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INCLUSIVE SIMULATION CHECKLIST

Resource From: "Addressing Inequity and Building Structural Competency Through Simulation: An Online Transformative Learning Workshop"

IMSH 2021: Bringing Learning to Life

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CONSIDERATION	SUGGESTIONS	NOTES AND EXAMPLES
Learning Objectives	❏ Include medical and non-medical domains (specifically Structural Domain) ❏ Write SMART objectives using Bloom's Taxonomy and Kirkpatrick's Model	For example, three objectives for a penetrating trauma case: 1. Demonstrate ATLS protocol adherence 2. Insert chest tube within 2 minutes 3. Name two structural factors contributing to penetrating trauma in our neighborhood
Collaboration	❏ Develop and discuss your cases (and overarching curriculum) with: colleagues, patients and community members, learners, and standardized patients (when applicable)	This may serve many benefits, including: ● Improving representation, diversity, and inclusion ● Reducing implicit bias ● Improving standardized patient training and performance ● Augmenting case fidelity ● Improving learner assessment Avoid leveraging the same people (i.e., same family advisory

		council members or learner/colleague volunteers) repeatedly for all curricula; pay special attention to the “minority tax” and “gender tax.”
Stereotype Avoidance	❏ Patients in your curriculum should represent a broad diversity of patients/people	Given the benefits of simulation for teaching low-frequency events, leverage your curriculum to represent diversity beyond what your typical population may look like.
	❏ Racial, ethnic, and gender counter-typical examples should exceed stereotypical examples	This promotes evaluative conditioning and outgroup identification. For example, scripting the father to be the primary caregiver bringing his child in for care.
	❏ Consider basing characters (including names) on real people	This may avoid writing characters as stereotypes, but can also become a pitfall and must adhere to HIPAA standards.
	❏ To avoid stereotypes in naming, consider using abbreviations or selecting names from a phone book or newspaper	As noted above, characters developed with community input are also less prone to stereotyping. Regardless of where you receive inspiration for characters, always consider scripting them in a way that people would feel honored by the portrayals.
	❏ Situate character features/accessories in context, to promote understanding, rather than as superficial traits that artificially signpost diversity	For example, a wig/hairstyle should not be used simply because it is viewed as a “black” hairstyle; it should serve a purpose for that character (i.e., the patient’s hair was styled for a party at which there was a mass casualty incident). Pay particular attention to diversity of skin color when it contributes to understanding variable presentations of disease (i.e., appearance of rashes on darker skin).

	❑ Run character visual choices by a broad range of patients/community members, including those who identify with character	Manikin features (i.e., eye/nose shape) seen as promoting diversity may instead feed cultural stereotypes.
Character Gender	❑ Vary gender representation to replace the "default" male	Consider that breasts, gravid abdomen, transgender anatomy, etc., may affect how medical care is provided (i.e., efficacy of chest compressions; chest tube, urinary catheter, or central venous line placement, etc.).
Character Sexual Orientation	❑ Allow for diversity in family composition and patient/family sexual orientation	For example, a child is brought in by same-sex parents. This diversity does not have to be relevant to the case medically, but should ideally be addressed/acknowledged in debriefing.
Physical Abilities	❑ Allow for diversity in physical abilities	Consider casting standardized patients (or representing manikins) who are deaf, have amputations, have cerebral palsy, etc. even if their disabilities are not germane to the chief complaint. As above, this should be addressed/acknowledged in the debrief (i.e., "What factors may have affected this patient's travel to clinic today?")
Standardized Patients	❑ Clearly define roles, which may be informed by actors' identities ❑ Ensure representation when casting ❑ Provide sufficient personal background for character development ❑ Provide conditional (if/then) statements for emotional state regulation	During collaborative case writing and review, consider allowing actors' identities (i.e., race, gender, ethnicity, sexual orientation, preferred language, etc.) and their illness experiences to inform case and character development. Ideally, standardized patient training should include patient/community member sourcing and feedback.

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Debriefing	❏ Acknowledge and promote structural humility ❏ Ensure sensitivity to racial trauma and trauma-informed restorative practices ❏ Refer back to learning objectives ❏ Refer back to your character or manikin choices made ❏ Brainstorm & practice stems using a language of structure ❏ Develop post-learning materials to target action items	Debriefing facilitators should know their learners/audience. Debriefing should acknowledge structural humility, including one's own limitations and biases. Debriefs should demonstrate sensitivity to trauma-informed restorative practices (including racial trauma when appropriate). Specifically, learners may be given the choice to opt out or leave debriefing, and the environment should be constructed to be safe, collaborative, trustworthy, and empowering to learners. Debriefing should target learning objectives, including in the Structural Domain. As above, choices made throughout should be discussed in debriefing. This can be done even if diversity resources are not available (i.e., "In our scenarios, we always use a white male manikin. Let's discuss why that is, and how our management might have been different if this patient were female/black.")