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*Heart, simulated*

# The Heart of the Simulated Matter: Interprofessional Training and Practices of Clinical Care

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This chapter is a critical reflection on the failing heart of a simulated patient. In a patient–actor’s portrayal of a massive heart attack in the medical simulation laboratory, the simulated heart takes center stage as a shared object of patient care around which medical, nursing, and pharmacy students coordinate their interprofessional clinical skills training. This failing heart is not a bodily organ whose condition can be visually observed. Its elevated heart rate cannot be detected by palpating the wrist or carotid artery, and its abnormal sound cannot be auscultated with a stethoscope. Yet, this simulated heart is seriously ill and must be treated. By tracing the emergent and distributed materiality of the collective making of the simulated heart across both material objects and the coordination of skilled bodies, I show how biomedical knowledge and professional skills are reproduced through the dramaturgical organization of clinical skills training. Breaking apart the fixity of professional scripts, participants in a simulation produce the existence of the same imagined heart through the joint coordination of different embodied performances of professional knowledge, role, and vision, without collapsing into an indeterminate "we."

Using humans as patient surrogates in the training and standardized testing of clinical skills has become *de rigueur* over the past few decades in the United States, where my research is set, as well as other places around the world. Medical educators call a person, often an actor, trained to simulate a medical problem a “standardized patient” (SP). Before interacting with students in a live simulation, SPs are carefully trained to perform disease processes and convey medical history, physical findings, and emotional states in a consistent, repeatable manner for different students. They know how a doctor or nurse should talk to patients, how to touch their bodies, how to explain care, and what are the specific clinical skills medical, nursing, and pharmacy students are trained to master in each simulated scenario. Many SPs could give more compelling and expressive performances, but they are trained to hold back. Although students are asked to interact with SPs as if they were real patients, SP performers’ acting skills are neither a priority for healthcare educators, nor part of the official SP training. Pointing to SPs actor’s craft would delegitimize SP training methodology since medical education in the United States has relied increasingly upon methods of scientific management, standardization procedures, and measurable competencies.

My analysis here speaks to the limitations of such reductive practices. Exploring the complex and uncertain *simulated matter* of interprofessional expertise, I address the problem of how different healthcare professionals are trained to work, coordinate, and communicate in a team around a moment that is happening faster than any patient is prepared for. I show that in the context of Interprofessional Education (IPE) it is the SP’s professional expertise that allows the student doctors, nurses, and pharmacists to coordinate their dynamic moment-to-moment living through the unfolding activity of their interprofessional teamwork. By trivializing SP’s actor’s craft, and other resources that SP performers bring into simulations, the healthcare community might overlook what SP simulations can introduce into the training repertoire of a new generation of healthcare professionals. The imaginary heart of the SP does not simply simulate the anatomy and biomedical functioning of the heart; it simulates the practice of performing professional clinical skills on—and with—the body of the standardized patient.

I draw on the concept of ‘professional vision’ to develop a practice-based account of *interprofessional vision*. According to Charles Goodwin, the ability to see the things that matter in any profession is not a property of the eye or brain, but rather a property of “systematic discursive practices, [such as] coding schemes, highlighting, and the articulation of material representations” (Goodwin 1994: 606), by which professionals demonstrate competence in their profession. He shows how the competent use of these discursive practices allows archaeologists, lawyers, and police officers to see—and help others see—the phenomenal objects of professional interest. I argue that interprofessional vision emerges when professional scripts, roles, and expertise, clash: it develops in the activity of making sensible the different professional perspectives as they intersect in one simulation to form a system of rearranged professional relations between students.

My argument develops an account of interprofessional vision as, first and foremost, bound up in the bodily interactions with others. The goal here is to identify the moments of the collective making of the imaginary heart—the moments of the heart’s making as a living organ, grounded in the heart’s biochemical, sociocultural, and technological materiality, that makes itself known as a system of coordinated, constantly unfolding relations. An intersubjective mapping of the heart of an SP, that all participants inhabit during a simulation encounter, becomes a pathway for the re-ordering of their professional visions and embodied subjectivities. But this intersubjectivity is not only established by means of "you" and "I" engaging in co-existing relations, but also through “the public nature of perceptual objects”), which are perceived by the self as well as other subjects, and thus they are “intersubjectively accessible” (Zahavi 2001:155-6).

My analysis focuses upon the “ethno” methods of an SP actor and students to reveal how they endogenously co-construct and understand their experiences of interprofessional vision. The basic premise of ethnomethodological method (Garfinkel 1988) postulates that there is an order in everyday activities, something which has already been organized by the participants following their “common-sense” (Schuetz 1953) interpretations into procedures and forms of action.

Following a brief description of a clinical simulation script, the chapter is structured around a “real time” description of participants’ intersubjective encounters in simulation to emphasize the lived experiences of an SP actor and student teams. I first describe the intake in the clinic, and then the patient’s transfer to the emergency department, where a second student team assumes care of the patient. My analysis of the video recorded simulation training is anchored in the perspective of the students from a post-simulation formative debriefing. The narrative is orchestrated as a performance of the script from the points of view of various professions: an actor performing the standardized patient, a medical student, a nursing student, and a pharmacy student. These excerpts are interlaced with interpretative engagements of a social scientist, who is reading the script, viewing the video recordings, and conducting interviews to write this chapter.

## Simulating Heart Attack

The 9-page-long training script for the SP actor includes a clinical case called “Mark Reynolds.” Mark is a 49-year-old, former semi-pro golfer who presents to the clinic after experiencing two episodes of chest pain earlier in the day. He is 178 cm and weighs 82 kg. The clinical script includes a detailed description of Mark’s family medical history, education, work, personal life, friends, what he eats, how much he drinks, and his exercise routine, even mentioning of his being ‘Presbyterian…because I married one’—emphasizing a close relationship with his wife. The most detailed section of the script is a step-by-step description of how the simulation scenario develops, first in a primary care clinic room and then in the Emergency Department (ED).

Justin, an SP actor, reviews the script. I am meeting Justin for an interview on the university campus, as he had agreed to speak with me about his experiences***.***

Justin: ‘We go in like we are short of breath, and we have all this pale make-up and act like we cannot catch our breath. So the students are supposed to, like, do our blood pressure, listen to heart, lungs, and all of that. And they took us into the Emergency Room and they have actually, like, a fake arm set up, so they can do an IV, and there is actually fake blood in the arm, so, when they put the IV the blood came out. […] So it is pretty intense! They hooked me up to everything, so…I found it to be, as an actor, very emotional, because I immersed myself into that situation. It’s like if, you know, if you think about the loved ones, you think about what you’re doing, you think about—you know—“Oh my gosh, I am having a heart attack, am I about to die!” You know, you start thinking about, “Oh is this it?” It became very emotional! Plus we had to mimic, or, um, you know, create shortness of breath. So breathing like [forces his breath in and out repeatedly]. Where you get light-headed when you do that. But I was actually—tears veiled up my eyes about three or four times during the event ’cuz, you know, I was into this guy who’s got ready to check out, maybe. And he didn’t know what’s going on. It’s pretty scary!

## The SP’s Professional Expertise

Although it has been recognized by the medical community that the cultural and social dimensions of medical simulation shape learning outcomes, healthcare simulations continue to be designed around psychometric research (i.e., Brennan and Johnson 1995) to evaluate the quality of clinical skills training and students’ competence. Using assessment checklists and rating scales, simulation educators in the United States aim to scale human behavior down to quantifiable and measurable units by reducing parameters of social behavior that contribute to variation and contingency by defining them as biases. The work of medical anthropologist Janelle Taylor (2011) on SPs’ performance of suffering is premised on a critique of simulation laboratories that are consciously discounting the actual experiences of real people, regarding them as distractions and obstacles to their educational goals. During the planning committee meeting I attended before the IPE event, some of the healthcare educators expressed their concern that, in past years, SPs were ‘being very different’ in their portrayal of the selected patient case across groups of students, undermining the fairness of the teaching and assessment event.

For healthcare educators the variability in SP performance is bias or lack of proper training, in life variability is essential to human behavior. In his book, *Man’s Rage for Chaos*, sociologist Morse Peckham (1967) uses the concept of dramatic metaphor to explain human behavior. Ascribing to all human behavior certain aspects of actor’s behavior, he states that the patterns of behavior appropriate for specific social roles we play are organized around (dramaturgical) scripts for action. But, as he points out, even the most detailed script cannot account for all possible details of future actions. There is always a gap to be filled once individuals perform the script. When individuals learn to follow a pattern of behavior, they in fact learn how to follow “the range, the collection of bits which are socially acceptable in a given situation” (Peckham 1967: 58). Justin’s account of his professional practice indicates that he needs to be aware and responsive to the always-changing interactional dynamic in the simulated encounter, deciding what behavioral patterns are called for by the clinical scenario script.

What educators deem the SPs’ mistake of ‘being different’ across students is, in fact, the very professional SP quality upon which the teaching event depends. The sense of SP’s ability to sustain and be responsive to a set of dynamically articulated social, embodied, and material relations, gives rise to a grounded professional epistemology. But this SP competence is not just the personal, individual experiences between students and the SP. It is “a concrete expression of a given [socio-cultural] system”, since the actors’ creative work is not only social in nature, but it also creates generally recognizable cultural forms (Vygotsky 1932: 237-241). As I will demonstrate through the case of the “heart attack” simulation scenario in the next section, SP professional craft contributes the key element around which the student healthcare professionals organize their own in-role training.

## Realtime Description

On the day of the IPE event, the simulation starts with Justin performing as “Mark Reynolds” to the “primary care clinic” at the Medical School, complaining of chest pain. A team of medical personnel enters the room. The clinic team consists of two medical students, Doctor Lian and Doctor Riley; and a nurse, Nurse Jenny. While the students work with the SP in concert with one another for the first time, they are observed by three facilitators, each of whom represents one of the three participating professions—physician, nurse, and pharmacist. I watch the clinic encounter unfold via video stream in the Monitoring Room. The laboratory is equipped with advanced simulation and information technology to record the simulation encounters.

This morning, Mark had been playing golf with a client from a large VIP business account. The pain and pressure began in his chest.

‘The pain was awful,’ Mark says to the team in the clinic, grabbing at the center of is chest with his fist. ‘I felt dizzy, like I was going to pass out. I had a hard time breathing and had to lay down on the greens.’

The team performs the physical exam. Nurse Jenny measures his blood pressure. The blood pressure monitor is fixed to read high: 170/95. Doctor Lian performs a cardiac exam. She listens to the heart using the ventriloscope, a simulation stethoscope modified to reproduce a patient’s normal or abnormal auscultatory findings (heart and lung sounds), that can be used on healthy SP actors like Mark. She continues the exam by looking at the neck veins and feet for swelling and checks pulses in his hands and feet.

‘I’m worried about your heart,’ Doctor Lian says to Mark, and orders an EKG and X-ray. The EKG shows the patient having a serious type of heart attack, during which one of the arteries gets blocked. During the course of the visit, Mark develops a third round of chest pain, prompting the clinic team to arrange a transfer to the emergency department (ED).

‘You may be having a heart attack,’ Doctor Lian says, touching Mark’s shoulder in a kind, empathic gesture, as Mark looks visibly shaken.

## The “Thingness” of the Simulated Heart

When I invoke caring for the fictionalized heart of the standardized patient, I am not referring to the staging of the heart attack as an illusion, or even to the staging of the laboratory encounter using advanced, high-fidelity simulation technology to achieve effective training. The rigged monitor showing high blood pressure, the ventriloscope for picking up abnormal heartbeats, the Electrocardiogram (EKG) fabricated to support a diagnosis of a heart attack, the pale make up painted on the face of the SP, the fake arm allowing the nurse to administer the right dosage of heparin as IV bolus—they all contribute not to an illusion, but to the construction of the heart as simulated *matter* in the laboratory.

Literature in the cultural sociology of medical simulation (Guarrasi, 2019; Johnson 2005; 2008; Underman 2015; Pelletier and Kneebone 2016) has established that it is fidelity to the culture of medical practice, discourse, and imaginary, and not the patient body, that makes immersive simulation a valid training tool. In my previous work (Guarrasi 2019), I examined how the standardized patient’s body is transformed into an embodied map that systematizes, organizes, and classifies novices’ knowledge into a unified system of clinical practice during the training of the standardized patient. For Ericka Johnson (2008), who studies practices of using high-fidelity pelvic simulators asserts, the high-fidelity simulator is a valid educational tool not because it realistically mimics the body of the patient, but because it authentically represents the body of the patient as experienced by the medical professional. These studies elaborate the epistemology that conceives the simulated body as an object that exceeds its ‘objectness’ by becoming a thing of simulated action.

The historian of science, Lorraine Daston (2004), asserts that objects are not equivalent to “things.” She proposes a compelling epistemological framework that disrupts the traditional binary distinction between object and subject. In her view, the “thing itself” produces different sets of relations in different domains of practice. Aligning my analysis with Daston’s injunction to “capture the thingness of things” (15), the collective caring for the simulated heart constitutes a new set of interprofessional relations that cohere with, but do not imitate, the established medical practices of treating disease and inhabiting professional identity in the clinic. Mark Reynold’s heart functions as a shared cognitive and imaginative marker around which the collective making of the social reality of clinical practice becomes possible. A simulated heart is not an object of medical knowledge that students know from a textbook, but it interpellates their actions as a “thing.” Tracing the coordination of professional practices of physicians, nurses, and pharmacists, in the next section I make visible how the simulated heart lives through the orchestration of different lines of professional attention, skilled bodies, and the collective imagination of the participants.

## Realtime Description

In the Emergency Department the second student team assumes care of the patient. The ED team includesDoctor Diane and Doctor Ben, both second-year medical students; Nurse Shelly is a third-year nursing student nearing graduation; Pharmacist Jasmine, a third-year student, has ample experience with simulation-based preparation at the School of Pharmacy. This is everyone’s first interprofessional simulation experience. The expected ED treatment plan includes starting a heparin IV based on actual body weight of 180 lbs.(82 kg). Heparin is a blood thinner, and the facilitators’ guide says that students should administer it as “IV bolus,” meaning to rapidly inject a relatively high dosage of the medication for faster delivery. The infusion should be calculated based on the patient’s actual body weight.

Ten minutes into the simulation Doctor Diane says, ‘So his blood pressure is starting to look a lot better.’

Doctor Ben says, ‘Should we give him heparin yet?’

‘Yes!’ Pharmacist Jasmine says, emphatically. ‘We definitely want to give him heparin!’ But she continues to study her medication administration notes with information about the dosage and administration procedures.

Nurse Shelly stands on one side of the bed, looking at the team, waiting.

‘It will be a five ml dose of heparin, IV bolus,’ Pharmacist Jasmine verbalizes out loud. She hands an IV bag to Nurse Shelly.

Nurse Shelly turns to Mark. ‘What is your name and date of birth?’

‘Mark Reynolds, May 12, 1971,’ says Mark.

Nurse Shelly asks, ‘How much heparin?’

Pharmacist Jasmine replies,‘Max 5000 units.’

‘Over the first five minutes?’ Nurse Shelly asks, attempting to confirm how rapidly she should ‘push’ the medication into the patient’s bloodstream.

Pharmacist Jasmine pauses with a flustered look on her face and looks back down at her medication administration notes. ‘I have converted the dosage, I just don’t know for how long…’ Both physicians join her next to the medication tray. They huddle together for several minutes.

Doctor Diane reads the pharmacist’s notes. ‘It just says it’s bolus.’

Nurse Shelly is holding a syringe, ready to inject the medication into Mark’s simulated arm. ‘Okay, so I am just confirming—I am giving 5,000 units over how much time?’

Everyone is looking at Pharmacist Jasmine. Pharmacist Jasmine is looking at her notes silently. Doctor Diane walks over to her and they are reviewing the notes together.

Doctor Ben turns to Nurse Shelly. ‘Let’s just hold off! Let’s hold off.’

For the next couple minutes, Nurse Shelly is standing next to the patient with the syringe ready in her right hand, waiting anxiously for the team to make a decision.

‘I think we can go with one bolus,’ Doctor Diane finally announces to everyone. ‘It just says administer at once.’

‘Okay, I just wanted to make sure,’ says Nurse Shelly, and administers the shot.

At that point, the ED team students hear an announcement: ‘Please proceed to your debriefing room to prepare your handoff and complete your team evaluation forms.’ I am invited to join the students and facilitators who are sitting around a conference table in person. Debriefing is designed to deliver formative feedback to both student teams and reflect on the key takeaways from the event. These discussions make visible the markedly different professional visions that students had acquired as a part of their separate specialized educations. Once made visible in the performance of the script, it becomes possible to trace the ways in which their individual funds of knowledge clash with the demands of a real world interprofessional practice. It is in this process that they break away from the scripted versions of their intra-professional training to deal effectively with the controlled chaos of everyday practice.

Jasmine (ED “pharmacist”): ‘Having the med students come in and do the handoff so rapidly…you are not looking at your paper like when you are doing your usual training. But having to listen to everything and you don’t have time to write things down. And then going from okay, do we give this? Did *they* [the clinic team] give this? What do we do next? Because *you have step-by-step* *in your mind*, but then you kind of have to figure out where to start.’ I went straight to my drug tray while I should have gone straight to the patient and started with that, or I should have gotten straight to the huddle and started with that. Because the way that we are taught, at least in pharmacy, first of all—*everybody is taught that they do everything by themselves*. So, immediately, me not talking to the patient and getting the entire history already turned me off, because it put me somewhere else in the line where I’m supposed to be. *And then on top of that you have an algorithm that you study in school, but it did not apply.’*

The fact that the individual professional scripts available in an explicit form (e.g., as a written protocol of administering medication) that students are trained to follow ‘do not fit’ the simulated living practice illustrates distinction that Daston (2004) introduced with the notion of “thingness.” As a physiological object, the student doctors, nurses and pharmacists share a wealth of common textbook knowledge about treating the heart. But seen as part of a culturally organized, scripted yet improvisational orchestration of professional roles, the heart reveals its fundamentally cultural and social nature and allows us to rethink its “thingness.” The simulated, collectively imagined heart is located in the center of the dynamic, collective effort to save the life of a whole human. Once the script (e.g., pharmacist’s medication administration notes) is performed in coordinated action with the professional roles of others, it emerges in situation as a different “thing.” As the students pointed out in the debriefing session, their conflicts—the moments of disruption and contested professional visions—as they worked together resulted in a paradigm shift, what Peckham calls the “psychological insight” of the theater critic (1967:57)—in how they thought about performing teamwork.

Shelly (ED “nurse”): For me it is understanding more the practicality—well—*the roles of each individual provider*, because, I am used to being in the clinic and doing everything on my own. But as Jasmine explained, how *she got the weight in pounds and you have to convert it to kilograms and then dose it out, and that whole thought process*—I would have never—we really don’t know about that, and so understanding that, and then translating that into our actual work experience and kind of, like, of understanding why maybe some things take longer than we expect.

According to Jasmine and Shelly’s reflection on their situational experience, the professional script they are following cannot be reduced to a list of clinical interventions; rather, in order to appropriately coordinate interprofessional work, the script must be interwoven into individual participants’ active abilities to take on the other professions’ perspectives and understand their professional roles. Looking at how an IPE simulation is organized and enacted “as if it was in the theatre,” rather than “as if it was real,” allows seeing how each profession conceives the clinical skills necessary to perform their professional role.

Lian (clinic “physician”): Hearing you guys dealing with the medications and what is going on in your mind helps me understand how I approach you and talk to you about the next step. *Getting that perspective of seeing the same case through someone else’s eyes* is really useful to understand the same situation from a different perspective. So in the future when we work with them, we can think, “that’s why the nurse did that, or that is why the pharmacist did that because they are thinking of this.”

From the perspective of sociocultural approach to learning human development, Eugene Matusov (1996) elaborates a participatory view of intersubjectivity by shifting the focus from individual action to individual contribution to joint activity at hand by making a distinction between “having in common” versus “coordination” (32) of participants’ subjectivities. In his view, “[t]he metaphor of sharing as "having in common" implies intersubjectivity in a sociocultural activity as a process of unifying or standardizing all the participants' contributions” (Matusov, 1996: 27). In contrast, understanding the micro-development of intersubjectivity using the lens of "coordination” allows understanding of interprofessional vision as lodged in the practices of each profession, each with their own optics, treating the heart according to their respective professional scripts and protocols. But these professional roles are not so much reduced representations of clinical skills as they are tools that mediate thinking and experiences in interprofessional activities.

## Conclusion

The medical community recognizes the importance as well as challenges of training interprofessional collaboration for development of shared understanding and clarity regarding professional roles in healthcare (Hopwood et al. 2020). Medical, nursing, and pharmacy schools have addressed this problem by starting to incorporate interprofessional training into pre-licensure curriculum. But healthcare educators grapple with the question of how to create simulation training and assessment tools that are responsive to the complex nature of interprofessional skills and its assessment.

This chapter traced the multiple continuities of professional attention as they occur in performance-based simulation, so as to identify moments of the emergence of qualitatively different ways of knowing and doing that resist assessment by checklists that work to guarantee the gold standard of interprofessional teamwork in healthcare. The reproduction of medical knowledge in simulation requires productivities and interprofessional micro-negotiations that are often sidelined or invisible to the frameworks that dominate medical education. The dramaturgical analysis of social interactivity in clinical skills training I discussed here resists the acquisitive model of knowledge, characterized by measurable outcomes. It explored the social practice of engaging in interprofessional simulation as principally an intersubjective phenomenon.

By making the simulated heart of a healthy human actor the central object of my analysis, I evoked a particular form of knowing, and showed that the heart in the IPE simulation is not a mimetic copy of the physiological human heart. Rather, it is a collective, imaginative orienting that gives rise to a contingent, immersive, and distributed paradigm shift in interprofessional vision. It is the shift in the interstices of professionality that makes itself known in its unfolding against the background of other professional visions. Students learn how to remediate their professional skills, scripts, and roles—the institutionalized behaviors they inhabit when trained separately in their own professional silos—into a qualitatively new orchestration of moves. What the interprofessional training event allows each professional is to view the simulated heart as if through a kaleidoscope of joint activity.

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