you know?

I think the feedback that I got was that they thought I was a patient from the hospital or from a mental health you know, from a 'psych' ward coming out to do this 'sim', so even though the setting is in a classroom and isn't real but it's the closest they can get. Or even just that, the pressure of doing it, if everybody, people watching you, so it's very real you know it might not be in the real environment but it's real for the student. You know added pressure so it's a good learning curve I believe. You have about what twenty people watching them and they know that they are being assessed by it, whereas as that's a stepping-stone to going to a work environment where there will be more pressure. I think it's good for them to have that experience of doing something that other people are watching you and just perform to learn how to perform I guess.

It's giving them an experience you know to, you know what I mean? It would take more practice in order to feel comfortable or have that pressure removal you know, removed, for you but I think the sim what it's done for them is that it's giving them that experience. Because I remember 15 years ago when I did my course there

wasn't any 'sims' so it was just basically you know thrown into the deep end and just go out there and do whatever and you know learn. It is not even about getting it wrong or right it's about learning, it's more about having a taste before you go out there and you know, know what to expect.

It's great because I've got some work and I enjoy doing it you know work, how I say, why I say work, is it is work. I get paid to do what I do and I think for me it works because I'm working in the community sector so I am pretty much used to the environment. So it's easy for me just to adapt to the whole simulated patient thing because I'm yeah I'm familiar with the field so it makes it a lot easier that's why I enjoy it.

I'm a youth worker at a homeless and youth refuge. So I deal with a lot of problematic young people. My role is to give them support, be a role model and assist them in making the right choices and hopefully empower them. And you know have a better life I guess.

My last simulated patient role was a mental health patient and I, *[Laughs]* I thought I did a pretty good acting job, you know, I don't know about I've had some feedback from the students they weren't sure if I was real or if I was just acting. Some of them said they realized towards the end I was just acting but at the same time they thought it was very good acting so you know I think it has worked for them.

I draw on experiences from my youth work so it was very easy for me to play that role because I, my work, I've dealt with a lot of mental health especially in young people. So for me, to mimic their, how they would act and all that that came pretty easily.

I can't say being a simulated patient has, to be honest, yeah it hasn't had an effect on me at all. And I'm not sure if I can elaborate on that. Because of what I am doing professionally (*as a youth worker)* I've always been around workers and nurses and people in the professions so I think this is just another example. I don't feel differently since being a simulated patient because that's how I've learned, without the simulated patient program.

I'm studying a Diploma in Community and Welfare services which takes three years because I'm doing it part time. I did this 10 years ago, I did this course exactly the

same course but under a different name 10 years ago but I got through it half way, then I deferred it and it's been over 10 years ago *[Laughs].* I wanted to start from the start, I just wanted to update my skills you know get all the updated information. I'm in my first year *[Laughs].* So I still have a long way to go.

It will help with employment, because back in those days you don't need to have qualifications to be in the, especially in the youth work environment position. If you have some sort of knowledge, life experience, or you know you pretty much put your hand up and you get a job and I think it's changing for the better now. You need qualifications you need to go to TAFE and all that. I was working casual but I was getting a lot of work and I thought I want to study just update my skills and all that yeah. The work is, it's all contract now. You do a, you sign a contract, a one year contract whatever it all depends on the funding. Yeah two year contract, you know whatever, but it's not permanent. I've been involved in this field for I think close to fifteen years now.

The reason why I got involved you know many years back was because given my actual, my background, there wasn't a lot of Vietnamese workers around so I thought you know, yeah, I wanted to make a difference and then I realized it's not that easy [Laughs] you know, yeah, so I have been in and out of this field for roughly 15 years.

I've been in Australia since 1981, thirty-two years yeah. Back then there weren't many Vietnamese youth workers but now there's quite a number of Vietnamese workers in all the different you know areas of the community sector, there are a lot more now.

It's helpful and unhelpful for kids from Vietnamese backgrounds to have Vietnamese youth workers. There is that stigma that you know especially within the Vietnamese community and look I daresay within all ethnic, ethnicity I think there's always that stigma. Sometimes a Vietnamese client they do not want to work with a Vietnamese worker because of you know "Oh they might know my family" or you know because it's a very small community so you know I think it starts from stems from the connection to their family and their might be you know other issues and given that it's a small community, people talk and sometimes you know sometimes confidentiality gets broken you know and so that's the downside. Then the benefit, you know, understanding the culture the specific needs not just for the client but for the family as well, I don't know it's a catch 22 I reckon, and look especially the kids growing up

here they are very fluent in English so it doesn't matter for them they are more Aussie than I am. They definitely get caught between the world of their parents and their friends, you know and usually there is a conflict there you know within the parents and the young people because they, you know, the young person is especially when they are more westernised because they go to school here, when they are born here, but with the parents they still have they are still very traditional and sometimes there is a break of communication or differences.

It is important, you know I think it is very important because there is no chance we are living in a multicultural country, people tend to stick with their culture and certain things that you know people don't want to change. Like family structures for example they are raised like how you are raised, you tend to pass that on to raising your own kid. Some people they are very traditional and they don't want to change and as a worker I think you know you have to keep that in mind and have that awareness of different cultures. I tend to especially when I work with a client it depends on, because I work with youth and a lot of them, they were born here. They are either born here or I'm looking for a word that I can't say, they are not as um traditional. They are more westernized. I think it's when I am dealing with the parents, I have to be careful of what I say, I have to be careful of how I present myself you know stuff like that. Of course because I have an understanding of you know, of my own culture it's a given for me yeah. I'm probably in the middle culturally but I can go either way if I have to, if it requires me to.

Of course that helps my work as a simulated patient you know being aware of being cultural, cultural sensitive is very important I think so but like I said, given my experience as a Vietnamese person coming into Australia I remember. Being a refugee you know living in a refugee camp, just the hardship I guess you know I have to adapt to a totally new country you know and find my way around. I was eleven. I lived with my brother, brothers. I was born in a war torn country so my family was scattered everywhere. It's pretty normal you know when you are born in a war torn country that your family is scattered everywhere running away from the war and experiencing the racism and the prejudism. *[sic]* Because when I first arrived the Vietnamese was the newest ethnic group to arrive to Australia so we were the target. So we had to put up with a lot of that.

School was difficult and you know I think that was, given my experience that's how we started to form gangs and it's not even gangs we would just get into groups just to

protect our self. I think that's a lot of how gangs start, you get together with the people with the same experience and then the groups form gangs, stuff like that. Over time I wouldn't say it got better I would just say over time people find somebody else that's newer to target. If you look at it now it's the Africans or Sudanese or Indians. So yeah I don't think you can ever wipe racism or prejudism its human nature to have. I think so, people need to be educated but it's funny how you know I remember when I was in Vietnam we were very racist towards the Chinese and other people that come into Vietnam so its human nature. I think you know racism and prejudism, stereotyping all that I think it comes from the fear of difference and even fear that someone is better than you, you know? So I don't think we can ever get rid of, as much as we want to. It would be a perfect world [Laughs] if we can. We can do something about it you know but I don't think we can ever ever get completely out. But when I think back to that time I was very happy, I was oblivious I was just your typical teenager growing up. We got into a lot of fights but as a kid you just kind of put it down to experience. I think human nature in general we adapt and yeah.

Even sometimes today I refuse to go to see a Vietnamese doctor, I much rather go and see a 'Anglo' doctor. Because they are more open they are more professional, my experience and not saying all Vietnamese doctors, don't take it the wrong way, but the ones I've had contact with, they are very closed minded. Look to put it in a nutshell it wasn't a pleasant experience for me. For example like my partner and I, we went to see this doctor and she wanted more information from the doctor but it wasn't given to her it was like "I am a doctor, I know everything" you know and my partner wasn't happy she went well I can't remember what it was but she got her results back and she wasn't happy about it because she wanted to find out more information about because she was worried. The doctor wouldn't you know, wouldn't give her the information or wasn't able I have no idea but pretty much he said "you are okay there is nothing wrong blah blah blah blah blah" you know I think the work ethic was very low you know and yeah, but look that's just my personal experience. 'Anglo' doctors have, I don't know there is, there is a sense of you know professionalism or concern. I think the reason why I singled out Vietnamese doctors is that given that when I was young I always used Vietnamese doctors so I've had a lot of contact with Vietnamese doctors that's why I'm singling them out. My family chose Vietnamese doctors because of the language barrier, it's back then their English was very limited so it's very hard to go in and talk to an 'Anglo' or you know doctor. It's very hard to communicate and say how you feel and what's wrong with you.

I didn't know what to expect when I first took on the role, my first role was being a translator for a Vietnamese patient. I thought it was fine, I thought it went great given you know the students an opportunity to understand more around how you would deal with a patient with an interpreter present. Just learning the way eye contact and all that stuff and so I thought that was very good practice for them, my experience was good. I haven't done any teaching before so being in the classroom with the students was a very good learning experience for me just to see how they how they would react to the whole situation and all that. It was very easy because I wasn't the focus of the attention I was just interpreting and I didn't have to think. If that may sound a bit, I was just interpreting whatever was you know needed to be interpreted at the time. The focus wasn't on me, so yeah, it was a lot easier.

My role as a mental health client was a lot harder because it was all about me. I had to play the role, I had to get into the role and I had to do so everything was about me and I didn't realize how stressful it was, draining. I did like four days in a row. My first day I did four hours and then the rest was six hours. Yeah and just one after the other you know so I was exposed to I think 200 over close to 250 students. Yeah you know and just asking the same questions. There was variation but I'm talking about you know like just one group from the other to the other and it was all repetitive and I have to keep in role-playing you know stay in role and I found that towards the end I can't remember which group is which and whether I have answered already or not you know and it is all, I found it a little bit draining towards the end.

I've never been asked a question in simulation I couldn't answer, I think because of the profession that I'm in and so I think I'm, I'm fortunate in a way that I've been working around you know well I've been working in the community sector for a while now so pretty much now I've heard all the questions. It was pretty easy for me, but I think for someone who doesn't have the background experience it would be a little bit tricky for them. I didn't have to memorize a lot for the mental health case, I was briefed and I got information about the role and that was pretty much it. There wasn't any training or anything. For me that was adequate if like I said again, I'm very fortunate that I've been around because I pretty much know before- hand what to do given somebody totally new they would be, they would struggle, because I can model myself on a composite of my you know of the clients I work with. I did, but I didn't really want to because I felt the students weren't ready, it was too hard yeah, they would not, it would have freaked them out. One of my character that I have to play

was a mental health patient about to be released from a mental health hospital and he was doing well he's experiencing paranoia and hallucinations but he was doing well, so that was pretty much easy. Down the track I have to play I think in two weeks, or three weeks I have to play the same character but he is getting worse. Given my experience you know I've witnessed some of the personality disorders and how they you know would act and I don't think the students are ready to handle that. I, initially I was going to test them you know to throw in a few lines, but I thought they weren't ready, they would freak out. Next time, I'm just going to test the water and see how they go you know and if I have to be gentle then I'll be gentle. Even if the teachers want them to see that so they know what it looks like before they see it for real, I would probably test the water and see where they are at and then just take it from there. I can tell how they are going from the questions, their body language, the questions they ask me, you know they would ask me a question I would reply and depends on how each individual session goes, that would be the outcome of how I play my role.

I had students came in and I could see they are shaking and I could see they are nervous and I go really gentle and I have other people watching over me as well so if it gets too hard they can just end. It's not like it's a set role, set theme that you just go in there and it doesn't matter how the students come across and what sort of questions they ask and how they perform you have a set answer. It is sort of you know we have a case study but I just make it up as I go along and it's good that I have that freedom to do that. The teacher gave me very positive feedback and she asked do I want to do it next year? Do I want to come back and do it if I am available? Actually I would like to do more, not just that character but others, different roles, translator, interpreter whatever. It's a good experience.

There were some interviews where some students you know had no idea they had no idea and after the interview I would leave the room and think they don't know what they are getting themselves in to. I wonder to myself you know it seems to me this is again my personal opinion I feel they just think being a nurse you go into hospital and look after sick patient and that's it. They have no awareness of mental health so they will be in for a shock and then you get others who are already working in the field or have some sort of experience with mental health and they are really good. So who knows? And hopefully you know the sessions that don't go too well maybe I am hoping that they will reflect, I don't know if I am using the right words here but to

reflect or soul search and see if this is the right course for me and is this what I want to do? Think about 'am I ready?'

In a really good session they know exactly what to ask they know about body language, yeah they, you can see they have some sort of excellence already. I remember a couple of students they came into the interview room with the attitude this was a game you know it's just a game for them very cocky, very sarcastic. I can see they may not last. I didn't respond because I was just an actor and at the end of the day they are students you know, but if they carry that attitude into their work or into the work environment and given the kids that we deal with or the people that we deal with they are going to get themselves in a bit of a you know. They can go off just like that *(Fingers click)* you know it's very unpredictable. I wouldn't say they would not tolerate the students but you just they are just so unpredictable.

To manage those clients well number 1 you can't be sarcastic, and look I can't really pinpoint but I think you have to be calm, have empathy because when especially when you go into an interview you need to be a lot of the times what I find is the clients I deal with are nervous themselves so if I'm nervous it wouldn't help. So I have to be calm and I have to be careful what I ask. It's very serious because we are dealing with human beings here we are not you know? I remember I took a young person to a do a psych assessment with two mental health nurses and that young person just went off. The nurses didn't do anything wrong just your typical normal standard patient. He just decided he wanted to go off you know he went off. They have the mechanism or the skills to calm the situation down or end it straight away. I wasn't sure if I could play the patient like that because I didn't want to over play it. So just in case it might freak them out so I was very aware of you know I'm dealing with students not health professionals and I have to be careful how I um yeah.

I think the training is very important you know and picking the right person I think that will, what I mean by the right person is that it depends on what role. I know as much as hard as it can be finding people like for example I'm just reflecting about my role as a mental health patient if I had, If I had no experience from the work that I do I reckon it would, I would really struggle. I wouldn't know how to react and I wouldn't know how to play, get into the character you know, because in all honestly there wasn't any training. Of course you can train some body to do it but having that you know experience would help, makes it really easy

I think it's more authentic if the person has real experience and I think it's very hard to find someone who has actually been through it and if even if you can find a person who has been through it are they willing to do it because it might bring back some memories. So I think you can only make it as real as you possibly can for the students because at the end of the day it's a, it's a, it's all role-play you know it's not real. I think the students will learn all the real stuff when they are in the workforce but to prepare them to be able to prepare them you know and make it as real as you possibly can I think that's good enough.

The (*psychological)* risk isn't a problem, not for me, but again it goes back to my experience working with people so I'm pretty used to that. It doesn't affect me at all. We train to deal with people who are angry I've done a few training courses working with young people with behavioural you know problems and all that, high risk crimes, we get training from work, we get a lot of training at work and we get debrief, we get debriefed whenever we feel you know we need it, we just ask management for it usually we get it. I think it's pretty confidential people don't talk about it, but we encourage it everybody and management they, they are very supportive when it comes to the debriefing stuff like that. I was offered after playing you know my role *(in simulation)* for a week straight I was offered if I needed a debrief. I said 'No' because it didn't bother me and I hadn't internalised it and then what happened really funny was on Friday I went home and I was spoken to my partner and I found myself you know speaking like the role that I was in and I "What am I doing I'm at home now" you know so I had to remind myself you know that you're no longer in role. Just some of the words you know and the way that I was talking. She didn't react she wasn't aware of it. I told her that yeah and she just laughed. I think that happened because I was in character for too long but it wasn't hard for me to just after realizing it just to snap out and be aware that hey you're Chinh you are not Paul. *(Laughing)*

My experience working in the field helped with that too, how to shut off when I leave work all that, it helps. Again like I said because of my background I think it made it really easy for me because I've had the training and you know I'm aware of, but like I said again if someone who's had no experience doing this before or working in the you know in the field, I don't know how they would they might they might need some debrief afterwards and they might not know they need it but how can you force somebody to do what they don't want to do? Because even before that, I remember, I went straight from the simulated patient straight from the uni to work and I found myself talking a little bit like I you know I was still in role at work as well. So I

recognized it and I try and stop it and then when I went home with my partner yeah I did it again but then that was it. It's just a matter of recognizing it and talking to myself and then talking to my co-worker just like a debrief. I didn't feel at that time that I needed a debrief. Having a debrief might have been a way to stop me taking that character with me but like I said I didn't feel that I needed it. I didn't realize I was doing that till I got to work and started talking to other people.

I think I've got the skills and mechanisms that to deal with it, but who knows I might need it next time, so you should always offer a debrief. But everyone's different and the level of um…. I can't even think of the word now what I'm trying to say is everyone is different some people might need it you know debrief and some might not but it's good to know that it's available if you need it. And I might say I didn't need it last time but who knows next time I might need it. Sometimes you might go in doing an interview session, doing a sim and you might get something that's really really hard to handle, to deal with and you might need a debrief at the end of the day who knows.

I thought the pay was very attractive you know that's initially why I did it was because of you know the pay that helps as well. I would say it's a fair amount of money but that's for me personally.

A1.4 Gabir

A1.4.2 Setting the scene

Gabir is a current PhD student. He was studying full time when we met for his first interview. I chose to meet in the library at the institution where he was enrolled, so as to reduce the impact on his time. Gabir is a 51-year-old Ethiopian man who speaks quietly. In his SP portrayals his characterizations are compelling and intense.

Gabir is paternalistic towards me. I am not sure of where this arises. I recorded field notes regarding his behaviour for both interview sessions.

I had chosen to sit at a nest of tub chairs in the interview room and ignore the table and office chairs in the same space. After we had signed the consent Gabir asked if we could move to the table and chairs because the sound would be better he said. He indicated the air-conditioning duct that wasn't making any noise I could hear. We moved but I wasn't sure why? (Gabir, interview 1)

Gabir organized for me to go to his new workplace and directed me to parking and said he would organise a room. I arrived on time but the staff in his office let me know he was at lunch. They told him I had arrived and I waited in the corridor for about 10 minutes. When he returned from lunch he apologised for keeping me waiting and we went to a classroom for the interview. I wonder if this is about power?

After the interview Gabir walked with me out to the carpark and bid me goodbye, like he was my host.

A1.4.3 Gabir's narrative

Well I've been a simulated patient maybe now for two years, a year and a half, yeah since last year. I've had a couple of works last year but, because sometimes you know, there was some other jobs, I haven't done a couple of those assignments. I did work with social work students and also nursing.

I think it's excellent experience in terms of, I think for me it's both ways, number one it's about expressing my experience through you know, even looks fictional stuff but it's not because sometimes you know, it's a true story and I used to kind of become a bit emotional because it reminds me of some of the journey, some of the journey I travelled. It was interesting, you think that's the role-play and, but sometimes that role-play is part of your journey, part of the journey that you travel across to where you are. Once when I was doing it, somehow I do reflect back about my journey or people I know, and particularly I do the mental health area when doing the simulation. So I found it, I drag into some of the emotions because it reminds me of some of the things I've been through. It reminds me what my friends been through, but also not necessarily what happened as a refugee but also when you arrive.

And also it's a reflection of the issues within my own community and the community I work with so one of the, I think one of the things I've done was mental illness, mental health issue so it become, it reminds me, you know some of the mental health issues with my own community. But also I feel happy in the relief because I felt I shared my experience and those students will go to the field having you know, equipped with some of the basic knowledge so I think for me, I have, it's kind of I have done my responsibility, my duty to you know, share my experience to educate those young people who will be going to the field and then, and those people will assist the community I belong. So yeah, it can be both ways, number one I was happy I share my experience, you know shared some burden from my shoulder as it, but also I thought I make a difference to the knowledge of the young people who are students.

One of the scenarios was about you know, mental health issues and so it reminds me a lot of the people with the community I belong who really suffer silently and when I, because there was also discussions and suicide was a question that students ask, all the practitioners ask, you know, it reminds me what is happening with my own community. And yeah, so it is that aspect, you know it reminds me, you know some of the issues they say but also mental health is a big issue in our

community and you know, we lost many, many people through suicide, should we know what mental health is as a community, we could have done something. So by sharing this to the students the level of knowledge that we have in our community, I think those people, regardless whether they are going through nursing, social work, psychiatric nursing stuff, they will come to the field knowing basic knowledge about what to look for and how they should deal with it.

It reminds me how a lot of people do struggle to get through those experiences and I become emotional because I witness a couple of friends, close friends I know, have committed suicide because no one has really noticed about what happened. So when I think about this, being a person with mental health and doing that simulation, all this really comes to your mind. It's not really role-play. It's really a real thing, actually exactly what happened. I'm not talking about, I'm not creating a story. It's really a story that has happened. So those mixtures really drag me into the emotion.

So, but the perception I see from the people I work with, you have to really go on the street, yell on the street and go half-naked. That's what mental health, the understanding of mental health is, from the people I work with, but I think for someone to get into that state that would be probably too late to really to support them and to assist them. So I think people should be educated about mental health is not about this but also it is this.

So that prevention would be quite critical and I'm talking about people who have high risk of mental health issues because of past traumas. So do we have really extra care and extra education to those people; I don't believe so. I don't believe so.

I think my emotion is more frustration, yeah, because I think it's more, that emotion is more about frustration why this had happened and what could be done about that. When I look at it, at this stage where I'm reasonably aware, I go to school and I have an idea, and sometimes I could have done better, I could have done more. I could have done more but unfortunately I'm not in a position to do a lot. But sometimes when I have access to different services and stuff, through my work and, so it feel that you get frustrated, why we have to go through, but also why people when they arrive here why does it have to go really slow, why there is a lot of resources and support but none of us really use that effectively.

Because community, the different communities, particularly the new arrivals, people from Africa and probably Asia also, and the people I work with, mainly the African communities, we have a different way of looking at mental health and we have a different way of treating mental health, but in this modern country we've possibly got every facility, they're not accessed. So I always say people should know what to do when someone has, you don't have to throw your clothes and go on the street half-naked to be someone with mental health.

One of the community I belong to few years ago they had a meeting and in that meeting they addressed some of the drug and alcohol and mental health issues with a couple of community members, and the decision was let's contribute money and send them back home, which they did. So I wasn't at the meeting but this is the treatment that we have. What is a guarantee of sending back people? Are we really exacerbating their problem by doing second migration? You're sending some people who have grown up here, born in a refugee camp, sending them back to a strange place on their behalf and send them to a strange place. Someone who is born in a refugee camp or left early, grown up in a refugee camp, come here, live the rest of their life here, sending, Ethiopia is a strange place for them. There is, and as a risk factor for mental health because you are taking them to an environment which they really don't know anyone or they haven't got any network. But this is how people approach ultimately because they contribute money.

So this is the kind of treatment we're approaching and I don't believe that what, this is me. I mean, this is why communities should be educated and I think probably just after we met I did actually work with mental health organization. I just done a choice and I say, "Well, look, I can't really watch. I have to get the knowledge, working, what this organization do," and I kind of thought, which I did. I worked for a bit and I've done my bit to, at least I have people, I work in a mental health support to my friends, to anybody. So, yeah, it's those kind of reasons why I say what I say, education, people should be educated.

So this kind of thing really it's about frustration and why people lose their life. So I think even if I think, I thought about the frustration and the emotional stuff but also I have a sense of pride and a sense of happiness at the end of the *(simulation)* session because I really, I feel like I have done well to see what it looks like as a worker, new graduates, what it looks like to be in that situation and they do observe that emotion also. They do observe that emotion because they can tell, they can read

how I'm presenting myself, and they can read it's even if I am doing the role-play, the simulation, but they can see it's real. It's real, real story. So, and I feel also happy because, well, I have done, I think I have done, my job in terms of getting that message across.

I was fortunate enough in many aspects to get through my issues, get through my trauma, those bad experiences, because I was fortunate enough to, it's a choice. Well, it's a choice but also it's an opportunity because I was in a position to go to school here and to know people who guide me through my career in terms of my education. So I think that relationship I have done with people really changed my frame of mind and that good people out there and so I, that's change of mind frame is more about positivity, where there is a lot in this world.

It isn't too real, I mean because you know, simulated patient, you know you see you act, it's an act but through that act you get connected with the reality so I think for me, I get connected to the reality through that you know. Partly my reality, a lot of it's my reality, huge chunk of it is my own experience but also we, I think we, I'm from Ethiopia and everyone's reality is the reality of many people. Because we live as a community not as individuals so you know, someone's reality, my family members, my friend's reality is my reality and vice versa so. Because I think we, as a community we celebrate together and we grieve together so that's how we survive and it's because we came the same journey, you know experience, quite similar experience with migration, the journey and that will be bringing us together as a community in addition to you know, the cultural bonding stuff that we have. But also that migration process bring us together as a community because this is a way of survival, in order to survive in those you know, harsh circumstances we need to come together.

Being a simulated patient has probably impacted my life in a positive way, because as I say to you, not directly to my daily activity but it's a lot of satisfaction when you do that and number one, as I say earlier you know, one it's a relief because you share your say because sometimes you know, you don't get that opportunity to share your experience. And when you have that opportunity and you share your experience, you feel relief because someone has listened to you. But also when you finish, I think to me, that I thought particularly when I see students interest, their question, their attention, I thought I have that impact.

When I say relief that is because I share you know, my experience, sometimes you don't really find opportunity to talk but when you find those opportunities and you act, you know, your only experience, it's important, I mean you just get a relief because you say whatever, what's inside you. Well, I think you need to live through that to, you can show some empathy or sympathy and you can feel pity and it might affect you and you can feel what I feel, but as a professional you might have those feelings but I don't think so. No one will feel their feelings and experiences a lot of people, you can understand it what it looks like to me, but in terms of, I wouldn't expect any one will feel exactly how I feel when I say that. I don't believe someone, unless they have that experience, will portray me in that context because this is where, when you're doing a role-play or simulation but you, sometimes you struggle with self to hold, "Hang on a second, I'm doing simulation I'm not talking about my real life." But without knowing it you are *(pauses)* Yeah. Without knowing it that whole emotion just starts to come and you just wake up again and, "Hang on a second. Oh, I'm just going too far. This is me. I'm talking about myself." I'm not portraying an issue, I'm portraying, I'm presenting myself and, yeah, look, I believe people will really feel about how I feel but not necessarily have the same feeling as they, as I do have.

One of the things was about, you know the mental health issue, you know I lost someone, you know very, very close to me. And that was quite emotional when I was you know, discussing about it, I guess it's because should I now get some of the symptoms of mental health, what has to be done, I could have intervened and I could have saved that person because I was early in my education and I wasn't familiar with how the system works. But also the community reaction towards that person, because if the community had known what was happening with this person's situation, the community could have acted differently. So you know, when I was talking about mental health and always those experiences you know, flashing in my eyes and my head and you know, so this is why I get happy to share, to be part of this simulated patient because I'm sharing what we as a community and myself believe what mental health is. Then those people who are coming to the field, if they knew what the beliefs, what the attitudes to mental health and they would deal with it so yeah, those are some of the emotion and also you know, just the whole migration process, you know you experience, you know a lot of things in a way, a lot of issues, a lot of problems on the way, on your journey and that also triggers a lot of, not necessarily mental health but also a lot of health issues, abuse, you know all this stuff. So yeah, that's what, you know when I say emotional, that's the kind of thing, it's a reminder of your journey.

So even though it’s emotional the empowerment is stronger for me. I think it’s the most important pathways because that’s why, because you know, when I, I think about any impact, after I finish I would say yes I have done, you know I educate people, I have that, it’s not about the relief, it’s not about I say what’s inside me, but it is, I educate people. It’s satisfaction because I would like a difference, I think this is my purpose of joining this simulated patient, it wasn’t the employment side of it which really interests me, it’s more about you know, that educational component. Because the educational component, as you probably know, it’s so busy with some other stuff, with my studies and stuff but I thought that’s an opportunity for me to act because it’s, I’ve been through all this you know, no-one can be better than me in terms of, I’ve been through that experience. So I can you know, I can act for it and I can express myself through that act so that was my main purpose of joining this simulated group because I think that’s important opportunity.

I think education, I found education was probably a turning point for me and I always remember the first time I went to school. That's probably, I never thought about what I, what I achieve now in terms of education wasn't the plan. It wasn't an opportunity. It was just an accident. An opportunity comes by self and luckily I just took it and then it changed me. It changed me. Put the education aside though, I mean, it's not the education, the qualification or whatever I got, it's the relationship I built with people around me in that school environment. That was probably the key turning point. Because it's not about how much I know, how much I got from my education, it's about the relationship I create around that education and that's probably the key. At that early stage I have developed good relationship. I was the only black person in about 30 students. So I was a stranger. But I don't present myself as a stranger and they accept that as I'm one of them, and that's really I was unique and that uniqueness really helped me a lot. People put more attention towards my welfare and my education, and every single student in that group for two years has really, they want to make sure I am at the right level in my education and they commit. Yeah. I am one of them. I receive my lecturers, my teachers, my students, they were standing with me. They really support me. They help me to walk and run, and that's critical. So the message is if you really understand someone and try to help them they can achieve a lot.

So that really creates for me, for me it's really created, it comes to a belief. It comes from a very harsh people just doing stuff they shouldn't do, people you know, people

you citizens. But come a stranger to come into a strange country and people do good stuff, hey, you know, I'm in the right place with the right people. So you have that set in a positive frame in your mind, and once I build up my confidence and I build trust and I, it doesn't really affect me. I never raise, I never use this wall, say, discrimination or racism because there are a lot of people who give me here who are whites. Why should I get upset with a drunken person who yell me at an intersection or roundabout? So I don't really see those. I think that really helped me a lot, to think that positive thinking. So I don't think so a lot of people I know from my community have that positivity still. That experience hounds them. That experience affects them, and it's hard when you have those feelings, it's really hard to move on, forward. But I think for me I was fortunate enough to be influenced by what is in front of me rather than be influenced by what I left behind. That's why that education is, number one, to educate the people but also to educate health professionals to have that cultural belief and concept of mental health. That's how people think what mental health is and that will assist as well. But once you get into help, the community know and they get into, some sort of help then that's fine. But I think there should be some education about how to get into it.

Education, that's an opportunity. I think that's, to me that's once probably in, opportunity to make a difference because to educate the community, as I say, you start from zero and it's a hard way, it's a really hard way, but to educate the professionals, particularly at this early stage of their education, I think that's, I thought that's quite important. That's really quite important because so you're not watching a drama or a movie. This is, they're just watching a real life but in a different context. So I thought, and I can see the questions the students ask and some of them, because I was interested to, some of the questions they ask are kind of naïve. They don't really expose before, but I'm so glad because I done this role-play with those people.

My experience more or less reflects all Ethiopians, almost all Ethiopians and some other refugees so it’s that reflection, when I speak, I speak on behalf of me, you know it’s a voice of you know, many of the refugees who’ve been through, you know difficult journey. Absolutely because they say, I will say I am in a good, in many ways I'm happy with how my life has progressed but I always see many people are struggling. So to represent, at the simulation I wasn't representing myself. I was representing a population who been through those and I have been there, and to be able to represent that issue, not representing people but representing their

experience, we, the people, who will be going into the field and doing something good. So I thought I have a big responsibility in addressing that as a person, as a community member but also as someone who have access to education.

So I think one of the reasons why I joined this simulation group was I feel like this is I have to, I have the responsibility to influence some practices, have the responsibility to represent my own community, not necessarily my own community but people who pass through this experience. So I have the, I feel responsible to raise their issues in any possible opportunities and forums. I think my responsibility was to the people who are here. They came through that journey.

So I think their concept is the things that I, the simulation I did was about migration experience. So it's more about the people. People in Ethiopia will have their own issues, which I am not in a position to, not to do a lot. But the people who share my experience, the people I share experience with, are living here around me. Some of them are my friends. Some people I know. Some people have the same experience than me.

So I think to me it's the people who are here, and the reason is because there is an opportunity in this country and I always ask why don't people access those services, the support system, but that is to the community. But also there are service providers, like the students, in a couple of years they're going to take that responsibility of working with those people. So I think my passion was just to let those people know this exists. A lot of them, I think from what I see, was quite young, never been through this sort of issues, never probably talked to people who have that experience before. So to see, and to see live from someone who has been through that, and also someone who really fight hard a way out, way out of that, that will have an impression. We'll say okay, if you really address those issues, work hard, people can achieve this. So, yeah, I think this is what, one of the reason I join.

The simulated patient experience has absolutely lived up to my expectations, it does, how I didn't know, when I have done, you know that simulated, simulated practice, I can see students try to opening their mouths listening and just the attention they have and lots of them as they are surprised. So and the questions they ask, that's really a good indication about how interested they are, they didn't know anything about it before, now wouldn't go to the field if it's at the end, you know, some of the, I think one of the sessions was about the question and answer, and the questions was

quite, you know sometimes you are, number one, they are young and they didn't have that, you know opportunity to meet, they've probably seen on TV, they you know, probably they haven't met someone physically or they might not have had face to face with someone who've been so and active or has story in a simulated context.

So I was so glad and I was, it was good in a way, and the feedback, the feedback's they provide they go we didn't know this before so all of this combination, combining all this. Number one I was also confident about this, you know it's, I was confident about you know, my task, the assignment I was given and I studied, I prepared myself so yeah, it was, I think I would say definitely those students when they go out to the field, I'm sure they would have some idea.

It's because the experience, you present yourself as a migrant, a refugee, how you have been through and because some of the questions you've been asked as a simulated patient, perhaps you'll ask me how my experience affects my health and that. So you know, when I share all of this, a lot of them they don't really know what migration showed me, you know walking on foot for about a year on the jungle, what that might look like and how that impact on the physical and mental health like when I say that was my experience, that was my experience clearly you know, walking from one country to another country on foot.

Because physically you know, they know from someone who has been through that issue, you know it's, I believe it is a simulated experience but it's best to only know the reality, it's the reality, you know, it's a reality. But also that emotion, I was so emotional when I talk about this and they kind of drag into the emotional so they become part of that journey so I think they, I think some of them, some of them I can see they travel with me.

That sort of makes me happy because they're quite young and you know, they're out there to learn I think sometimes you, I know at their early stages of their study so really don't know what to expect, what the reaction might be. Do they take it as a role-play and, okay, let's get it done and get the practice side of it and we're done. You're always, but I think from my point of view I have a mission to really influence those people's thinking, that's why I went there, and I can see people are just, the students are just opening their mouth and try to listen because they just, honestly I was looking at very unreal, such young students they're not taking their eyes off you throughout that session, keeps them awake. It's really hard to maintain over that

hour or hour and a half. It is something hard to maintain and I believe they're quite smart and they will learn more, this gives them a bit of idea of what is happening with the refugee and migrant's mind and you know, through their education and their own research, I have no doubt that will, and that's exactly what they say.

But I was just kind of looking at the students and everybody was just at attention and I just feel like, "Hang on a second. Wow, I think I'm doing a good job," because at least I keep them awake and focused. So that makes me happy. They were so interested and I thought that's why, that is real. I think they realize it's a real story, simulation but real story. So I think they connect with me. They connect with my story.

So that real story interests them. So, and the cautions and the discussions after that and the compliments they provide, all of that makes me feel happy because make me, I was so happy now I have done a bit of difference. People will go home and they will ask themselves, "Is that so." They will read some textbooks. It depends you know, how much they will take some issues because some of them might be specialized in you know, say torture and trauma or refugee counseling or mental health nurse you know. So it depends on the area they choose, the profession or the specialization they might have in the future. But I think from my sense looking at being there is you know, it's a feeling, those people, it's a feeling they have, you know you saw, I didn't know that before, got no idea before so yeah. So I think it's often like, it's a really important project, I really enjoy to being part of it, I wish I had time to attend every session and every assignment I was given but I think it both ways, it's, but also I learn a lot from the questions they ask. Sometimes you, assume, everybody knows about refugees always in our face, but the reality is not that, you know, when they ask about migrants and refugees and they see, they think they, it's the same but they are different.

Refugee, migrants, asylum seekers you know no, because every journey of those people, different categories, have significant impact on the mental and the physical health of, you know. An economic migrant who wants to work here, you know coming from plan you know to plan, you know, they wouldn't have the same mental health status from someone who travelled fully in a jungle from one country to another country with fear, frightened of animals at night, you know all of this. So sometimes you think you know, people would know but unfortunately. I actually asked initially I asked the students whether they know the difference between those

and almost I think one student come very close out of 60 students, there's only one student or two students just come close, they know that they're not the same.

After the simulated patient role is finished all in all I was okay, I was fine, you know at the end, I was fine, as soon as I came out, I realized I was acting, it's simulated. I prefer after any, and after any session completed probably, I mean a five minute debriefing would be good but you know, how do you feel, what you know so, because you kind of feel that to get rid of it and to change that mood, yeah that would be helpful because sometimes, we have this meeting since after, you know this whole simulated patient group meetings stuff, but that's, you know once I'm there, in a couple of months, once a year, but even after every session even a phone call. How was today, how do you feel and you know, that could be helpful?

I think the program is well structured in terms of I don't have any you know, feedback, I think the program is well structured, we've been trained well, we've been given the support in terms of our training, we've been given the support prior to the training and with the case studies given was quite clear, the modules was you know, quite clear, what the expectations are. Yeah so I think I don't really have any feedback but apart from the only issue is I know there was a couple of you know, sessions cancelled because you can't, there are two people involved sometimes particularly when there's interpreting stuff two people involved so one mightn't be able, you know. So that was a bit of the issue, I didn't know how that, you know when it involved two people.

I cancelled a session because I couldn't do that but I think from, yeah this is, and as a, probably a suggestion would be the people who involved can't speak English, a simulated patient and for example in a simulated context I as an interpreter and as a person, a patient, we both listen and speak English. But I was just wondering what that might look like if the person, the patient cannot speak English. I am an accredited interpreter and I do interpreting you know, with people, of course who cannot speak English. It's not only, well the people we, most of them both of them are educated people know how to express ourselves and we know how to express ourselves orally but what is important is when body language is used because a lot of those people, you know in my experience anyway, those people who cannot speak English, they do have a lot of body language which the practitioner can pick up straightaway and act on that. Sometimes that communication because sometimes I get surprised when before I even interpret what the patients say the doctor's kind of

just pick it up straightaway from the body language, from the non-verbal stuff. From their emotion, from their expression and that is surprise sometimes, you know, before I even interpret, they just turn away, they, the doctor's started to talk and I go hang on a second, how do you know? So I mean because that's my, because how the students will, you know, because I love to see what that might look like in a real life because the person, the patient actually in that simulated context, the patient you know, hears and he prepares, as he or she goes they are preparing their answer so there is no emotion into it.

Also how interpreters struggle particularly in a nursing context, in a medical context, how interpreters struggle with the language, the medical language. The terminology, it's hard because an interpreter has to ask many times you know, what is this the doctor, what do you mean by this so the doctor has to explain that in a different way, one word maybe he might, they might use pictures to draw what it is, you know what I mean, so that's there are some medical terminologies we don't have equivalent language but also we don't have that, you know medical terminology, now they get an interpreter so you always struggle to interpret that. So you know, the nurses or doctors have to really, sometimes they have to really use some drawing, and you know, sometimes you know, arthritis for example you know, well we have language for that, we do have but some patient ask, you know what's the symptoms and how will it affect and all of that. So they have to draw this is a knee, this is a, you know this is, all these things and I remember when I was doing hips replacement for interpreting, you know the doctor drawing a picture, this is the socket, this is where it's done, you know so then, and then you bring that picture. That struggle is, that struggle interpreters always we do struggle is also important. Yes, but there's a distinction though, I mean when you ask as an interpreter, when you work as an interpreter, it's not as a representation, it's as a job, it's a job that you do. But you don't really have much voice.

As an interpreter you don't, you don't have any voice, you are just a carrier, just take the message from one person to the next but you don't have much say and professionally you get bound by that you respect the ethics of that profession, you know the profession and you act, you don't have any voice. If you have to raise you know, if you want to become a voice, let's say an opportunity like simulated stuff and some other avenues. But you know, yeah as a community member you're present, your communities at a different level and a simulated patient was one of them for me it's about, you know about the voice, about sharing not only my journey but my

journey's you know similar to, to hundreds and thousands of people. So I think that's a, so this is a, that's why this program was important because you know, let me do some difference you know, I wouldn't do that, I have to indicate, how to share my experience and people should learn from my experience, they shouldn't learn from books.

Some people, they become very emotional about it, they cry and I say I win. So you know, inside me say yes that's, I win, so this is my emotion, so welcome to it. Well, I think it's more, as I say before, I think when I joined this simulation, it wasn't, honestly I can tell you it wasn't for the employment or fame because that was nothing.

Yeah, comparing to time I spent, but mainly this is an opportunity to catch those people before they go to the wild. All right. And, when I see those sorts of reaction I say that's a win because I just, I make a contribution. I mean, I make a contribution very tiny but it's significant contribution. So this is probably, but the other thing is also with the right support, appropriate help, people can achieve something and see me. To the real world so this is exactly what is simulated patient has done. So because it gives me that, "Hang on a second, those people they will remember me at some point." "I've seen, we've seen this bald man sometime say this, say that." They will remember that at some point, at some point of their life. So I think for me it's a win. That's what I have a sense of, winning.

Last week I volunteered myself to a program called human library, you probably heard about it? Human library's, you have a, I'm a living book, I'm a living book, so as a reader you have a library, someone comes and asks me about my experience. It's called human library, it's new in Australia, I think I volunteered myself personally for this and I was fully booked, a reader have only 20 minutes to read me, ask me questions, as a commissioner of work. So I was two hours fully booked and people actually come in and pay us in order to do that, so it's about, it's a narrative, it's sharing stories and the reason why, it's quite similar to the simulated patient because you know, let me share my experience, it's an opportunity. They have a bit of paragraph about me and the questions they want me to, the questions I want to answer but you know, usually we don't, just keep quiet and people just ask questions.

It's part of the diversity week celebration in *(named suburb)* so that's why you know, I always every opportunity I got I just jump into, this I believe, this is real, this is

important. So yeah, when I, I say everyone, I join the simulated patient I thought this is a real opportunity to really act your true life and to educate those young people at this early stage of their education so that's why I commit myself to do this, having you know, fully booked. This program can make a lot of change, it can make a lot of change to the way people practice, fully aware, but also it can make a change to the way you know, a refugee, migrant, can receive treatment. So this program can create a bond and you know, I do this every opportunity I got, I do it and you know, I was approached by another university for a similar program, yeah I have done it because as I said earlier on, you know every opportunity you think you have to represent you know, the voice of your own and your community, yeah you just, so this is quite important, you know piece of you know, work I have done, honestly if I'd been asked to do it for free I'd do it, if I have, using my time I will do it.

It's about the opportunity to share your experience, you know, education is knowledge and knowledge is quite important in how you relate to others, how we work with others and how we treat others. So and knowledge doesn't really come to me anyway, it doesn't come formally you know, it can come through conversation and so sharing experience and I believe that's powerful and I use that opportunity of sharing my experience and change and influence the way people interact with certain groups of people.

A1.5 Hwei-ru

A1.5.2 Setting the scene

Hwei-ru is a Chinese woman in her sixties. She has a serious face and seems reserved most of the time. Her accent is particularly thick and sometimes hard to understand. I travelled to China just after our first interview and she is keen to ask me about this, and how my experience in China was. She travelled to the same city just a fortnight after I did. She is eager to laugh at my exclamations about the traffic and some of the smog conditions in major cities like Beijing.

After the second interview Hwei-ru presented me with a gift of a Chinese silk purse with a press button attachment. She waits while I open it and seems so pleased when I hug her and thank her for it. I am not sure why she has given me this and when I ask her she simply restates "This is for you".

I chose the pseudonym Hwei-ru, as it means 'wise and intelligent', and this is the persona I associate with her.

A1.5.3 Hwei-ru's narrative

I think it is two years I have been working as a simulated patient. Two zero, 2013 until now. Yeah, two year. I think it is a good job, yeah. Yeah. Good for students and good for me. Is good experience. You know, as the patient I think student can learn how to talk to the different people. What about other people's different beliefs. And different people, how can connect with, to the different people. Yeah. In different thinking. Is, for student, they can learn more.

But for me I think I can learn something from the student, yeah. Example, respect to different beliefs. I think they show the respect to the different beliefs. This is, I think is good, yeah.

You know, in China is, long time ago, only one belief. You can't believe all the, you only believe what the government. You only believe this, you can't believe some other, some Bhuddism and thing. But here I can see the student respect to different belief. This is a good thing. Long time ago, I lived in China then, when only one belief. I come here, I've lived in Australia here for 40 years. At the time it's different from Australians and now you can believe with the Buddha and believe, in some anything. Yeah, but I wasn't in China, no, so I look at the students and I think that they, mind is very open, is very good, yeah, is, like to me, feels good. Yes so it gives Australian hope.

Even the student today, same as long time ago in China, you only believe this, you only believe this is no good for the young people. If young people can open their mind, the world is nice. You know, as a simulated patient that I have told the student that I go to the temple. You know someone believe as a Buddha, someone believe as a, the ones that go to church, but they can't. They have to do it very, very be careful in China back then. They believe in the Buddha only at home. At home and they have to close the door, close the window and everything, don't like the neighbor knows. Well the people, you know the government is very strong. The people only do something under the table, yeah. They have to, they kind of angry or something, you know, if somewhere else that know this, maybe tell the government, they having the trouble. I don't believe in the Buddha, so no trouble with me, but I have some family member, they believe in the Buddha. Yeah, they only do something at the

night. They do not talk about it you know I am a family member so I know what's happening. You kind of believe and is as a revolution, yeah, cultural revolution.

When I was the lecturer, the student not like here the student, they are not open the mind, yeah and no more question ask the class. They're only listening to the lecture, different to here. Here the student, the mind open, they can ask good questions, they can then liaise with various activity in the classroom.

You know I learn the aged care, the course. Finish it. I should go to the aged care facility people. They, the course asks the people to pay respect to different beliefs. I understand the different beliefs because of the work with the simulated patient. Is good for the patient too. I think everything is okay for everyone.

Simulated patient experience has changed my life I think, because I will work at the aged care facility. This experience let me understand the resident. I play the patient act, I know, I understand that a lot of people need the help. Yeah, the people getting old so they need the help. So I think maybe I do the aged care I can help all the older people, older than me, the people, yeah. In the facility some people 90 years, more than, 100 years so, yeah. More than four people are over 100. Yeah, they got the Queen's letter.

I'm not working yet, just in the placement. I started the course in Two thousand, 2013. After I started the simulated patient work. My background is not in health care. In China I was a university lecturer in management. I look at work in aged care, one, opportunity. Just look at the position. I went to there. One is the job available. Another thing is I do the simulated patient. I think maybe the aged care can help with old people. With multicultural clients. In the aged care facility a lot of the people have the mental health, yeah, some dementia, some are depression, yeah. A lot of people like this. Yeah, after the simulated patient, I believe the patient there, I understand them. Before I think that they are so strange. I understand it because I know that they are sick, yeah. Yeah, you know the people, I play the, some are asthma, some are diabetes people. Yeah, I think, yeah maybe more people have this sick.

I worked with, the nursing and medicine. You know in the aged care facility there are a lot of nursing and medicine people. And now maybe the student later is in this role. I think the nurse in the aged care, before they are students. So I contact with the student so I can know what they think. It is similar to nursing and the medical worker

in the facility. You know in the facility I have to work through the nurse, the nurse and the doctor, yeah. Most of these is a nurse, yeah. Before I never had contact with the nurse. Yeah I don't seem to know what they think, what are they like but I contact the student and I know they will be the nurse, what they think, and they are very careful, they're very kindly, yeah, same as the facility nurse.

That helps me for example, in the facility I work with the placement, I work with the nurse together. So I know the, they have the patient, they are very, very nice to the client. I can learn something from them. I feel very comfortable. So in the facility I like contact with the nurse. Before I think that they are very serious, their job yeah. Yeah, change my idea, I think, yeah. So I contact with the nurse I feel more comfortable.

Being a simulated patient is similar to how I imagined it would be. I like it. I can control my emotion as a simulated patient. I think I am very strong. Afterward I can relax. I can forget something. Today I am playing a patient for mental. I am worried, anxious and things. But the class finishes. I go back. No problem. Going out I'm feeling is happy, everything good? I forget this story. Just finish it today. And tomorrow morning I'm thinking again because I need to work again. You know what I'm saying if not able to forget then I am sad. At night nothing, I don't worry about the case. I think though I have good control. I get this control by thinking of the happy things, yeah, I finish the University job I'm going out and look at the blue sky and look at some things, making me happy.

You know sometimes the mood can continue, yeah, continue sometimes in the, when I sleep I wake up, I can thinking about the case, yeah, what I have to do something. I think of some of the happy things and forget this. I have to, yeah. People, one day at a time Monday worker, your work that you can forget, but most of the time I do the week three days, Tuesday, Wednesday, Thursday. I finish as a Tuesday worker, you have to think of Wednesday. You finish on Wednesday you have to thinking the Thursday. So I said, sometimes I wake up and I thinking this but I let me stop. Stop it I'm not thinking too much. Have to have control, yeah. I think I'm a strong person so I can control. I can control my mood, yeah. Yeah, make me strong. Yeah, so I can do Tuesday, Wednesday, Thursday, yeah, every day different, yeah, finish you're finished and not to think too much.

When I went to Australia many years ago, I say something to my family, only say the happy things. I don't want them that they worried. Maybe they make me control my mood. Like it's a long, long time I control my mood. Oh, sometimes my family worried about me because I came here by myself, yeah, sometimes. My sister went to here. But is I think it was 10 years ago in China getting the visa not easy. When she come here, no worrying, no, because, I'm always very happy.

My friends, I don't think they can understand *(about SP role).* I just say I am working here, I have the very interesting job. Yeah. I don't explain. Some things they don't understand, I say I am an assistant to the class. Too hard to explain. I understand these things now, but I don't want to spend a lot of time to explain to them when they don't understand. I just say I assist in the class, at university, and it's a very interesting job.

They know, I was a lecturer at the university as well, they think she can go to the university. It is good for me. University is good for me. They say you have a good job, you enjoy your job. Working in the university in China helps with simulated patient work now. You know is similar, I have experience here, is a big class, with 40 people. So my experience is useful for me. I can comfortable. Not scared. No, so many people. The class is very big in China. But I think my experience is good. I think someone should be not worried is the best for simulated patient. Be used to class size and too many people watching.

Then only need to think about the student questions. Not worry too much. Sometimes, the first time, first time I don't know what they want to ask me. So I ask another simulated patient. She has experience before me. So I ask her. I said I am very anxious. She said no worries. Relax. Yeah. I forget what I was asked because it was a long time ago. Now I am used to it. We have the teaching materials. So I know what they want to ask.

For the feedback normally they are very kindly. Patient. Patient. And they are very smart. I think their teacher can teacher them for improvements. I think, the university teacher is very good. You know the feedback, I only give them the good feedback, yeah. People are not good, you know, when they do something the teacher can stop, yeah, and say something wrong you have to do something different, yeah. I think that they are good. There are even some mistake, is a small mistake and not a

serious one. The teacher stops them, yeah, and lets them do some other things, they control the classes so is good.

Because I was a lecturer in China. I like the students. I want to have the opportunity to go back to the university. Yeah, so I think this is an opportunity for me. Yeah. You know if I would never work at the university. I would be scared. Yeah, anxious. Okay, with the student. Understanding culture it's a big problem I think. If I look for some simulated patient job or work and I think I should be understand the work, if it is about medical sickness and not culture, I will do, what they ask me to do. In my thinking, I think it is, different people, different thinking.

I was comfortable with the training. Even no training. I can do this properly. I think the training is good. Something I can research would be good. The pay is good and important. Yeah and I'm interested in continuing with this work.

A1.6 Khyath

A1.6.2 Setting the scene

Khyath is a 26-year-old Indian man who first came to Australia as a student and following completion of an accounting degree was granted resident status. At the time of our first interview he was working on a casual employment basis in a warehouse. By the second interview he had been employed full time in an accounting firm.

Khyath seemed happy to participate in the research but it was quite difficult to identify a time where we could meet. Our first interview was at a shopping centre near his home. He was coming after a work shift so we planned to meet at 4pm. Khyath did not arrive or answer his phone when I called to check if he was still able to come. At 4.45pm he returned my call and said he was on the way. He did not offer an explanation.

At the interview he is relaxed and friendly, I buy him a coffee and a large cream filled cake that he chooses. At the second interview on a Saturday morning we meet in a café and I buy him some breakfast, he seems although somewhat bemused that his stories are valuable to me. I wondered how seriously he was taking both the interview and research process and the work of being a simulated patient.

Khyath is very laid back, almost bragging in his style of talking about how easy SP work has become. He tells stories about his work as a simulated patient that seem unclear and unlike the work environment I imagine. Is he underprepared to work as a SP?

A1.6.3 Khyath's narrative

I think it's been a year. Probably just a bit more than a year. I don't remember it exactly what date I started but I'm pretty sure it's been a year I've been a simulated patient. It was quite helpful in regards to, like I could help people to understand other people's background, not just mine. It wasn't just a, because my background is Indian where it's not been about Indian; it's about being someone different from, not just having Australian background and, besides that, as well, I just didn't even know about any issues about mental health and, but just simulating it I was made aware of what are mental health issues. Just because I had to act like one, so I had to research upon it a bit more and I got to know about the depth of the mental health. So, it was helpful to me as well as the students I was acting in front of. I got to learn about mental health because I was acting as a depression patient. I always thought depression like someone was being sad.

Yeah, just like sad, normal sad but then it turned out to be a technical term used by psychiatrists and stuff and what it actually meant to be depressed because I had to act like one; I just couldn't be like normal sad in front of the students and, you know, hope that they would understand that I'm depressed.

It was pretty exciting. It was exciting because I was confronting a lot of people at the same time and I haven't been a professional actor ever so it was something I really wanted to do ever since I knew there was this field called "acting" but in front of the nurse students? It was mostly exciting because it was something new that I never knew before.

When I was given the different scenarios to perform. The one was abdominal pain, which I thought was all right, something a lot of people go through it. Then one of them was being an immigrant and having an interpreter. And that scenario included being mentally ill as well. That actually got me excited, that while it's considered as an illness, separate to like, not separate to what they just like the other physical illnesses, sicknesses. And I wanted to see how do they integrate it in the simulation program. Like is it just for name sake that it's a mental illness or is that to really like to dig into it and find out what is the guy going through and stuff. Basically I wasn't actually sure what a patient simulation program was about, to be honest, to start with. But I had this idea if I like to interpret what patient simulation program would

be, it would be like oh I've had a fractured hand or headache or something. So when mental illness stepped in I was really surprised. At first I was, I found it exciting because it's definitely something new for me, patient simulation program, I've never done it before. But took it to another level of my surprise when I heard that mental illness was included.

I did an accounting degree so I didn't really actually have those aspects of simulation. All I can recall is that we interviewed the manager of McDonald's and we could only say that it's for research purposes. We couldn't say that we were a student and probably that time I had to act like I was a reporter or an investigator. The only acting experience I have had is school's annual function and they perform. They plan and display performance art and can be singing or acting. I was always casted as something, the acting part of that annual function. It's huge. Every parent was invited and the school would have at least around 15,000 children. I did this through level 3 to level 12, yeah. And I didn't do it in 11/12 because it was the last year and we were supposed to study and not act. When you come out abroad and then you think, oh I've done a lot of acting. But in India with 15,000 children in my school and they have all to perform something to please every parent. It's a very common thing that you are participant in annual concert. I don't think acting is new to me but the content of the program got me excited, not the acting.

Before I went into the classroom I was always told that they *(the students)* don't know that I am simulating, I'm simulating and it would always be, like I would be always eager to know what their reaction would be when they get to know that I was actually just acting. So I would put all the effort to make them believe that, "Look I'm not simulating" but when they were told that I was simulating they would be just awestruck and I would be like "Wow, so it worked, I'm all right then" *(laughing).*

But surprising people like so is just; it's a good feeling. Yeah, and surprising professional students, like people who are going to be professional later on, it's pretty exciting. For the first couple of times I did get nervous 'cause it was my first time and I didn't even know what it would be like, how the students would react and would my acting be up to the par to let them believe that I'm not simulating but after the first couple of times it was pretty easy. I would look forward to go to get the email for the next round so that I could master my acting out.

In the first couple of times itself I found it harder, I don't know why but after those couple of times it was 'cruisy'; maybe I was prepared for the questions of the sessions but the second session I was confronted by students who were not able to understand what my situation was or what I was acting as and they started questioning off the track and I was like, "Oh it's not in my script. What do I do now?" I just made up stories. Yeah, and I hope that it's all right. I was looking at the teacher present in the classroom. Like if I was in their shoes, if I'm asking those questions, what would be the reason behind it and try to relate it to what I would do. If I was the student and I wasn't sure that if my left side of my stomach is aching.

When I stepped into that class there was a lot of students of very different backgrounds and because they didn't know that I was not a real patient, I knew that they would not stick to the script. I knew it definitely before I actually stepped in and started acting. So one of the girl asked me about, there's definitely jumped onto what I was going through and not actually trying to see where I was coming from or what my health status was. But one of the girl asked me so, I can't actually recall what the question exactly was but she asked me about the culture, in a different way which was not in the script. And then I had to make a story about it. I think I had to say that I was belonging to a certain sect where I can't really talk about it much because I didn't have an answer for it. There are castes where you can be offensive really quickly. It is not uncommon to offend people from different sects easily but I actually got to that story because there was an example given in our training about a Muslim woman suffering from abdominal pain and I think the student asked her "are you pregnant" and she got offended because of her cultural background.

I was prepared to have a one-on-one session and it was a whole class asking me questions at the same time. They would discuss what question to ask and they would start giggling and I was like "Man I'm, I know that I'm simulating but you should understand that I'm not simulating so respect the part where I am in pain and not giggle and discuss questions; you just fire questions straight out because I'm in a lot of pain". I gave them that feedback afterwards. I was really apprehensive about should I say it or not but then like they should know that. I let the teacher know that I'm sorry but I have to give this, the feedback this way but this wasn't acceptable and first of all that I wasn't prepared to have the whole class asking the question at the same time. Because it's not realistic. It was at the end of the session so I didn't get to know what teacher thought of it but I just gave the feedback and left.

I felt terrible that they thought I was being a bad guy saying, asking them to do something which they should already know. And I didn't want to take the teacher's spot, commanding them that you should do this and you should not do this. But as I was told in the training that give them feedback of whatever you feel which is necessary for them to know. I thought I was being rude. I felt like a mamma, do not laugh or do not giggle. There was no polite way to ask please do not smile. It still seems rude you know. Please do not smile or giggle. I think I said "if someone is in pain laughing at him or with him doesn't help". They suddenly went silent and then the teacher took over. Yeah he's right. I thought that teacher would step in while they were giggling.

That was my first session too. I was comfortable about the last session, telling them whatever I felt like which would be helpful to them. But the first session where they were giggling and I had to tell them that this might offend people, wasn't personally me that got offended because I knew that I was acting the scenario, they can do whatever they want. But by the last session I made it sure I remained in my character, whatever they do is affecting me. And yeah I was fine with my feedback. I certainly had this in my mind that they would definitely know it's a scenario. I don't look like a patient. Look at me. And I was certainly not confident in my acting as well. So when I got to know that they believed definitely that I'm a sick person, then I got the confidence, okay, alright. I need to take it as it is and not give them the freedom or liberty of having an advantage, or being a stranger.

And my motive to do this program was to help people know that what cultural diversity is about, hopefully, and help the students and my community as well to be more expressive. So when I saw that aspect of the, that these guys didn't know that I was an actor and they were taking it seriously and my feedback was taken seriously when I said that giggle doesn't help, and they all went silent. I could see that they were feeling bad as well. Then I felt the point where "oh I'm helping them, really I'm helping them, I'm carving their personalities in a way".

Most of the people from my community particularly are really shy. And if some of the people don't even go for headaches or normal pain in different parts of body to a doctor. They would just take a pill and really they could get better. They do not take the illness as seriously until it's really, really serious already. They don't take the normal low effecting symptoms as an alarm. That it might get serious later on. Until it gets serious they won't visit doctor, because it's not free over there. It's free here.

So I have noticed that people are really shy about their health because it's a cultural thing that they don't go to doctor for every single thing. That makes them a lot, they're quite ignorant about the symptoms, as I was about the mental illness because it's a costly affair and it's a cultural thing that you know, we'll get the home remedy thing done and you'll be fine. Which was one of the part of the scenario that I was doing. I really connected to it because that happens a lot. A lot of the times it's just about home remedies. Mix of spices or herbs and expecting you to get better instantly. But when you compare to the Western medical world, my community, I don't think they're more expressive about the conditions they suffer from.

The impact of this work on me, as I told that, the word "depression" for a lot of people in my circle meant the same; before I got into it just means sad. Yeah, and it's not a big issue back where I come from and people use depression very leniently and say "Look man I'm depressed I failed my exam" so people think "Oh he's just sad". So when I was doing the simulation program, I told my friends that that's what I'd been doing, apart my work and they would ask me more questions about it and then I would let them know that this is the thing, I have to act like someone who has abdominal pain or someone who's been affected by depression and they were like "So you just have to act sad", like "No, depression is much more than sadness", so I would explain it to them as well they would become aware of it too. I don't have anyone with depression, but they could relate it to someone in their family back at home and they would think "Oh, well", you know, no-one reports it but I think it's the same you are telling us what it is. I'm like "Oh man, someone's been affected by it already and it's not been reported because of lack of awareness", yeah.

Depression isn't really talked about in India, it's frowned upon I think. Well I left India when I was really young so I can't really speak for the society but as far as I know, it's not a good thing to have so people just don't share what they're going through. I got to know about mental illnesses and it's life changing, you wouldn't believe how ignorant I thought. I think now that I was. It's a very serious issue and a lot of nations, including India, can't afford to take it so lightly. Now I know that it's a very serious issue.

I got the sense that the students had still a mile to go. It was not the end of their studies I think cause when I would be going to a doctor, he would be straight-forward, stick to the point, the precise questions to be asked and know what is going on whereas the students were, I wouldn't say beating around the bush, but they

would actually try to know as much as they want to know before they come to a conclusion whereas a doctor would just go “So you have a pain”, “Yes I have”, “Where it is”, “There”, “Have you ever puked before”, “Yes, I would definitely would have puked before”, and so “How many times and how was it” and where the students were like “So where do you have pain”, “So abdomen”, “To the left or right” I would say “Left”, “So have you been pregnant before”, I was like “No, I’m a man”. Maybe they were following a script? Not all the students but I got these questions so yeah.

I do actually think differently when I go to the Doctor now because then I get to know how many patients that would have gone through and how many of them would have been just simulated to actually to get to that point where they fire just whole questions and get to the conclusion instead of asking questions for hours. So I have a better impression of them now. If it’s a polite doctor.

Well, to be honest, I’ve only been to the doctor who came here from overseas ‘cause they’re cheaper. So, they struggle to communicate as well but they know what to ask but they struggle with the, I would say, English probably. You still have to fill in the blanks and everything.

The first couple of simulated patient sessions were just the whole class asking me the questions at the same time so it was like “Oh man this is pretty different than what I was told” and for those couple of times, I was not sure if what I was told was right or should I just go with the flow or should I just stop in the middle of the class and let the teacher know that this wasn’t what I was trained for. So the first couple of times I went with the flow. But then I let program staff know that this was the case, that I wasn’t asked like one-on one, I wasn’t a one-on-one session; it was the whole class asking me is it the same thing, is the same simulation I stick to or there was just a mix up, maybe I wasn’t supposed to be there, someone else was but she made it clear “No, this is the case but it’s upon the teacher how she would let the students ask the questions to the patient”. But besides that, it was, because it was simulation, it was a planned script, this is the abdominal pain on the left side and you haven’t puked before or you have puked before so I just had to stick to the script and I was always excited to do something like that because it was, first of all it was a challenge to face people while you are pretending and second that I would get to know about the field; I have no idea about the medical field.

I come from India and it's riddled with diseases which you would not even get to know ever in your life. A lot of people on the streets and they wouldn't come over here either because you know, the stronger border security and the standards for visitors to visit before. I mean before entering the country you can't even have the dirt from India on your shoes. Like the high standards and those won't travel. People, you see a lot of sick people all the time. Whereas when I came to Australia and the health sector was so important for people. It's almost free and I couldn't even believe it before, that there is a card called Medicare which lets you go to doctor any time you want, every time you want, how long as you wanted to be, the visit and how many visits, it doesn't matter. I was really surprised.

If the system was existing in my country I wouldn't see these many people sick all the time. But I thought that was the most prominent one because as I said, the people fall sick all the time in India and this is the basic thing to be taught to every young person, that health is wealth and everyone has to know it. If you don't know it then you are stupid. So when I said I didn't know about the medical field I was really intrigued by how it's free and how can they afford it and how do they provide so many nurses and doctors available to so many people, because if it's free then everyone's going to be there and how do they tackle the supply and demand. But that was a health industry as total. Why I really wanted to get into it so this program was as close as I could get to know more about it.

I did expect it to be exciting 'cause I was told that there would be, I think I was told once that it would be the first simulation patient experience so I knew that they wouldn't have much idea about what to ask or when to ask and like how precise to be but yeah, it was pretty close to what I expected.

It was easy travelling to classes and finding my way. Because you had to be there an hour ago as well just to be sure because I was told that it's really important that you're on time 'cause class has to start when they say.

There was one incident about, because there were a few students who were actually, when they were told that I wasn't a simulated, I was just simulating and I wasn't a real patient, they were quite surprised and happy as well that "Oh wow, that's all right" and they appreciated my acting because I was on cloud nine already and I was starting, I started talking about other stuff as well like when they were told that I wasn't a patient, they became really casual with me. They relaxed and started talking

about “Do you know much about the pancreas or the gastro stuff” and I was like “No, I have no idea”.

They got into it and the conversation went beyond just to beyond the point where it was just technical about medical. It actually went to why nurses are, wasn’t or maybe now as well, the popular profession and they started talking about why, they started questioning it and people from different nations were there and they were saying their reason so I had to contribute as well while they were like sitting there and listening to, okay, they don’t want to be this or they want to be this but they had this idea that this is a profession which was frowned upon back in their country. So it was actually working hand-in-hand because I was a patient from a different background but the nurse was a different background as well.

So it worked out pretty fine when they asked me the question because I’m from a different cultural background and I let them know that this is the case and I would ask them questions like how is it to be like a nurse from a different culture. It was just once though. It was pretty unusual.

It wasn’t much about the culture itself ‘cause I was treated as a patient as it is. Because when I would step into the class, there was one point where they were told that I don't speak English and that I would have an interpreter and she would ask me a question, they would let her know what question to ask to me and I would let her know what the answer. But, it was this point where I was actually thinking that the questions asked through the interpreter to me were still really technical; it wasn’t much about my culture and then, I think the teacher realized it as well and then she pushed in a bit saying that “Do you know where he’s from? Why is he using the interpreter” and then they started going into the culture thing. If you step in the class and you just are holding your abdomen and they would just stick to the point, they would ask you, the students would not, they would not go off that point. They were really safe. Yeah, they were being really safe, they would just ask the questions which would be still technical where, you know, they would still get an idea because it was their first experience, I don't think they knew that that was the way to go asking about my culture.

That’s why the teacher would actually ask them that this is a patient from a different background, maybe you should ask these and then they would actually do it but really safely, and, at the end of the day what actually I could see the expression of

enlightenment, “Oh yeah, I should have asked that before but I don't want to offend him this way either”.

So there was this point where I was a house-husband, my wife would be working and they asked me so, no there was this point where they asked me the question that “Do you have any other friends”, even after knowing that I was just there with my wife and no friends at all so I, it cracked me up ‘cause, like “Oh is he implementing infidelity”, cause you know, I just know. It was a really private question even if I was going that way and I would let my interpreter know that this is true or not. The teacher asked me to make it a bit complex for the person who was asking questions ‘cause I wasn’t speaking English anyway so when he asked me “Do you have any other friends”, and I was asked to crack up as well and I cracked up naturally too, to make him uncomfortable because he would then think “What did he say” which would have if not offended, then amused me. And then he wouldn’t try to know but he was playing really safe so he’d never ask why did I laugh. Then it was brought up later in the feedback session “Why didn’t you ask? You could have participated as well”, like, “Can I be the part of that joke too”.

It’s not a challenge anymore. It’s like because it’s a challenge or it’s a very different thing to do; not many people I know do it and so yeah it makes me feel special. Me and my friends were also because some of the patients, simulated patients were from my circle and they would always, when we will meet outside and they will always talk about this, when this is happening and “Are you going there next week or if you’re not then you should” and stuff like that. They were excited as well. I could sense that, because those people are really new in Australia and this kind of experience was making them feel special as well and I could sense the building up of confidence just because they were confronting people in a very different way. Well my friends, as you would know, we come from India and Bollywood is a big part of our culture. When my friends got to know that this is some sort of acting they partially felt like they’re stars. Because it’s such a strong part of the culture that if you get to act and you get paid for it, it means you are doing good in it. It gives you hope that you might end up in Bollywood someday. The actors are adored and everyone wants to get that status. And even a single percent of that whole is quite powerful. I wouldn’t say personality changing but it makes you happy.

It’s a great advantage to them, yeah, but it might not be so advantageous to the students because they might still struggle because they’re really new in Australia.

They don't have that confidence yet. So, it would be really helpful for those people being simulated patients, but I don't think that's the purpose of the program. For the new people, it's a very safe environment because the student would not like to offend them and they're still communicating, beyond communicating with them; they are acting as well and they are just not talking, they're letting them know, they're giving feedbacks, they're having feedbacks and so it's a very good way to get to know people. Some of my circle, when they first started, they were just six months In Australia.

A1.7 Leyla

A1.7.2 Setting the scene

Leyla and Abida are friends so have organized my Saturday. I will start at Abida's house and then travel from there to Leyla's for each of their first interviews. The first interview had gone over time but Abida had phoned Leyla to say I was on my way.

Leyla is an attractive middle-aged woman who looks younger than her 50 years. She has long jet-black hair and wears contemporary clothing and red lipstick. She is a Muslim and chooses not to wear a hijab or other covering.

She laughs and hugs and kisses me three times every time we meet and tells me each time this is how we do it: three kisses always. Like most interaction with Leyla, I find it best to bend to her will and be swept up in the whirlwind.

I recorded the following field note regarding our first interview:

No lights were on and it was cold inside although Leyla was warm and welcoming and knew I was running behind time. She had bowls of food out on the table and the house smelled of recent cooking.

We had coffee and did the interview at the dining room table. Lina's house is new and has contemporary decorations with no photos or other personal style items. After the interview Leyla made a couple of phone calls and then started serving food and plating up pastries and deserts. She asked me to plate a large cake tin of slice while she started her car and put a hat on.

She then moved food onto a plate which she said was for me and had me cover that and the others with foil. Despite protesting that this was not necessary she insisted that I take the food and that I follow her to a nearby landmark from which I could find my way home. I gathered by now she was in a hurry for her next appointment so I said if we were separated driving I would be fine and not to wait. But she disagreed and said if we got separated she would stop and wait.

A1.7.3 Leyla's narrative

I think it's around three years I've been a simulated patient. First when I've been asked to be taking part in this program I was surprised there is something like that's happening because it gave us opportunity and the experience for us as well to have this kind of knowledge and then later on pass it on to the student. When this opportunity come to me and my other colleague it was like we talk about it and we say, during the process it was a wonderful experience, it allowed the student to have a knowledge when they are working in the field. So I never had any chance to participate in this kind of project before. I'm very proud of that.

We talk with the other colleague as well, like other simulated patients, we say when they gave us the training on the first day and then we talk about it, me and my friend, how "Oh, this is wonderful. Why others, university, they don't do the similar things." We all thought it was exciting. And people, like the others from my community, wanted to participate but because their language preventing them to come and sometimes because their work field as well, or the study, this is the only limit, but if this is, was like announce it, you would have 100 people definitely, like in one go, because really, because if you say like there are so many people, if they know about it and they benefit later on and the student benefit, they will, the whole community will come, just because of the programs limited fund that only needed this particular numbers. Probably when people don't join the program they're not clear about the role and what is the outcome from it.

Like even us when they tell us. Like now when we hear the benefit and we know when we go there and we see like the feedback from the student or the doctors, that we know that this project it's very good project for the community to, this is a chance for them as well to tell other people like about their culture, what's acceptable, what's not acceptable. And at the same time it's like some time like you know when I'm not looking at your eyes doesn't mean I disrespect you. But like all these things, if we didn't have a chance to do this role we wouldn't be able to tell others like the doctor, who are going to the field, if they come across people who won't let them touch them, or who they are not looking in their eyes it's not disrespect. And again the experience with the interpreter, it's happening again because again the interpreter is a part of the community. Sometimes student's talk you know, "Hello, how is your children?" But she's there to interpret. And sometimes it's awkward on the

interpreter. And I think community will know that's really a positive program to be linked. And so many young or, maybe they are in the beginning students will be shy, but when we explain the aim, explain the benefit, I think people would love to come and join the program.

It was like the training and the time, the briefing, it took us, we wanted maybe a little bit more training, but because it's our time, their time, it's you know, like in the beginning we were like, you know, even we are happy but still we need like a bit more extra support to go in classes. When we were doing that, to practice that straight away maybe, would help if we had more time to digest what we were going to do. When we went to training and it's like, the instructor gave us the story, like and all of us need to practice. It's like in this one day we had this chance just for that and like one day just to talk about the program and the second day just like the story *(scenario)*, and then the third day it's during this time, even we had that two days but we found it was little, but one day extra. It's again like the first day it will be what's the program all about; the second day it's like the story; and the third day by itself like just doing simulations and someone telling me the feedback, and it's practicing that, you know, Leyla you shouldn't do that to the student, it's just that, more practice, more practice. Like to be straight away put it in the practice with the real student and then to tell us like our feedback, this is it. You know and then it will give us more skills that, "This is went wrong". So for next time if like, because maybe from my experience or I've been like a long time. But for people new I'm saying like you know it give them like just a taste. Not big group, small group. But again a student or someone else other than the instructor to practice with.

It just give them the way like you know in the end they will feel very positive. They will feel like you know the message you know it went well, they understood me and it's both way, like giving and taking. So for them maybe the third day even like it's a short time for us to be put in and practice, like real practice, but it's good. Rather than feeling like when I go to do the work, like maybe high expectations, but then I will be then look, confident, I mean like self-esteem, and less pressure on me what's the question, what's it going to look like, how they look at me? Maybe for me because I was you know like part of my acting I could, it's easy. But for someone like you know who cannot act and is recruiting, because it's not that simple. But like you say when we have done that we have the opportunity the second and the third, maybe the fourth day. It's not like maybe that, then even if like two students or they are student simulation patient, there are, it's not like the instructor. I mean because no matter

one, you know like I feel if I did wrong it's still like the instructor, want to support me, and want to give me great positive feedback.

But when, in practice I don't want to go, I'm scared. Like even for me like it's not scared, but still nervous every time, I do presentation or, it's kind of like presentation again. But where if you have these skills, so we support them like that and they will feel the young one, or like the new one, the peer, they will say, "Oh yeah I could do it. And I could see the impact on the student and the response." Because I wanted to, I wanted to know from the student what I did wrong, what I benefit them. But when it's happening in the end we didn't felt that we are doing it as a play, we were thinking it's like sharing our experience and give the student the best outcome.

I get knowledge like when someone make a mistake and the simulated patient instructor pointed that you don't straight away tell them the negative things in the beginning, you just give them their positive things and then later on break it down like you know, it will be this way rather than, "Oh, that's wrong, that shouldn't be like that." I have definitely used this feedback lesson. I will think about it first, maybe like in our culture we could say, "Oh, this is wrong," but it's like when we learn from the expert, and then every time something happening and, or even it applied to my family and apply to the community, I have to think first of the word, like the instructor says, because again if we make it sound like this is no good, again it will break their, you know, confident, but you know, I use a lot of the technique that I learn during the training. It's wonderful. It made me think like, "Think before you say," like you know, "Don't just act straight away, think." Even like I will never upset anyone, but even like, you know, but we used to say, if someone make mistake we always say, "Don't drive the speed," or something, but now I will say, "In a way I really love you and I want you to be careful when you're driving." I was saying my daughter that I love her, but now I say, "No, I have to make it in a way," and this is a technique that I learn from it.

I think the training, like the support by the instructors, like you know all of them, like guide us through that. But it's still because I think all of the instructors have a great nature, and train us like and we love them. Like from the beginning it's not like you know something, I'm saying but it's important that the relationship with the instructor, like we felt, they are safe. If something goes wrong you know they will support us to improve if something goes wrong. So we felt safe from the beginning. So the safest I felt that's mean positive, rather than feeling negative, I'm not sure if I'm shy to ask. So the instructor gave us this feeling that if something wrong or anything I'm not sure

I could ask. And they clarified with me like if not that over the phone. And they guide us like this is the way. They welcome us. It's all of that. It's important for us to be in a program. Sometime maybe you go to the job you're just doing the job. But no, it's you feel like you're being supported. There is a great outcome from it. So it's a shame if the work will stop.

Yeah for me the first experience I had I could visualize what my involvement with the teacher was going to be. Like you know I feel supported. I look at the teachers face is all like smiling and comfortable, and at the same time like giving us each of us time. So it's important to feel 'I am special.' I can feel special. My colleague feels special. All of us feel special by the instructor. So, and special treatment and special sensitivity and caring and this is the role. So it was from day one the staff were like make us feel like it's like a home and it's like the outcome is going to be very good. Because when I was acting it was like this is the role and people you know come and they watch me. Get paid and you leave. But this one, it's not that. It's just to deliver the message for other people what is appropriate of my culture and what is not appropriate. So it's something, it's something more than acting.

So when we went there, to the simulation, because as well I, myself, are a refugee liaison worker and sometime I'm not saying I am interpreter, but I do assist in situation, even where there is interpreter and sometime it's the dialect will be, it's difficult. So I will be in the similar situation to the scenario, and I work with the refugee health nurse. So I am familiar with the assessments, so when we do home visit the interpreter there. I am there just for support, the cultural support, so I was feeling that I am still in like the same field; to me it's natural being, acting like assisting in interpreter, and being as a support, like culturally support. And I felt like it's me, like this is day-to-day, it's, to me it's not like something I am acting.

And similar situation which is recently we've been at simulations of refugee health assessment, so some of the student, they didn't know what's mean, assessment, so they, some of them think does this patient, they are in the hospital and they're coming to us, then what's wrong with them? So the student doesn't know really know our role, why we are there. So being as, like the knowledge I have that the health assessment, so when the student was struggling they didn't know why we are there, and just like the teacher, she was there and I knew they are confused, so I just have to put my hand and I was saying again, "I work in the community health centre and I know the nurse will have this health assessment form." So I just want to give them

confidence, so you don't have to know the questions. It's on the form, it's already provided to you and you just start, it's just knowledge about the age group, where they come from, and then you break it down to medical history for you and for the family background. So, and then when I said that it give them opportunity then they say, "Oh, now we know why you are here." So it just, I felt like say, and because I've been in the field, but if wasn't that it will be like confusing for this student, some of the student didn't know that why we are there, or we are there may be in the hospital ward. So of course, when they asking people from the hospital ward it's different than if someone already you call them to come to this centre so they already know that you called them, you've got at least their names and you've got, you know, they're coming to do the health assessment that you call them, and because by when they say, "Why you are here? Why you are here?" it's the three student say that, so when we explained the role so it's make it easy and I felt so good because I know that the student are smart but if we give them some direction they will be able to follow-up.

I got involved in the program because, I'd been approached to that to be taking part. And I was looking to the benefit of the student. Of course for me it's a training and it's an income, to be honest, another extra income, but it's the knowledge that if we could be able to share with our student, because here it's, I found it really, if they start to be in touch with real people, real community, when they go to the field it's still, it's not been a worry or they feel scared, like if someone come for the first time they feel so scared. But when this opportunity, like oh, it's even with someone wearing the scarf or without the scarf, this is the fear, even if they have the knowledge or they've been excellent in their marks, but practice, that's what it's all about.

It benefits the community too because then it allowing us to share our cultural sensitivity with them, so they will then tap it on, if like I'm not looking at them doesn't mean I don't respect them, so they will go back again, they say, "Oh, I had this practice when people not looking at the eyes doesn't mean we are not, we are less respect, it just because we are respecting them I think we're not looking at them direct to the eyes." So it's again they will understand our community culture and again, the female, the male. Maybe if they don't have this bit and someone come and they say, like they say, and again I learn to say it, "Is there any chance if I could have a male nurse or a female nurse?" in a nice way, rather they say, "No," because I know from practice as well I don't want him, I don't want him. And just because I say, "We checked. There is no one around and he is the only one here." So it's

making the community as well sensitive when they wanted to say, “I don’t want you,” again, it will be offensive for the nurse, the male nurse. Because I am again in the field, and sometime they will talk to me in my language and, “I don’t want him. He’s a male.” And I said, “Look, we have no nurse, like in the moment, only the male nurse we have, and I checked for you. I understand the cultural belief.” So it’s again for boss, we need to let them know, like the nurse, that first when they ask for them that if you say to them, “There is no one around. I’m the only one. I know that you request that.” So making them and reassure them that you know, “If I am here and you requested something and I am here and it’s not against your request, it’s because I look around, there is no one in this particular time, I’m the only one. Are you happy for me to take part or not?” So, and again, I said to them, “Don’t just say, ‘I don’t want him’ it’s, you know, it’s offensive-, for him as well. So just say, because if there is, ‘I feel more comfortable in that,’ and it’s later on you say, ‘If there is no one else,’ and it’s up to you to go ahead or not to go ahead, but don’t just say it like that because we learn that they do get offensive,” where before I just like, straight away, like when she’s, “I don’t want him and I used to say, “She doesn’t want him.” It just luck, yeah, so we learn, even that, because to me sometime like passing the message exactly the way it is, but I am not interpreter, I am assisting. So when I am assisting it’s, I could say to the client, “Don’t just say it in a rude way.” Different centre now trying to do the cultural awareness thing, so it’s a new strategy that our centre using now, empowering all the, the staff like the receptionist and every single one of them, it’s about this issue, because it’s become a big issue.

And even like you say this is telling them the positive things, we found that they will remember us or they remember the scene, they remember the culture where if we’ve like offensive them and we say oh they’re no good they will go and maybe they will hate this culture. Resentment. So it’s, we are there, you know they went there and they like probably maybe from guidance you know or they or the Muslim they’re not like so bad after all. Because now we all live in very like you know something goes wrong like all the Muslim community feel tense.

If someone come to the hospital wherever you go, to transport or you know we feel it you know. So we don’t want against someone like a nurse coming has already like you know inside him like scared. For him as well is like this is another culture and if he did something maybe it’s offensive. But they’re not. Maybe I’m sad because I left mum and left it and he come and touch me. It’s not me for you know reacting towards his touching me. No it’s all these things. And if he’s just like again if he like

understood just like “Hello,” like you know the way he react to me like a small smile, or “Is it okay I touch you?” Again it’s I feel I am safe again and when, rather than I say oh it’s again everyone scared from the hospital and for me it’s like I feel scared about my sisters because she is covered *(wears a hijab)*. You know I feel like if something goes wrong in the media for Islam and every time I feel like I have to be with her, I won’t let her go by herself. Again the culture, again they have to be together walking. They feel against, there is you have to be supported by other, but we feel sacred yes. It’s not us if someone bad, we don’t want them to label all of Muslim, all of that.

Every time. If I hear stories someone murdered someone I say, “Tell me what nationality?” If by example he’s Asian or something I feel relaxed. Even though it’s bad, but I feel relaxed. All the time. Yeah so really sometime I don’t watch the news. I don’t hear news. When they tell me something shocking, so I don’t want to have this feeling, negative feeling. I want to feel people love us, we all love each other. I want to have this feeling. Like when sometime they say oh this, like even like with work and everyone they say a Muslim and that, you that. I say “It’s not Muslim.” I say, “Don’t label the Muslim. This is bad people.” So I’m living my life to defend my religion and my culture. That’s enough. We had enough. So really, and my sister like every time she go and like because she’s nice person. Like you know if someone drive and do their hand for her or the rude finger for her and that, that’s not acceptable. I was with her when this is happening and to me it’s, and like they beep behind her and she’s driving the same limit. She’s good citizen like you know she will drive, she doesn’t speed and no need for that. No need for that. Why do we have to suffer? We come here all of us to escape from the war, from bad people. We don’t want to have it here as well.

Sometime when a client comes and they look at you, of course you think you speak slowly or you speak, you know, it doesn’t matter. So trying to, like we say, like a smile and trying to say like you know, language, make it like you know, aware that you are trying to help them rather than keep going, keep going, and then if you talk slowly or you don’t talk, to them still there is no understanding. And again, when they say, “I don’t want this doctor,” or, “I want the male and female,” and then they’re trying to tell them it’s about the cultural issue. And again the way now they respond to client by smiling at them and having different staff worker from different nationality in the reception area so to reduce anxiety, because if people go there even from the Aboriginal background, when people go there they feel they are discriminating, there

is no worker there like them, you know, because, like the other day I was in, participating in a consultation and he say, “If you have a, like the picture, a baby, just the color of the hair are black, I feel this is my community.” It is, like even a picture in their booklet, they say, but he is Vietnamese, I say, “It doesn’t matter he is Vietnamese,” but because he has black hair it’s straight away, “This is my community.” So when I come to this centre and I don’t see people like, I’m saying even they are you know, just like I look at them, like from experience now, I’m not discriminating or anything but if I could see like someone have a dark hair and someone you know, blonde hair, if I am confident to speak the language I will go with the blonde hair, but if I’m not I will come with the dark hair, like I will feel, “Oh, maybe she think because we are related I don’t speak the language and she can understand me, even maybe the same things I don’t have any word of English,” but it’s that, you know.

It’s like, you know, first because if they say, “Oh, if I come to maybe her, like she speaks quickly or fast or something,” I’m saying like, you know, it’s, they love and they respect everyone but it’s just like, “She always speak fast. I wouldn’t understand then.” And when this one, like I say, it’s the language, and again, like she will feel this is my English as a second language, so she will know she could be like Macedonian or she could be Greek or Italian, so she could know that my first language, if I say no, so they will try to make even like a ways or sign or hand that, that’s what they think.

It’s very important to them now and even like I’m saying if now there is a choices like when you go to the medical practice or you can choose your own doctor, your own beliefs, or you know, when he prescribe prescription for you that it’s halal or not that, and no pork and everything. So now there is a more choices than before, was like if you wanted to go and see the doctor or, but in the, still in the hospital, still there is not so many in that could, you know, they come from your community group. But still I find it, it’s now better than before, very much better, their awareness and you could see, like I’m talking about the area that I am living in, so I could see doctor from my community. And the hospital and nurses coming, so they know the doctor straight away, he will say like, we are accepting if he’s a doctor, you know, where if like I say, if maybe different pick, like if say, English doctor and Arabic doctor, he know that when he want to touch you in that, like even himself, like where others maybe he say, “I’m going to examine you in that,” but he will tell you, “I am not want to examine you. I’m going to put my,” like he will remove his hand completely when he’s doing

the examination, and he will try if there is others as well, other female doctor, he will try to link her in.

I've got a doctor and when I used to say, like to him, "I have this issue," but example, for the Pap test and that, he understand and he will say, because he knew I wouldn't do it with him, he knew that, he say, "I will give you a good doctor, female doctor to do this, and come back to me and she will send me the result." So he even know that. If he's from my community group I don't have to explain it to him, like the doctor, he just, he will do it automatically with me, you know, I'm saying in term of that. But if there's another doctor, or even this has happened to me when I had the accident and I felt all the nurse, all male, and they all come to me, I wanted to go to do a urine, and then, like everyone come and on top of me and I'm trying to say, "I just want if, it just" I'm trying and no one heard me, just no one hear, it's just like, "Come and lift," so again I was very, very hurt and because they didn't respect my belief and they didn't, doesn't have to be believe, or just like, my wishes. I wouldn't be, I wasn't comfortable to expose myself because they take off all my clothes and then they put me to do like the urine. But it was, this is uncomfortable. I'm trying to say, and they have a, like I've got the collar so I couldn't move and it's just like it was a horrible shocking.

It's not because I have the pain, it's just like the way they treat me, it was in the hospital and I say, "I can't, I don't want you to touch me, I don't want you," it's already they, I am exposed, already I am that, and the whole experience, like not from the accident, I was thinking, "Oh, I was exposed," even that's their job. And even it's traumatic. And even like when I was staying and one nurse later come and I say, "I'm not comfortable doing that," and she say, "But this is their job, even this is their job." To me it's like when you are exposed, like this part, especially it was horrible experience. So I wish that they did listen to me rather because I couldn't talk well, like and I say, "I don't want you, please," and because I am lie, you know, and then they are concerned more for me if I have a break in neck or my back or that, so there wasn't listening to my need.

When I remember this way, like you know, I was exposed and you know, like sometime it's, we like just this, you know what I'm saying, even the part down, you know, it's because of the culture when we grow up. Before we go to see the female doctor you will shave. Maybe like you know you don't have time to do that, you know, sometimes you know, in an accident. So before we go there we have to shave, like, and make it like, you know, for anyone I'm saying, but this is particular because

it was accident and, so even if I do the practice I have to make myself you know, like a shave and have all this, the area clear and go because not every day you do that, it's just like, you know, it's painful as well and that. So then it was like I was so embarrassed I wasn't shaved and that's what I'm thinking, you know, like so even emotionally, physically, because even if I'm going there to female doctor I will prepare myself and I know psychologically like physically I'm like I will shave and I will look, you know, because it's important to me. But when I was there, "Oh, I'm not shaved," it's, "Look at me, I'm dying nearly," but this because back home if you go, so to have baby or something and you don't shave it's like the stigma about it, "What's wrong with you? Look at you, it's like a bush," you know, it's even the nurses there, like some of them are rough with you. They say, "Like you didn't clean yourself." It's like you know, they wouldn't say, "Let's do it for you because you're not prepare yourself," but it's just like that, they will say, "Oh, you come, you're not clean? You didn't clean yourself?" So that around that, people, like I'm saying not to clean, like that's why.

In the time I have been a simulated patient, my life it's like together, it's they are together now, it's a part of that. The play or the act we will call it, it's, I think it's come with me now automatically, it's like merged together as again it's because the students don't know about it, we have to give them the opportunity to know, not assumption like, "He doesn't respect me, he doesn't that." So no, it's just lack of awareness and it's become, no, it's very good impact on me, this play.

Now I'm sharing it around the community and saying, "I've been in this simulated patient," sometime I say to them, "I'm very proud to be taking part of this simulation patient in this university," and they *(the community)* say, "Oh, that's very good Leyla, that's wonderful experience. You will be able to share and get knowledge at the same time and share your experience with others and make a big impact on both, like me and them and the community and the student." So really, everyone say, and why they don't apply it in every single hospital, and university? That's stuff like that, it's very important, something like that I've been talking about and if it's like someone you say, they're trying to understand how wonderful just for the community to know that this particular project trying to have their culture understood and ways how to deal with this situation, that's something really, really should be, you know, it's like a need to be, have a medal, gold medal.

I say to the community, “It’s, you have to know both way,” like even like I will say sometime, “If you are in that situation and like shaking hands, and that it’s,” embarrassing for the nurse when they put their hand and they’re shaking hand with a client and the client doesn’t respond. So for me I straight away say, “Don’t shake hands before, if you see anyone covered Muslim, don’t shake hand unless she put her hand first.” And around stuff like that, so even I say like, you know, if not only one time, like need to follow-up a lot so she could be able, they have to trust. I see like so many now refugee, and from this experience, like you know, first day they come, doesn’t have to be something wrong with her health issue, but there is other social impact or issue or that, so they’re not going to tell you from the first day, but you know, even or like domestic abuse or that. So it’s going to take time, but try again and again with them and then you will get the trust and later on they will open up more.

I feel like my role very vital at the community health centre, and I’ve been there so many years. And like they’re trying now to say, “No more contact Leyla,” because she had enough, so they’re trying to say like everyone has a problem, they put myself in the middle and they say, “Everyone have problem; they come to Leyla for expert.” Imagine Leyla not there. What do you do? You have to go and again do your work rather than rely on like, you know, someone come again, they sit, “I want Leyla.” It’s like again, if Leyla not there the client waiting for me; I have a meeting, I have that, but the client want me, want me. If they follow the client like you know, they could talk to. Yeah, so it’s now they’re trying again, it’s like similar things happening in every centre, they’re trying to see how can we approach them, how can we help them, you know, not only all the time using me and putting me in lots of pressure. Too much pressure, because this doctor say, “Oh, this one, I’ve been contact so many times, he’s not there and the hospital want him for emergency, you know they need him as soon as possible.” It’s not my fault to follow-up, you have to follow-up and that because she’s from the same community, it’s your job to do that. I have to do it. I say, “I’m happy to do it, it doesn’t matter,” but they say, “It shouldn’t be you, Leyla. If something goes wrong, like the client there, he doesn’t want to talk to anyone, it shouldn’t be only you. You are only working two days and you have to train them to take it differently.”

For me it’s any training I take opportunity, I like to be engaged, it’s like if there is something, awareness about the skin cancer or something, you’re doing research and you want me to have this knowledge and pass it to the community to share in as

well. For me I really, I will participate but I think the simulation, it's the refugee assessment, this is, because, now every people coming through refugee or asylum seeker. This simulation way of teaching them, like the assessment, this is very practical. And from that you will be able to know with the client not only the health issue they have or they need to follow-up or and there is other issue you could be engaged. I think the same things not changing, I think I like it this model, it's like the health assessment because that's what, everyone come first time to get contact with the health service through this health assessment. But if you say, "Come," and there is information session about that it's again for me I will learn it and I will try it because I, this is my community, I will break it down an easy way to pass the message to them. But it won't be as successful as this, the way it is design it.

Well, being a simulated patient it's much, much better when I was thinking, I wasn't thinking like, you know, "This is the outcome going to be," it's like I was thinking, I was happy to be taking part but back then I didn't have the knowledge or the confident, like I am now, "Oh, this is the outcome." It's actually way more positive way from, the beginning, I didn't think like for me it's, this is the outcome is going to be like, maybe the instructor say, "Oh, it's really benefit the community," but not to this, no, it's a lot now, I know it's a lot now, more impact and changing in both the community and the student, their way of thinking.

Back then I am actress, so to me when you say acting, it's just like the inside me, yes, I wanted to act, but again it's, like the beneficial and for me I like it because, it's good for the community, but it didn't sink in in my brain; I was after acting that's what my, I've been all the time my life acting. So as soon you say acting, play acting, and to me this is what's attracts me. And then later on it was like the benefit for the community in that. I study four years in Lebanon acting, so I did theatre play, and I did movie and I did series, television series. It was all like script you write it, and then you'll act on it. And when I come here as well I participate in *(suburban)* Women Theatre, and it was my life story sharing with the, it was the community for a whole, one month, and the training was for the whole year. But yes, but I didn't like it to then because I felt they are using my story, just, so I had to stop that. Where I like to be giving script and then I will, like one day I am like the good loving one and I am the naughty one, or I am someone with real power message and someone, yeah, so when this project come, and just you're going to be playing acting, this was, I say, "Oh, I wanted maybe to try different," so this is like what attract me and just like in the beginning, but it's, I realize later on it's, you know very different.

I'm there to collect the feedback and to gain like a perspective that they understood our culture and maybe later on it will be like they know more about the Islam culture, or more about you know the different culture. We shouldn't say the play. It's more like educating. Just when I feel like the collection feedback from them, it's very good. It's very important to know that people, even if we are bad and the student especially don't know how 100% they hear us, the message. Like you know even we are there for the whole class, maybe they only understood one message and this is enough for me. I don't need for them to understand the whole scene. It's just like message like, she wasn't rude. Just like she, that's part of the culture. So if one key message I leave from the, I say education session, it's enough for me.

The simulated patient character for me I like it the way it's designed like that. It's very good, because it's important, like all this information is important to be ask, otherwise you don't have the knowledge about this person you need. So I was protected. It was something to do with me again, with, I didn't have to be shared, I felt like I am safe and the message will pass from the client to the student. So, I felt like the whole process, there is nothing that will hurt me culturally.

I am comfortable because the way, like the instructor say, they train us if something personal or hurt you don't have to answer that. So it's again from the training, we get this knowledge like if something will hurt us we could say no, or yeah, so from the beginning we know it's not going to be something going to hurt us or damage us later on. I will go back again to my play at the Women's Theatre, I have to feel and live the moment that someone hurt my sister and my sister injured, and my mum trying to save her, the same moment I have to live and I was crying every single play, day and night about it, and then this is, I felt in the end it's damaging me actually. So that's why I withdraw from them because the support I didn't get, and to them, they just want me to play on this particular one, like I like to play on the laugh bit and that, but not on this particular hurtful, and I have to beg on the soldier's knee because this is why my mum, she had to do that when my sister had been injured, so she had to beg him and tell him, "Please, can you let me save my daughter. Let me go to the hospital," and he said to her, "No, you go to hell, you and your daughter. You deserve to die," because we have, we are from different belief. This happened in Lebanon. So when I was telling my story she only want this particular very painful moment. This was awful. So like to me I felt like when I said, "This is the play," and then the way they talk about it, and it's like in the beginning I didn't feel it, but when,

like my story, like saved five people, and in the end I only have to act on that painful part. I felt why was all my story only I have to act on this particular, the painful, you know, every time I talk about it, even this was, I'm saying how many years, 20 years ago, very painful. I was crying real cry every single night. Not acting cry. So even when I do and go back behind this scene I couldn't let, stop myself. And it was during, again it was during months of Ramadan and then I felt like this is a sin, like I'm acting, I'm fasting, my family doesn't know about it because during these months I shouldn't be, but it happened, like the play around the months of Ramadan, so it's all again I feel guilty, I feel how come I only doing that, and like the amount of support, even they say they support us but it's, to me every single day I am crying, people come, pay money and back again, it's all like volunteer, we didn't get money from it, and just even for transport. I'm not saying that, but I said, "I am enough."

Yeah, so when something like simulated patient, like a play, and then like that, I felt you know, but when I learn about simulation it it's actually, it's like an experience, it's a pleasant experience actually, making the student aware about it and in a positive way, even if they touch on something like, you know, even when my colleague, she was saying like, she was coming through to her journey to Australia, even that was painful, but it's important for them to know the story. It's not like done in a hurtful way, it done professional way, and I was thinking, "Oh, I was so wrong. It wasn't anything like the acting theatre".

It's important for the student to know because sometime they think people, you know, "This is not your country," or you know, "Go back to your home," "Go this, you don't belong here." At least when they know we've been forced to come here, it's a beautiful country but it's when you come to the country willingly it's different when you've been forced, like you know, my whole building collapsed, to me, when like, when I look back why I come here the whole building collapsed, my sister injured, my cousin killed, their neck gone, so it's that what make us flee. Someone one day tell me, "You don't deserve to be here. Go back to your country," because again, like I was so hurt but again, ignorant, they don't know why. So that's why it's important if it's true this, you know, like we call it a simulation, but we call it a play, this is like I'm saying to me it's sharing experience, it's not a play actually, it's sharing experience. I think if it's passed to others, it's a student, and more of that, and then again it will be every student will have this kind of knowledge they wouldn't say to me, "Go back, you don't belong here."

Acting experience isn't enough to play the part. Need to be someone that goes through the experience. Because sometime when the person talk about it and if, just one word, like when they talk about it and they stop, you will know, like even when you translate it you will stop exactly the same way they stopped because you could feel it the same way. Because when you say like you're being trained to act like you know, and the tone of your voice like that, but when you are with the student and you maybe prepare yourself they ask you this question, no they ask you another question. And again the voice you have to change the voice according to what he's asking, the message what he's asking. So it's all there. You have to make sure that when they ask the question that they get answer for the student and later on the message will pass to others. So it's again, it's not like the word is going to be, "This is it I'm going to say like that." No. And again if they didn't understood me this way, I may try in the other ways. And even like the setting, the location, it's all of that. I have to change according, what's this student you know? And maybe some time even the student if this one asks me, "What's her name?" And gone and come back, "What's her name?" And go. That to me you know I have to improve. That's mean like you know there is something you know missing there. Like you know why everyone's asking the same question? That means that they're not really there with us. So we have to make it in a way like very like engaging rather than just like watching.

Acting there it's, you have script and you can't make your voice loud or you just according to the direction. Where here you have to answer, again I couldn't say play. I have to educate the student even like you know educate them according to their need or their you know, the question that they ask. Some of them they are very high educated so again the tone or the amount of information. So it's different, according to each student. It's not like they're all the same.

No, it's just like when we talk me and my simulated patient friends and we talk all of us together, it's just everything like a positive, positive about us involving in the project, the great outcome from it, it's like when they call us, even are working, we let, we stop everything. In the beginning like I say, like it's for me it's a play and income for me, but now I don't think like that; I just think how benefit the student that will benefit from that, and for us as well to show them that our community not the way they are thinking, like we are not burden as well. So they would really have a feel and fear, like you know, that when they got to practice those people, they really deserve to be here and we should make sure and on different ways to approach and see how can we help them. So it's really great project and I wish it will be successful; it just

not one time and finish, I wish, it's not because I am involved in it, it just, maybe if other university have the, as well, take the opportunity to be involved and with other community to pass this experience.

It's wonderful, it's wonderful project, and I wish it will be continue to have this opportunity for all years, like first year, second year, third year, and you know, from the beginning. If they have this knowledge from year, first year, the students second year will be skilled and equipped and on when they, the last year I don't think they need any education because from the beginning they had this experience.

They will be ready to practice, because these are our children, these are our, in the future they're going to be our health nurse or doctor. These are the generation, if they have the opportunity to get skills when they are in the first year, second year, third year, not the last year, they will impact on them, and again, change their attitude. They will feel like which way, like to approach a refugee or non-refugee. So it give them great experience and skills, and if wasn't like that there will be continue the same way they are acting now, even like she will come and it's like this is her job. It doesn't matter, this is her job. While you are here, tell me what about, okay. She will write a report, she doesn't need help, next. So to me it's important for the practice, the health practice to have this experience.

And we felt it when they don't know, just by saying that how the impact straightaway. And again, when they're trying to ask and she's not answering and then again and again, like they know nothing wrong with her and she has this issue, this issue, this issue to follow-up, and the amount of like strategy they become to trying to get the word from the client and later on to assist her. So this is again, if sometime the first contact person from refugee background, it will be the nurse. If the nurse didn't pick up on this issue this person will go, stay back home, depressed, isolated and that. It was one word, it could, the nurse, she will know, you know, he's isolated or she isolated, you know, where to be link.

Yes, even like from my work, like cars when someone, you know, they are expert in everything and they say, "She's from Arabic background. She need, she's isolated," and I say, "This is there number. Let her go there and go there. She doesn't have time to be home after that." To have that and then by say, "Wow Leyla," because I say from experience, because we have to share our experience with other, from someone like I see through domestic violence and that, she need to feel safe, she

need to be like, you know, and again to be connected with the community. It's important, like from this person, she has no one and now her and others I could see they don't have time to contact me as well. It's, I'm so proud when I see that happening because again, because when they come I say, "How are you?" she says, "I'm fine." Because even when they've been refer, by example, she will say, "This lady has domestic issue and that," even I speak her language when I ask her first time and second time and just like she'll say, "I am fine," and like she has been escape from home. And then how long to come in to get her trust, I speak her language, I speak, you know, and I link her with, later on she will open honestly she will say, "I was depressed, I left home in domestic violence, and this one Leyla, she was able to touch on my needs and link me with all the social groups and I don't have any minute now free of my life and I'm so happy." So to hear that feedback it's given me greater pleasure because again I am speaking her language, if I don't make effort as well to let her trust me so she can talk about it. Everybody, and even like your own daughter, sometimes something bothering her and you know, even you say, "I'm here when you're ready to talk to me," and she won't say first day, first week, later on like you know, it's again ways. And we've been learning even like this, like you say from the experience that we share it with you, we are learning, we are being, having, even we have our expertise, but we have skills now.

It's wonderful because the program, they respect us, they give us the time before and the opportunity flexible, suit us, doesn't suit us, you know, even it was like for, by example for another simulated patient she had two children and you know, and when you say 8:00 to her that's me 7:00 and for me, like 6:30, so even that, you know, that how we go for the extreme, but just we felt so good, we organized like you know, I say, "If you could put your daughter and your mums, or have like," they planning, the program give us enough time for planning to be taking part; it doesn't matter if it's early or late, we will leave everything to come and participate because of the understanding and the way it's like my friend she say, "I never had this experience and the work, because the kindness and like the fairness," she say, like, "They're looking after the kindness, the fairness and like, and they give us the opportunity when is not when, and that, and the plenty notice to give opportunity for everyone to participate and the choices, and it's never a pressured," even I'm saying, never a pressured. Yeah, never a pressure, and with other jobs it just sometime we feel we have to. But with this project every time, like when they call us, even we have lots of different work and task and it just, we say, "Let drop everything," just because we were thinking the positive outcome, how can we improve this student thinking, how

can we improve their knowledge, benefit, not for their money, not for, you know, for us we don't think about the money because we found that the money they gave us is fair, very fair. You don't use us, it's like very fair, the amount of dollar you gave us, it's really very appreciated, like we've been working, myself, with so many research I feel like it's like are using us. But with this project it's, we felt so generous, very supported, give us flexibility, and appreciated, and one to come and one, it's really right.

I've been with so many different research and project, and I felt my God, it's not that, but because like they say, we're going there and coming to the classes, and then like even when we are there they say, it's like we never felt like even the break, they are included, and everything included. It's like we say that's, "Wow, it's very," like because the simulation instructors are there, you know, we went there, that's it. But with other, it's like they gave us maybe 100 page expected to give us like small amount money. To me, need to be fair, it needs to be fair.

The preparation. The travel. Yeah, believe me, like I'm saying I never work in my life with any research company or any project like I am so proud to be taking part like this. I am very, like wherever I go I am so proud; they are generous, like they're supportive, and everything like financially, emotionally, physically, I say, this project very successful and I'm not saying just to please anybody, that's what I feel. I swear to, on a Qur'an, like this is the only project I am so happy to be taking part in. And not only me, everyone say that I'm driving them and coming back, they say, "Look at them," even like I never felt I've been used, I never felt. And every project, sometime I take it as because I look at the community's benefit, every time, like I take the paper to the community groups, volunteer, but I will say, "They will get $80 or they will get $50." I look at, I will, I said, "It doesn't matter. I don't get anything," but I pleased. These people that I chose, they will get benefit. But it shouldn't be unfair, I will take the, you know, I'm a driving taking the booklet for them, so at the second day, when they open they ask them question. To me I say, "I pleased there is something, the community, the refuge, they get some benefit which is $80 of $50." But when I hear like she gave them $20 and this research like that, $100, for me I'm not saying, to me if they give me $1 or $50, for me I know like I will always look for the communities first.

I've been volunteering my life, so many years, like 20 years in my life, so many award I receive, and it's like the full garage award and that for the volunteer work I

do. But I feel sometime that if, like I say, this participating in that, I feel I am so like proud it's like I won a gold medal because the way they are looking after us in the simulation program, it's everything. And the way I've been participating, now I've be looking for other job, even now I am saying no, I never said that. I'm saying, no, I'm not going to be taking part in the research because I found they are using me. Like I needed to be going next week and I felt someone near *(distant suburb)* and I ask, I just need a transportation and my time, and in the beginning they say, "We'll give you your time and the transportation," and in the end, just to clarify that, and she say, "This is, we're not giving you for your time, we're only giving you for the transportation." And from the beginning, if like you say, from the beginning I know I'm not asking for the transportation, I know, but when it's written, "We will pay for your time" I'm saying like she say, "I will give you for your time with transportation." And then I say like, "I just wanted to know if I catch the train or I catch taxi, I just want to clarify." I say, "How much you think of my transport?" She then changed and she say, "Oh, this is the, only for transportation." I'm going to take off four hours from my work to go to *(distant suburb)* who going to pay for that?

Before I was all the time like feeling like, you know, it's a shame to say no, but after, believe me, after this project I felt valued and I felt, "No, it's my right to say no." Yeah, and it's like I say, "No, I'm not going to participate." And it was like a research, you know, if you want me you could come to me. I don't have to go all the way to *(distant suburb)* and because for me I'm not familiar with the roads so much, like you know, this is what's for a skin cancer, for the community, and she make it sound very good. "You've got money for that," I'm saying, I just need like to go there, it's, I have to know which way I go. If you're paying $100, it's not that, it's the whole idea, like from the beginning, like you say, from the beginning simulation instructor were clear, you know, this is the amount of money you're going to take, this is the amount of hours, and that, even if you say like $1, for us we had so pleasure working with them. But when we look at it it's that generous, you know, even my friend she say I work that, no one give me like that. I'm saying, I say like generosity, supportive, you know, I feel valued and respected. What else do I want? I will drop any project now and just waiting for someone like, for more work with this kind of project because it's, the outcome from it is like for everything, it's cover everything.

A1.8 Onam

A1.8.2 Setting the scene

Onam is a 27-year-old woman from Iraq. She has lived in Australia for most of her life. She has strikingly beautiful facial features that are framed by her hijab. The absence of hair accentuates her beautiful skin and facial bone structure.

She is something of an enigma for me. She is able to speak in perfect unaccented English, in broken accented English as well as Arabic. In simulation I have seen her perform as a newly arrived refugee. Instead of her customary lace covered hijab that is light and feminine, paired with contemporary clothes that cover her fully, she arrives wearing a black abaya and hijab. I am struck by how much this changes her appearance and simultaneously shuts down her expressiveness.

Management of her image is important to Onam I think. Her house is large, fashionable and opulent, but still incomplete. My field notes detail this:

Onam's house is in a new area but all those around it are completed with gardens done. Onam's house has not been rendered and the front porch and steps not yet built. There is a temporary wooden platform and no steps. There is however video surveillance of the front door so she can presumably see who is outside without opening the door.

At our second interview, she explained how she could be uncovered in front of me, but not anyone who she could feasibly be married to.

After talking about being uncovered and telling me she would cover to answer the door if a parcel was delivered, that exact thing happened. Onam took a hat that she had previously indicated was there for that purpose, put it on, before answering the door to receive a parcel.

A1.8.3 Onam's narrative

When did I start *[working as a simulated patient]*? I think two years? I think it was two years. Or a year and a half, something like that. Oh it's really good. You know we got the training, which was helpful, and we do need the training. Well it was, like it was detailed and the way, there were PowerPoint presentations. It wasn't just talk, talk, talk and, or just listening and not having a clue. We were able to role-play as well, so get a feel of it. They had sort of examples of someone that had done simulated patient before so, we saw that example too. It also went, not just about the performance part, but then going back and giving, you know, criticism and stuff like that and the way to go about it, what's positive and what's not, so that was good too, that helped. Yeah, so like it went through everything really, so I don't think, yeah, after that we weren't really lost. All the information we needed was provided, so that was good.

I don't think there was anything bad about the training, it was fine, I think. I can't find anything bad. Maybe, you know, it could go for longer, I wouldn't mind, because the more training the better. But apart from that, no, I think everything was fine. And it was good because I liked the venue too, because you could find parking. Because that's important to me. It's very important, because when someone tells me oh, you may struggle, I'm like, oh, I don't want to go. It's a put off straight away for me.

You need to know why you're doing this and then what they're *(the students)* going to gain out of it. So you know sort of what to look out for and probably change the way, you know, you act or you come across. Because if they're first year students, for example, and that's why it's important to tell us what background? Are they professionals, or are they students, so you know to go easy, you know to make it a bit more challenging, because at the end of the day, you know that's what you are trying to achieve for them.

And then it was the, like a little sort of mini training. So before going and doing particular case, we would get trained up like in a, the tone and behaviour and all of that that we need to do, and you'll just double check to make sure that it was good. And that would, yeah that helped boost my confidence and make sure that I knew what I was doing. And, it was really good, everyone was supportive and the feedback was good. That I received, the way that I played the simulated patient and that, from students it was expective [sic] and they learned from it, and it was, yeah it

was all mainly positive, which was good. Pretty much positive. It was, I don't, I don't know, obviously you're not going to get 100%. I don't know, because when they tell me overall it was positive it was great, but I wouldn't know feedback wise. So it was from, I can't remember her name, the lecturer, so she told me it was very good, so from her point of view, I guess.

And then to find out if the students gave good feedback I asked the program staff to give me a call. The students said it, it was like a bit more detailed, as in they found it important, useful, and I was very convincing and stuff like that. So it was part like the, the overall experience and then the way that I demonstrated, well, how you say it, portrayed it. In the beginning I was very, because I was doing the mental health, so I was really in to it so I would speak in a low voice. So I just had to, yeah, keep in mind that I had to raise my voice for everyone to hear me.

Feedback has always been the same, yeah, like people are shocked when I can speak English. Oh my God, and then like, because I'd speak, you know, like broken English. So they'll just be amazed, they'd say like very convincing. From the students and then as in like overall as well. It's like the whole experience, they found it useful and it would help and they came in and they learnt something new. That was, I think some of the questions and feedback that was always positive. But yeah it is, before going, I do get stressed obviously.

I'm just a stress head, that's because, that's the way I am. I'm never relaxed. Actually look when you first walk into the room you're like [inhales], and then when you start that's it. It's all good, I'm in role and everything's fine. And it depends on the student and the way they are, so if they are listening and their engaged, and then that obviously makes me more confident. But when you see some talking and on phones, then you're like, you feel, am I doing something wrong, or? It does make you get worried. But I just continue on. Sometimes, if I feel, because I would notice I'm a bit low, then I would, I raise my voice. But that's throughout the role. So when I'm talking to the person then I would probably act it in a low voice, then I would repeat it a bit loud. Because I realize that I spoke low.

My nerves are as in, just worried am I going to make it on time? Am I going to get held up? And just making sure that I'm there, I have enough time to get ready and then where I really stress out is when I get the roles and think, I mean *(nominates University)*, because parking. That's awful. That's me. I don't mind *(alternate*

University). I love, I'll go anytime, *(specific hospital)*, all that, no problem. But a place where parking is a bit of a problem, that, more stress. Just trying to get there and how you were going to manage yeah with your transportation and stuff, yeah. It does play a role, yeah.

Once I think, where was it in Melbourne I think on a Saturday, and it was, I can't remember one hour or two, I can't remember. It was, I was like, to go all the way and then, and that's, because that builds stress for me, so I get stressed, and I'm like I don't think it's going to be worth the stress itself. So just go in there, try to find the parking on a Saturday, leaving my family and for just that one or, I can't remember if it was one or two hours. At least if I have built up the stress, I've gone there, it's been worth it, come back or, yeah.

I know there will be a lot of people when I first walk in, but then they don't bother me when I'm performing. Because I'm just engaged with the person in front of me, because that's all I'm, all I care about. Everyone else is just in the background. So I'm just focused, especially when I do the mental health I'm just like oh [laughs] I don't know what's going on, yeah. I think you shouldn't take it personal if someone is not concentrating. Like, because I see everyone else listening and you'll always get the, like I remember as a student, you know, not everything was interesting. And I'd probably be on my phone as well and you know, they're probably just not interested or not taking it seriously. Whereas you've got the others that do, so I don't really take it personal.

I'm like, oh, okay. Because I know I'm doing a good job anyway, so it doesn't bother me. And I know everyone else is listening and they're in to it because this usually happens just with the more earlier, yeah, so you get the first year or the second years, but all sort of the more advanced are more in to it because I think they've had the experience so they know how it's like and they're sort of trying to get more ideas. Whereas as a student you haven't gone through that, so you're still thinking oh what's this? It doesn't affect me at the moment or I'm not going to go through this so probably I find it not relevant. You know?

It's more, because like even if you get the one or two who are on their phones or talking, most of the times they've been talking was I thought they were just talking because they were rude. But it turns out some were translating to others or saying something in regards to what we were doing. So just further expanding, not like a

different topic, it was more related to what we were doing. And then that's when, like they would, I think probably one time they actually said sorry if you thought we were talking, we weren't, we were, I remember it was something to do with the topic. And then like, as I said it doesn't affect them because it's not disruptive or loud or it doesn't affect the moment. You know, if it does get to a point where everyone is rowdy and you can't concentrate and I'll probably tell them, excuse me, you know, I've come here for you, as in like it's just, yeah, it's, if you're not interested, you know.

But apart from that, like it hasn't affected, because as I said, they're just in the background, you don't feel it. Because you've got, you know, like around 20 people that are engaged and then you get like one or two, which is nothing anyway. And as I said, when I am in the role, I don't, like, because I've acted the mental health a lot so I've always been looking down most of the time. I don't pay attention to what's going on. Because all I concentrate on is like what they're going to ask and then just, you know, being in the role.

You know, because a lot of it, at the end, it's always been challenging for the students, like they've always said, you know, like this is very challenging, we didn't think, you know, it would be this hard. And like when you get in to that seat all the questions sort of go. And that's because I think they are so nervous about the next question. Usually with that mental health scenario it's very intense and I've had students that have said like it's very stressful and intense being in that. Yeah, like I had a class where they actually got a bit affected.

The program staff gave us the templates. And then put in some ideas and prefilled most of the areas, so that helped with the scenario. So I just always went around those answers, I didn't come up with anything for myself. It's better to be safe you know? And everyone I get, students were different, so no-one's, no-one knows what's going on. Yeah, so if you always reappear, well same thing.

The simulations, they're always different. All the time. Yeah you get some funny ones, and then you get some really good ones. As in when you say don't give a lot in the beginning, but then some students were able to ask the right questions and then you're, you just have to disclose, you know? So early on because they've just been really good. Some, I drop so many hints, and no, still will not ask the right question. And most of them will just repeat, so what happens is some, they don't realize that you're supposed to carry on from the next student. No they will repeat the same

questions as the one before. Thinking of this like a different person. I'm like I said it 100 times get it already. But I would never say, no. In the feedback I'll tell them, I'll go look I did drop a lot of clues and I was trying for someone to pick up on it, I wasn't going to give it away, but it was a hint, ask the question. But yeah they'll learn, that's the whole point that is.

I always liked, then it's my problem, and my husband always yells at me, he's like "stick to one fricken job", because I'm always doing so many things. But I like getting involved in things because I like to learn new things. And this is a whole new experience. And it was good to know what's out there, and what the governmental, or you're trying to achieve and trying to help others. So when you sit down and you speak yeah I did this and I did that, and it sort of you learn things.

Well I've learnt that, probably that, it's good to see that, I don't know is it the government yeah? Yeah it's a good, they're actually trying to make the effort of getting nurses and, who are, who is, to understand and deal with others from a different background, not just brushing them off. Because it is important, and at least when they do come to the country, they know that yes this country does care about us, and they'll start to treat it a bit more different. And it's good to see, because obviously a lot of people have come from very bad situations, and poor countries, and they've dealt with a lot. So to bring that across is I reckon not good. But obviously it's hard to get rid of, but if they start to see that this country is trying to help them, and making the effort and respecting them, obviously then they'll start to treat the country different, yeah.

You're never going to satisfy everyone, especially like from our community, as in they expect everything, you know, to get everything and everything should be like given to them you know, or, if something happens, that's it, they'll blame and go oh everyone's against us, or, it's not good enough or the government's like trying to do this, or whatever. So I think because it goes both ways, as I said, because over there's completely different to here, the way they've been treated in like the health system is very different, like over there very rude. And the hospitals, because you'll notice that a lot from our background, because the way they get treated from hospitals, the nurses were very rude. So that's the way that they think is okay. It's all about communication, because you can say something, you got to mean it, they're going to take it the wrong way. And so for the health professionals to understand how to deal with particular cultures, and then know okay, it's not okay, that's alright. At

least that way even though they were trying to do the right thing, might come across as bad.

Well I think they just have to, like they respond to that, so I think that's maybe why when they go to the hospitals here they're expecting that. So I think it just takes a bit of time for them then to realize that no, you know, the doctors or nurses are not here against them, or they're not, they actually are treating them well and they are caring for them. But I think it's just going to take. So that's, it goes both ways, it's not just doing this program for the health professionals to learn how to deal with people from different backgrounds, but also they should have an awareness as well.

Just because the helpers may come across maybe offensive or rude but you need to keep in mind that they don't know anything cultural, they are trying but they don't know everything. So you know, you need to understand that too, and if something happens like that, you know, I'd probably speak with them or do something. Don't get aggressive and that's not the way things go, or, you know, the only way we're all going to be able to communicate efficiently together is by having an awareness for both, I think.

VASS, Victorian Arabic Social Association or something like that, Services, yeah Social Services I think. So they help as well. So refugees, people that have come from other countries, can't speak the language, so they deal with all their Centrelink forms, referring them to the right services. You've got a lot of aged people as well that do activities for them, programs. You've got social workers. I've done a bit of work with them, but not much, but so, I know so many people. So it's good to have that understanding, because when I see someone talking negative about something I'll be like no, but there's this and that. And they're trying to do this. Let people know.

I've also worked with the city council. It was, what is it called? *(named program*). That's what it was. So they chose five people from different backgrounds, and I represented the Muslim community. And then pretty much then had a, four dot points about what we are. So with me it was professional accountant, doting Mum, likes a girl's night out, and then all of the above. And that pretty much had that's for everyone. And then it shows that we all the same, no matter, don't judge us. They wrote articles, and they just explained a bit more of our background and religion, just to clarify misunderstandings. And I think that was really good, because I read some others where I sort of had some preconceptions. I just went to an audition, they just

took a photo. I don't know how many people there were. And then they chose me [laughs].

It was my auntie. Yeah my auntie. See because my auntie, because she works with *(named program)*. And they're connected to all these programs. So she'll tell me what's out there and what's going on, and if you want to partake in these, whatever programs and such. So that's the way I know that all these exist.

Yeah look I'm not the type who goes out and preach, like some people do, because I know that comes across in a negative way, and I don't like doing that. But in something like this where, it's just getting to know us. I'm not trying to enforce anything on it, but it's understand. And that's what, and that's why I liked it. And as I said it did change my life, and the way I've viewed myself, because I was always like, oh other people going to judge me, and how they're going to see me, and I used to worry about what people thought. After the photo, it was like you know what? If you can't accept the way I am well too bad. Don't care I'm not changing for anyone.

The thing is I may, you can't help yourself, okay? Never. I always battle this, all the time, like if something happens or someone looks at me in a weird way or looking at me I think oh yeah, it's because of the way I look. That's just in me. Especially for girls, yeah, because it's obvious, because we wear the scarf. So, and sometimes, but this is like a long time ago, like I've copped a few comments. And then like, because then during work, when I used to, like I used to go meet clients and stuff like that, so I'd be so scared I'd think, what are they going to think, oh my God? You know, this and that. But then when they're so nice I'm like oh, okay, this is good. You know? So it just depends, I don't know. Like, you can't help it. Because you hear all this stuff anyway and you know, you can, of all this hatred and things that go on. I'm always thinking, I'm like, okay, you know, you don't know what the other person thinks. Are they looking at me because of that, or is it? I don't know, you'll never know.

Like especially, you know, with what happened as well, like you know. In Sydney. [Sydney Lindt Café siege by suspected Muslim extremist associated gunman] So we were like, oh shit. You know. That's how we felt. A lot of my friends, a lot of my friends were too scared to leave the house. Like their husbands would say don't go out just in case, stay at home. If it's not necessary, don't leave. A lot of them. So because we were just so scared that they're going to put this back on us, people are not going to understand. It is a big deal. Of course it is, yeah. Because you think

okay, everything is going okay, you know, you haven't heard anything, people are sort of, you know, trying to forget about all this stuff or not, and then when that comes up, alright, here we go again. You know what I mean? It's always there. Like, as in like, you know, because I read, there was, in Queensland there was a Premier, or I can't remember, who was saying, you know that tweet thing, ride with me or something. How he was talking negatively about it. He was saying, oh yeah, you're being disrespectful towards the hostages, you know, when they're going through that. Everyone's too busy, you know, doing this stupid campaign or something. And it was like, okay, like we under, obviously everyone's affected and, you know, we do. We're so concerned, what's going on? But at the same time, we can't help it, you know, that's the reality. You know, when something like that happens we fall victim too, because of the media. And what happens.

I would say it's the uneducated *(who are racist)*, because if you go to any person that actually sits down and understands and, you know, probably takes the time to read a little bit or, you know, take a step back, they'll understand. Just because someone did something doesn't mean everyone's like that. You know, just say he was, I don't know, like from some other different culture, does that mean they're all like that? Why is it every time, you know, some Muslim comes up, why, I don't get it? I did struggle for a long time. And as I said, until I did the campaign with the city council, the *(named program)* but then I realized, as in like we had, if you don't accept me, tough luck. You know, that's just the way I am, you know? So that sort of helped. I do struggle.

Being separate, recognizable, all the time, it's always there. All the time, I struggle with it day to day, every single day, it's a struggle. We talk about it, we do, yeah, like for me, when I was working at the bank, I used to work, and I used to say to myself, you know, if I wasn't *(covered)* I probably would have been able to get up higher positions and stuff like that because I wouldn't always feel this way and so yeah, I feel that that affected me in work as well. Yeah. As I said, it may just be in my head, but it did affect me anyway.

But so we were very surprised that no, it was positive and you know, the media sort of didn't. And I think that is so important, because that actually, like instead of trying to divide us and, they actually create the hatred. It's the media that creates it, not us. Yeah, and they feed it, so no, when you see, okay, no everyone's actually all together, then you're like oh, you know, like, so you're confident, you go out, you

don't have the negative thoughts, and we're all together, like, you know, really like as one and we're all there for the same cause.

It's more because of what goes on in the media and so, and then you get a few incidents here and there where you think, it just takes one or two to think that everyone's against you. Although it may not be the case. But you can't help to feel that way, you know? And you always remember, you'll never forget it. So yeah, like, and that's why we always, yeah, we always battle that all the time. No matter what. That would always be like, yeah, this is me, I don't know about everyone. Look, some of my friends, no. I find, and they don't let anything get to them, they don't care. But then, yeah, some do. So just, everyone's different in how strong or how.

Well it just, because we're supposed to *(wear the hijab)* and then my Dad was sort of strict anyway, so it's not an option. If I didn't cover he'd disown me. So yeah, like that's not an option for me. Yeah, and like my husband doesn't care. He tells me, do whatever you want, he doesn't care. He tells me, if it bothers you take it off. But then I'm like, it's who I am, like I can't, I can't any more. As in you know, it would sort of be embarrassing, like in front of your friends and so it's just, that would be very weird. I wouldn't mind, like if I go somewhere. Yeah, no one knows, so maybe that's what, but if you know someone it's very awkward. Yeah, because the whole point is for them not to, you know, like, yeah. You cannot uncover in front of anyone that you can get married to. So you can, in front of your brothers, your dad, grandfather, father in law, so anyone basically, yeah, you can't get married to is fine. Anyone that you can, you can't. Yeah. So as in, because obviously hair is, you know, like the most attractive. Like we found it, so then trying to sort of be a bit more modest and, yeah.

That's why I say, it's so hard on like the girls. Like the guys, they don't care, they can blend in and, you know what I mean? It's the hardest for us, it's, yeah, you know, we always have to cop it and deal with it and then sometimes they say why most people are bitter or are trying not to fit in. Well obviously if you don't give us the opportunity, well then that's the way they're going to feel. Pretty sure you'll feel the same way, you know, but, whereas when people respond positive.

It's like, you know, on a few days ago I took the girls, take photos with Santa, I do it every year. And he *(Santa)* was so happy, he goes oh, like I'm so happy and good on you, and I know you don't celebrate Christmas but it's very nice to see. I go no, I

do it every year. Yeah. And for me you know, it's just a celebration, I love it. You know, it's a happy time and it doesn't necessarily, like you don't have to believe in it, but celebrating, why not? And it's nice, like, as in because everyone complains oh, you know, they're in our country, and they don't follow our ways and all that stuff and as in they're trying to, but like that's what I mean. Like for me, I don't.

And a lot of us do that, like a lot do. Obviously you're going to get some that are very, you know, extreme, but it's not everyone. You know? You can't, and not say that oh, you know, they don't want to fit in or they don't want to do, no, it's not true. It's not true at all. And I love it, like every time I look back, I love Australia, I really do, it's just a nice, peaceful country and you can do whatever you want and you know, no one there sort of saying no, do you know what I mean?

I don't like the way they run things in some Arab countries, I don't like the way, you know, the way, especially, like Saudi Arabia, I would never go there. Never, the way they treat women. And as I said, it's not everyone. It's just, the country and its laws, it's not the religion. People need to put them both separate. Yeah, so when people complain and say well, you know, why is it that if I go to Saudi Arabia I need to follow their laws, and then if they come to Australia they have to impose theirs, well. It's the laws of the country. So if Australia is very open and accepting and then telling everyone they can just do whatever they want, then that's it, it's the country that's allowed it.

So if they were to say no, everyone is not able to do this, well then that's fine, everyone should, we'll just follow, it's the laws of the country. And it's like in our religion as well, it's whatever, whatever laws are in the country you should follow. Unless it goes very, like completely off your religion, then that may be a problem. But in general, no, it's not a problem. You know, because it says you need to respect the laws. Where they say, you know, ban the burqa, that is not our religion and that's just a cultural thing. So, and for me, I do find it *(fully covered burqa*) as a threat like, as in if anyone can just walk around covering themselves completely and you don't know who's under. For me, that is a threat as well. It makes me uncomfortable I just look and I'm like, why? Like, why? Yeah, and if I, and I said to myself, if I feel that way, what are the others that are not from, you know, sort of similar, you know, background, are going to think?

I don't blame them. Because, yeah, to me, that's just, there's no need. Because I know it's not part of the religion, like why go that far? I don't get it. Yeah, you don't know, you never know, because there has been a lot of incidents where men rock up to, you know, ladies functions, wearing it. To the swimming pool wearing it. You know, trying to disguise himself, pretending to be a woman. It's happened many times. Yeah, specially like overseas, because, yeah. So you never know, so when, yeah, and it is, like I think okay. Same thing. If you walk in to a bank and you're wearing a helmet or you, you need to take it off. The same thing. We cannot see your face for security issues. I'm not going against your cultural belief. But you need to understand that this is the problem. And, you know, would you like it if someone was disguised and then something happened because of that reason? So people need to take just one step back and if, you know, if they can sort of convey it in a positive way and understanding hopefully people may understand. I can't say they will. But you know, and not always think that oh, they're against us or they're trying to do all this.

Look it goes both ways, okay, we both have to try and you know, put in the effort. If you're trying to do your job and you're getting negative, well negativity, it's only normal that you're just going to try and defend yourself or react the same way. So as in, as I said, like it's nice to see that the government is doing this and there was, I did as well, for palliative care. So as well, trying to get, like from different ethnic backgrounds, like awareness as well. To know that there's a service out there and how much they're *(the government)* trying to accommodate for different, you know, cultures and beliefs.

And that's what I tell them, oh you know, there's this and there's that and all that stuff. And so if someone, as I said, if someone ever says something negative, well obviously I'll be able to say no, this is not the case. Like that's why, because I know of all this stuff that's happening, that's why I like to have the knowledge and get in to all this stuff, because I'm able then to. Because before this I didn't know that things like this existed. So it's good to know because, because I'm sort of stuck in the middle where, because you know, like, English is, as in like probably first language to me. And then so if I can help the community members, because they all come to me for everything. I have to fill out the Centrelink forms and I have to give them, they think I know everything. Give them advice and stuff. So then I'll tell them, all this. I've just always been like that. Because for me, I just, I live the way we're, what goes around comes around. That's what it is. I go, if I help people, one day if I need help

someone will, someone out there will. That's just me. So I like helping people, like I've always liked to.

There isn't any difference between us and other women, no, in fact if they come and see us, we're more crazy and, we have such a good time and you know, and they look at us, like a lot of, when we have parties and things and like we get a lot of Australian friends and whatever and they look at us, like my God, you guys can, you know, have such a great time and you know, we didn't know that you guys do that. And I'm like, we're not different. There's nothing different apart from this. Apart from that, nothing. Music, oh I love music, I'm dancing all day. You know, parties, yeah, we go off. Go wow, always with my friends, you know, like our husbands are beautiful, let us go, and I can come back at three o'clock, four o'clock, he doesn't care. You know? Obviously, and then I think in all religions and in all cultures you'll get some that are like that, and then some that are the opposite. It just depends on their personality, not what they believe in or where they come from. Yeah. And then I'm just hoping people understand. Whatever you believe in is between you and what you believe in. And that's it; it should not affect anyone else. That's it, everyone goes by their day to day lives and then at the end of the day, if I believe in something else, that's fine. I go do it without, you know, disrupting or anyone else.

Yeah, and I think that's what, if you're able to, like mix within a different culture and they understand, then they'll start to, yeah, to be able to tell others and then others will be able to tell others and that way everyone will understand each other. Just have that understanding of like, these are like what we sort of believe in, this is what's important to us, just to understand where they come from. So if I see someone on the street and I see them doing something and I'm like what are they doing? Or why do they wear that, or, then I know, okay, this is because that's what they believe in.

Simulated patient work has changed the way I feel too. Because then, I actually know, you know what these people are not really judging me. Because I was under the impression that I was, the people were saying oh look at her blah blah blah, you don't know what they're thinking, so of course you think the worse. But then when I meet new people and I meet all, from being a simulated patient. These people actually don't care and are trying to make the effort of learning different cultures and are not judging you because of the way you look, or come from or, and all that, so it makes me more confident.

I've told people from my community, I've told, how, when I was involved in the (*council program)* how that changed things. And telling them it was good to see how you are trying to make the effort of educating pretty much your professionals to deal with others. And that's really good. And then I did the palliative care, now as well. Palliative care, they like the idea of this simulated patient work, because that's what they're trying to do. Because they were trying to target non-English speaking backgrounds about the services and the benefits of it, and how care could help them. Yeah, and help to deal with every culture and what's accepted and what's not. Pretty much exactly the same like this. So I was like yeah I've done something like this. And then they wanted the details to get in contact and to see what work was done and maybe collaborate or something. So it was really good because I told them that same thing, we're educating our health professionals, and doing the role where just to show them, get the experience of how to deal with people from different backgrounds. And that's exactly what they wanted to do as well. So you, I'll go and speak in Arabic. Bilingual educators.

Look to be honest, it's so good to do but obviously people don't have time these days. And you're not going to obviously go out there and do it. I know it would be nice to, but as in because you're getting paid for your time, that helps. So I know yep look I'm benefiting the community, but I'm also getting rewarded for my time. Because as you get, you are getting, going away from your family, own time, my own work as well. So I thought, I can still do this, and get paid for it, and even though I left my own work it's okay. I'm getting compensated. So at least I'm doing something different and benefitting others. But it, to be honest if it wasn't for that, I would say sorry I don't have time.

And that's where, with the simulated patient, that's what's helped. And that's why I'd be like yeah that's fine, I'll go, because you are getting compensated for your time. Find that I've left my job. I know others have taken leave, but, because you know you're not missing out, because they would never accept.

You know I was a bit like oh, how am I going to act this or do that? I was a bit scared. No matter how much you prepare it's never the same as when you, when you're actually doing the role. But it was good enough to be able to actually do it good, as in getting the positive feedback obviously the training was beneficial and I learned from, it. It was the second training, the one when we met at the venue. That was where I

was able to ask all the questions, get all the answers I needed, just verify and make sure I was alright and that's it. Just get that confidence boost, and that was it. But if I didn't get that, no I would've been stressed. It was good, and I felt, as I said getting the positive feedback, I'm like yeah you know what, this is good. I can do this. And that's why I said the feedback is always important. That's why I always chase up the instructors.

Tell me the feedback, I want to know, did someone say something bad, good, I need to know because, maybe not to do it next time, improve, it's very important. Everything else was as expected there was nothing foreign, everything was the way the instructor said. You got the classroom, you got the students. There was just only one time where we walked in, me and another simulated patient, all day, and there was one class, because she had taken over for someone else. So she didn't know what was going on. So that was a bit like oh, yeah, students didn't know what was going on. That was the only time. But apart from that yeah, it's important, you need to brief the teachers. And they need to know what they're doing for it to be beneficial or else there's no point. You're just wasting your time.

We were just going, they didn't know what they were asking, they didn't even know, they were asking her what's in room? Where are we? Where's this? And she wouldn't say anything. She didn't know. And then many times I would be like oh, I want to say it but I thought do we say something? Do we not? But then when we weren't getting anywhere, that's when the other simulated patient interrupted and said look. That was my worst experience because I can't think of anything else.

We got one student who could speak the language, we got one where she was, we were doing the interpreter case, and then she said it was funny, it was hard, she was saying it was hard for me, because I understood what you were saying, because you were speaking Arabic, but she goes you were doing a fantastic job. As in, because she understood. So I was lucky. Everything I say is interpreted the way I say, and I answer the questions according to what I'm asked. That's why she was like, it was really good, you answered everything perfectly. And yeah so that was good, so we were lucky, because we usually walk in going does anyone understand? But you can't really tell.

Look, everyone's different in the end. And the whole objective of this is not telling everyone okay this is the way you deal with a mental health case, this is the way you

deal with interpreter. It's just to get an idea of the situation and how you can go about asking questions to get where you need to go. So it's not, okay if you get a mental health case it's, this is how you have to deal with them, no, because everybody's different.

And I'm not, for me personally, because I'm not affected by, because I haven't gone through it. So I can't really say it has affected me. I just go in, I do the role, and then that's it. Pretty much when I'm up there, that's it. Really when it ends that's it, I, that's it. And it's for me and I introduce myself and I say, my name is Ona, and this is that I'm not mental health. I don't have any problems or whatever, like that. And there, it ends for me there.

When we speak and the feedback I give at the end is, you need to ask questions, never be afraid, the only time you'll stop is when the person goes I'm not going to answer, or I'm not comfortable. But you cannot assume, because a lot of them would assume. And when they would give the feedback I was too scared, I didn't know whether I was getting too personal, go well you can't make that judgment, you need to ask, it's your job. If I tell you no, that's it. Yeah because I said everyone's different. Even though someone may have those issues but maybe would want to speak with someone, someone else may not.

Because it's very hard, as in because when they come in a lot of them feel stressed in the situation. A lot of feedback as well was like it was very stressful. It does feel real, yeah. And then when they see that I start speaking, like oh my God, you know? And, so yeah it's just getting them comfortable.

The mental health scenario is very intense. I actually, I don't think I stretch my muscles [laughs]. Have to stretch after it because I feel so like oh. Yeah and just so oh, the negative energy. Well it's like you're acting. Really. And because I'm so in to the role, you know, like I'm so tense because I, you know, I think that's the way you should feel. But because I'm like slouched down and depressed and in to it, so obviously I need to go and stretch because my muscles are aching. Yeah so then after it I just oh, just try to shake it off. It's easy for me to shake it off. Look I have gone through a similar situation myself, where, because I was pregnant for six months then lost my own baby. Because I haven't gone through a war-like or, it's different, you know, it's different, yeah. I just take it as in, it just, like a job, as in I'm there, I play a role, and that's it. As I said my main important thing is just getting the

feedback, to make sure that I can do it right, better, if there's anything I, and that's about it. Obviously some people may have past experiences that may come up, because it may be similar. And that's only fair, that they feel that way. I haven't gone through those, so I don't know. But as I said, because I, I'm taking this more as, I'm acting.

So I'm taking a role. Like that's it, it's my job, I'm doing it. And I'm just trying to make it as, for the, all I care about are the students, not me. I didn't care about me, I care about, they walk out and have learnt something and have gained, you know, something out of it. I don't care about what I think. To me, it's more. In our training, the instructor always told us that if this case is going to affect you please let us know, we won't put you. And that was fine, I think that's very good. Because if someone does feel that they're going to get emotional or feel that you don't want to hurt them and that's very, that's the only thing that you can do. There's nothing else you really can apart from okay just find something else for them instead of having to do this particular role.

For the students, because that's going to be part of their job. They actually are going to come across people who are in that situation really. So you need to learn how to deal with it. So we can't sugar coat it in the class room, because you will come across this. If you did feel stressed, call, talk about it; try to come up with ways to try to deal with it. Maybe think is this the right thing for me? I will be dealing with a lot of people in similar cases, or not. You know? But you can't sort of go oh no, well I'm very sorry, no, because this is reality. So you just have to learn how to deal with it. That's why we're here and doing this. It's the opportunity for you to sort of have an idea of what you will come across and then learn or educate yourself.

If I saw a student getting stressed or crying, for me, it's not my position to say stop. I think it would be the teacher. Because I don't know if I should continue or not. Maybe she does want something like this, you know, to happen or the students who come across something like that, because as I said, that's what they may deal with. I don't know, like for me I don't think it's my decision. When they (the students) do feel that way, like I feel no, that's good. I managed to do it as real as I could and for them to start thinking oh no, you know? Like this is serious, you know? I will be coming across people like this. How do I deal with it, yeah? So that's good.

I don’t tell my family and friends about the scenarios. Well then they’ll make fun of me, yeah well that’s not very hard for you [laughs]. You do have mental health problems. Because, it’s not like we’re playing this for some other profession that is totally irrelevant, as in this is something that they, health professionals deal with. And you need, I know it’s probably in your face, but you need to deal with it. You are going to deal with it. It’s better that you, you’re properly more equipped and trained. So, because these people are already traumatised, and they’re already going through problems, and the last thing you want to do is upset them. Have a clumsy health professional. Because then they’d be like where do I go? That’s it. They’ll just loose hope. But if they see yes this persons trying to help me, and do it, so they’ll open up and then you’re actually are helping them without realising, just by being, or being able to treat the situation in a, correctly.

My number one hint for others? Trying to be as real as you can, for each situation, get yourself away, your personal experiences. If you have gone through stuff like that, keep it separate. Because I know it can affect the students, because I know somewhere, some do cry, and then they get scared whether it is an act or, is that really what they go through? So it puts stress on the students as well. And just to remember, at the end of the day you’re only acting. Basically for training purposes and to deal with others.

It’s better to keep it separate that way. And then you can do your job better, because when they see look I've made a role, I’m giving back feedback, I’m telling them how it went. Well obviously to me that’s, I don’t know how to say it, but, how would I say it? As in you know it’s worked. We’ve gotten what we want out of it. We’ve achieved what we were there to do, yeah. Because you don’t want to, by the end of it, get all these poor students upset or stressed, and then make them start doubting oh no can I do this? Or what’s going to happen if I got out?

Most important was the training. That was very helpful and very important. And I think yeah it’s very important to, and maybe also, if you want to add with training, get a simulated patient to speak. At one of the trainings, and then get them to do a simulation. And see how it is really, because we never got to, to get that. So we didn’t know how things were until we, we actually did the simulation yourself. So, because we only saw the video when the instructor showed us of someone doing just full health, and but still you can't, can't get in that. But getting that live, they can get a feel, and be a bit more confident, and they know what to expect. Apart from that no

everything's good, and as I said the instructors are always on top of things, they'll send reminders, very important.

So that's what's helped, and always, getting to the venues have never been a problem, everything's been clear as I said apart from the parking, but everything else has been fine.

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APPENDIX 2

Information to Participants

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled **An Exploration Of The Simulated Patient Experience On Culturally And Linguistically Diverse People Who Have Worked As Simulated Patients**.

This project is being conducted by a student researcher Karen Livesay as part of a PhD study at Victoria University under the supervision of Professor Kristine Martin-McDonald from the College of Health and Biomedicine Victoria University.

Project explanation

This project aims to explore how people from culturally and linguistically diverse backgrounds find being a simulated patient. It also aims to find out about the people who undertake this type of work.

What will I be asked to do?

You will be asked to meet with the researcher and participate in two interviews each lasting one to two hours. These interviews will be audio recorded. After the interviews you will be provided with a copy of the transcript of your interview so that you can confirm it is accurate and reflects the information you wanted to provide.

What will I gain from participating?

There will be no benefit to you directly in participating at this time although over time an understanding of the people who participate as simulated patients may alter the way simulated patient training and programs operate**.**

How will the information I give be used?

Information from your interview will be used to write a thesis and other reports and conference presentations that explain the simulated patient experience. You will be given a different name (pseudonym) so that you are not identifiable in any reports or presentations. Your real name will not be linked to any information you provide in the interview.

What are the potential risks of participating in this project?

There is a small risk that participating in an interview may make you feel uncomfortable. To make sure this does not happen:

- your participation is completely voluntary and you can withdraw at any time before or during the interview
- you will not be required to give a reason for your withdrawal

- participating in the research or not will have no impact on your future work as a simulated patient

How will this project be conducted?

You will be invited to participate in an interview lasting 60 – 120 minutes, which will be audio recorded. You will not be identified individually in the audio recording and will be given a pseudonym (false name). You will be referred to only by that name in all information that comes out of the study. The recordings will be analysed to understand the stories you tell and identify important information that will provide insight into your experience. This will be written as a story that will be returned to you to correct or edit if you feel that is needed.

Who is conducting the study?

Professor Kristine Martin-McDonald
College of Health and Biomedicine
Victoria University
Kristine.Martin-McDonald@vu.edu.au
Telephone 03 99192276

Ms Karen Livesay
College of Health and Biomedicine
Victoria University
Karen.Livesay@vu.edu.au
Telephone 03 99192123

Any queries about your participation in this project may be directed to the Chief Investigator listed above. If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4781.

APPENDIX 3

Consent Form

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:
We would like to invite you to be a part of a study exploring the experience of people from culturally and linguistically diverse backgrounds who have worked as simulated patients. Participants will contribute to two interviews in which they will share their perceptions of being a simulated patient and how simulated patient work makes them feel both at work and in their life more generally. In the second interview the researcher may ask specific questions from information provided in the first interview. Each interview will be audio recorded and then transcribed verbatim. Participants may feel uncomfortable talking about their experience or home life and may terminate the interview and withdraw from the project before or during the interview.

CERTIFICATION BY SUBJECT

I, ……
of ……..

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study:
'An Exploration Of The Simulated Patient Experience On Culturally And Linguistically Diverse People Who Have Worked As Simulated Patients' being conducted at Victoria University by: Professor Kristine Martin – McDonald supervising Ms Karen Livesay.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by:

Karen Livesay

and that I freely consent to participation involving the below mentioned procedures:

- Two audio recorded interviews

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date:

Any queries about your participation in this project may be directed to the researcher
Professor Kristine Martin-McDonald
9919 2276

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4781.

[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]

APPENDIX 4

Interview Guide

Interview 1

1. Thank the participant for offering to be involved in the research
2. Brief explanation about the study

This project aims to explore the experience of being a simulated patient in health professional education and to find out about the people who undertake this type of work.

3. Brief details about how the study will be carried out

In depth qualitative individual interviews will be conducted and audio recorded by the researcher. The information for participants involved in research as well as the consent form will have been provided to all eligible simulated patients. The information form contains details about the interview being audio recorded; the precautions that will be taken to protect confidentiality, and the right to withdraw consent for whatever reason.

4. Give the participant the Information and Consent form. Give the person time to read the documents.

Ask if the person has any questions. Answer questions to her/his satisfaction. Explain the confidential nature of the study and that she/he cannot be identified in the data.

5. Obtain Consent

Ensure the person signs the consent form.
Remind the participant that I seek both positive and negative views and that they are encouraged to express themselves as they wish. Explain that they have the opportunity to tell their story any way they wish and that as much detail as possible is useful.

6. Begin recording
7. Welcome the participant. Explain that at any time the participant can request that the recording be stopped.

Question schedule

1 How long have you been a simulated patient?

2 Please tell me about your experience of being a simulated patient? How have you found it?

3 Tell me about your life in the period of time you have been a simulated patient? Has being a simulated patient had any effect on your life? In what ways?

4 How has the role of being a simulated patient compared to your expectations?

5 Would you like to make any other comments?

5. Closure

Ascertain if the participant has any questions

Thank the participant

Switch off the audio recorder.

Interview 2

1. Thank the participant for agreeing to meet with you today
2. Explanation about second interview

This time I will ask the participant to go back to some of the things they talked about last time and explain them in more detail ('probing' interview technique), or ask questions related to a topic they spoke about to improve my understanding of that area or to ask for more in depth information ('elaboration' interview technique). Once again I would like them to answer as they wish and would encourage as much detail as possible ('expansion' interview technique); however this time I may ask more questions.

3. Obtain Consent

Begin audio recording

Ask participant to re-confirm their willingness to participate in the interview

Question schedule

This will vary between participants and be a reflection of the information gained in the first interview.

Question stems may include:

When I interviewed you last time I had the impression you..... please tell me more about that?

At our last meeting and interview you were telling me about..... and I wonder if..?

After asking a series of questions designed to probe original information for greater understanding or clarity and pursue sub stories from the initial interview the interview will conclude.

Ascertain if the participant has any questions

Thank the participant

Switch off the audio recorder.

Inform the participant that I will be in contact when the interview material has been transcribed and analysed for them to review it at that time. Reinforce that they will be able to verify that the interview has accurately captured their thoughts and feelings and that they can request changes and omissions.