Teaching Communication Skills

Using Action Methods to Enhance Role-play in Problem-based Learning

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Summary Statement: Role-play is a method of simulation used commonly to teach communication skills. Role-play methods can be enhanced by techniques that are not widely used in medical teaching, including warm-ups, role-creation, doubling, and role reversal. The purposes of these techniques are to prepare learners to take on the role of others in a role-play; to develop an insight into unspoken attitudes, thoughts, and feelings, which often determine the behavior of others; and to enhance communication skills through the participation of learners in enactments of communication challenges generated by them. In this article, we describe a hypothetical teaching session in which an instructor applies each of these techniques in teaching medical students how to break bad news using a method called SPIKES [Setting, Perception, Invitation, Knowledge, Emotions, Strategy, and Summary]. We illustrate how these techniques track contemporary adult learning theory through a learner-centered, case-based, experiential approach to selecting challenging scenarios in giving bad news, by attending to underlying emotion and by using reflection to anchor new learning.
(*Sim Healthcare* 9:220–227, 2014)

Key Words: Professionalism, Communication, Bad news, Simulation

In medical education, role-play is a learning method designed to build first person experiences in a safe and supportive environment.[1] The emphasis in role-play is generally on the understanding and development of communication and interpersonal skills,[2] such as those associated with interactions with patients, families, and colleagues.[3,4]

These competencies have become increasingly important in medical education.[5] They are essential for teamwork and professionalism, in imparting information clearly, in addressing patient and family concerns and for supporting the patient and family during the crises inherent in serious illness.[6–9] For this reason, they are now a required core competency for medical trainees.[10,11] Moreover, it has been emphasized that these skills need to be learned experientially.[12]

While some role-plays focus on learning very specific skills such as when standardized patients are used to help learners practice medical interviewing, role-plays can also be used to teach the affective or emotional domain of relationships with patients and families.[13] This is important because many medical encounters involve a significant emotional component, both on the part of the patient and the clinician. Examples of this include revealing the diagnosis of serious disease, disclosing medical errors, and discussing end-of-life issues such as "do not resuscitate" or hospice or resolving of conflicts around limiting care.

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The authors declare no conflict of interest.

DOI: 10.1097/SIH.0000000000000019

In teaching this emotional domain, we can identify several unique and desirable goals of role-plays. First, because attitudes and feelings often underlie much of human behavior and communication, role-plays should foster a sensitivity to what is not spoken as much to what is overtly stated.[14] Such insights can improve communication by helping learners address not only what is overt but also what was implied. Second, missed opportunities for empathy are a major problem in clinician-patient communication.[15,16] Role-plays can help learners recognize emotion and learn to respond compassionately. Third, role-plays can enhance professionalism by helping learners enhance their awareness of their own communication.[17] For example, we have used role-plays to raise awareness of how a doctor's own anxiety can lead them to avoid end-of-life discussions with patients and families or to be overly optimistic about available treatments.[18,19] It is illuminating when learners recognize that these latter strategies are unhelpful because they can confuse the patient about the goals of care, thwart patient autonomy in decision making, and even erode trust and confidence in the doctor.

To accomplish such goals, specific role-play techniques called *action methods* were developed by the psychiatrist Jacob Moreno in the 1930s.[20] Today, educational role-plays based on action methods are used in corporate, government, and mental health settings to train professionals in communication skills, teamwork, and interprofessional competencies.[21–25] For example, in Trial Lawyers' College, plaintiff's attorneys are prepared for trial work using a specific action method, role reversal, (Table 1) in which they assume the role of jurors to hear summary arguments from the perspective of those who will render decisions on cases in litigation.[26]

TABLE 1. A Glossary of Action Methods

Warm-up exercises. They are intended to increase the spontaneity of group members and begin to move them from passivity into the action required for the role-play. They also enhance the working relationship among group members through sharing of information. In case-based learning, they are a learner-centered method for selecting cases for the role-play.
Role-creation. The group is led by the facilitator to create characters for the role-play. Participants take on the role of the characters in the scenario.
Doubling. In doubling, participants stand behind a character and speak the thoughts, feelings, and attitude that they imagine the character might be thinking or feeling but not saying based on the communication challenge, which is facing them. Participants can also double themselves as characters. Doubling also enriches the role of characters by including the "inner self" in the role.
Role-reversal. Used to reveal the social dynamics in a difficult conversation. A learner may take on the role of a difficult patient or family member. Role reversal is also used to allow a character to experience, in the role of others, the impact of their own actions and communication. Thus, the learner in the role of a doctor who tells a patient that there is no hope for them would reverse roles with that patient and become that patient to experience what that statement "feels like."
Group-processing. This provides an opportunity for learners to articulate what it was like being in the role of others. It also allows instructors to make *teaching* points or reinforce important observations that emerge from the group.
Role-training. This is a form of role-play where participants practice the skills that can help them in becoming more expert in their professional role.

Action methods are uniquely suited for enhancing role-plays to accomplish the goals stated earlier. However, they are not well known and scarcely used in medical education, leaving a void in the preparation of clinicians in providing patient- and family-centered care. In this article, we illustrate how action methods can greatly enhance role-play when addressing challenging communications in medical education. Specifically, we will describe the following action methods:

- Warm-ups—used to prepare a group for role-plays
- Role-creation—used to create characters and immerse learners in their roles
- Doubling—a method for revealing unspoken thoughts, feelings, and attitudes
- Role-reversal—asking 2 individuals to switch roles so they might experience a situation from another's perspective
- Sharing—an element of debriefing when learners share feelings about what it was like to be in one or more roles.

APPLYING ACTION METHODS IN A HYPOTHETICAL ROLE-PLAY TEACHING LESSON

STAGE 1: PREPARATION

Role-plays can be conceptualized as unfolding over a number of stages (Fig. 1). The first stage is preparation. Let us imagine that a faculty member is meeting with a group of medical students to teach skills in how to give bad news. We will assume that the learners have had experience in helping care for patients with serious disease and have observed attending physicians giving bad news to patients and family members but have little experience in doing it themselves. After our instructor has reflected on the learners' likely skill level in sharing bad news, she formulates goals for the role-play. As a framework for giving bad news, she has selected an article for them to read describing a communication strategy called SPIKES [Setting, Perception, Invitation, Knowledge, Emotions, Strategy, and Summary], a six-step process for disclosing unfavorable medical information.[27] SPIKES is a communication strategy, which represents a consensus of "best practices" in giving bad news found in the literature. The goals of the instructor are to illustrate the skills needed and especially how to deal with some of the possible reactions to giving and receiving the news. How might an instructor think about setting up a simulation of breaking bad news using action techniques?

In our group of students, the instructor might first organize learners in a semicircle, so they can clearly see each other and the role-play enactments. She could then review the article with the learners and invite questions. This provides a clear structure for the role-play. She then explains that she and the group would be taking on the roles of people in an enactment, so the group could see what a possible bad news conversation looks like and try out skills that might help make the encounter successful.

STAGE 2: CREATING SAFETY

Role-play has the advantage of being inexpensive and less complicated to organize compared with using standardized patients. There are data suggesting that it is equally as effective in communication skills training.[28] However, learners have mixed feelings about its use.[29] In the study of Nestel and Tierney on student role-play, the issue of safety (feeling intimidated and embarrassed) was a negative comment not infrequently brought up by learners.[5] Others have also underscored the importance of safety.[30–32] Thus, an important prerequisite to the process of role-play is the establishment of an ethos of confidentiality and responsibility.[5,31,33] Learners must feel that when they participate in enactments, their behavior will not become the topic of gossip, their effort will be appreciated, and they will not be criticized or humiliated. A sense of safety also promotes the critical reflection required for debriefing and for learning new knowledge.[31,34] Thus, our instructor would ask that the group pledge not to use the names of people in the group if discussing the role-plays outside of the group. She would also frame the exercise as not having to be done "right" to begin with and that there would be ample opportunity for trying again and experimenting with variations of approach to explore alternatives.

STAGE 3: PROMOTING SPONTANEITY/GROUP BUILDING

Role-taking, a prerequisite for role-play, is the process of stepping into the shoes of another. In effect, we are asking a person to suspend reality (you are not whom you seem to be) and to be creative and imaginative in assuming the characteristics and behavior of someone whom they are not. This requires spontaneity (the process of not planning an action), which can only emerge when the mind relaxes and comes

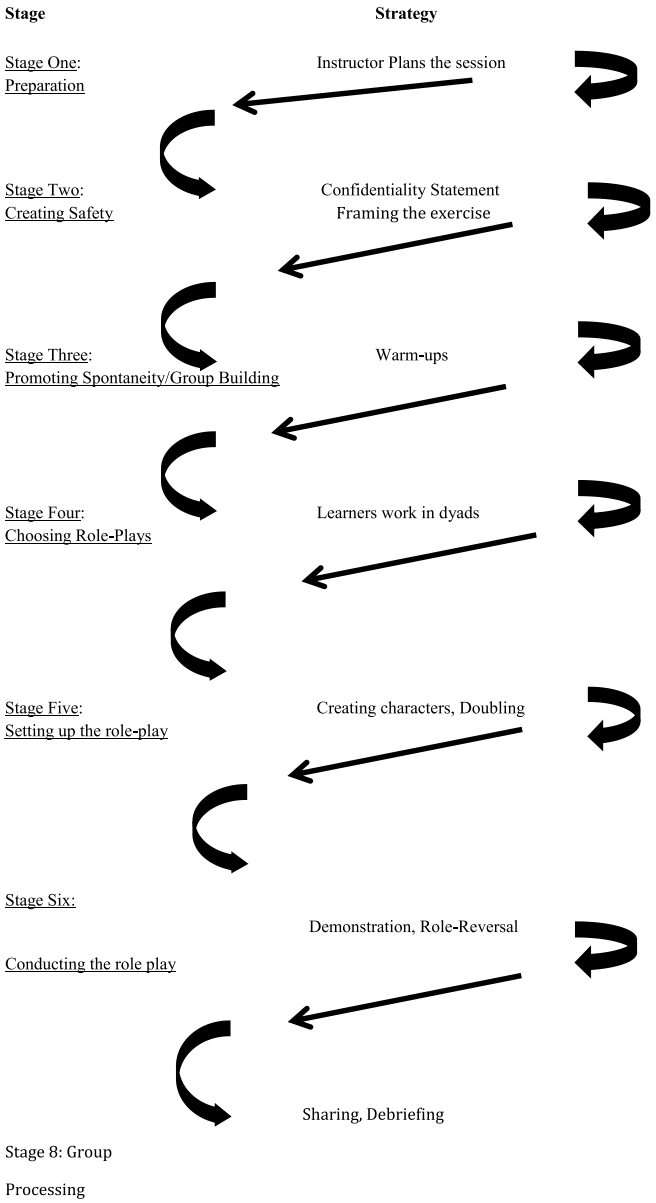

FIGURE 1. Stages of role-play enactment. A role-play may be thought to evolve in stages. Stage 1 is the setting up of the role-play that the facilitator must do. This piece of ''preparation'' involves reflection on the learning task, the characteristic of the learners, and the preparation of the didactic material. It is sometimes called a *facilitator warm-up*. Stages 2 to 5 may be thought of as ''group building'' because they promote group cohesiveness and facilitate cooperation and collaboration of the group. Stage 6 is the actual role-play enactment, which might be simple (2 characters) or complex (many characters taking different roles). Stage 7 is the debriefing and group processing. Some add a stage 8, which would be a practice session, and/or a stage 9 or transfer of learning where learners can take skills to the bedside.

off the defensive, and when the activities seem emotionally safe. Helping learners be spontaneous in the role of another is facilitated by warm-up exercises,[35] which help reduce the considerable anxiety and self-consciousness often associated with "acting."

The goal of the warm-up is also to heighten the group's anticipation and lead the group toward a stronger and more intense involvement in the problem.[36] Thus, warm-up exercises aim to move the group toward a progressively more involved and intense focus on the problem being considered, in this case how to give bad news.

Our instructor might begin with simple, nonthreatening warm-ups[19] such as asking each group member to say something about themselves that others usually would not know. When the learners discover that other group members have an interest in cooking or are mountain climbers or have recently run a marathon, it breaks the ice of seriousness and relaxes the group. Warm-ups should progress from the less serious and even playful to the more revealing[19] and eventually become focused on the task at hand.

Returning to our example, our instructor may progress to a "step in circle" whereby learners are asked to stand up, form a circle, and step in, first in response to informational questions by the instructor such as "step forward if you've seen clinicians give bad news" progressing to more personal questions such as "for me I can imagine that a hard part of

giving bad news would be knowing where to start or what to do when patients (get angry, become silent, become tearful)." This experience of sharing thoughts and feelings in a gradual way allows the task of disclosure to unfold slowly and safely. It also further builds group cohesiveness and prepares members to work collaboratively together, reinforcing one another and bringing the totality of their experiences into play.[31]

STAGE 4: CHOOSING ROLE-PLAYS

Warm-ups can be used not only to promote spontaneity and connections but also to wed the objective of the teaching exercise (learning to give bad news) to the role-play by incorporating the experience of the learners.[37] For example, our instructor divides learners into pairs and asks them to reflect on the SPIKES reading and discuss among themselves any of the skills of SPIKES that they observed during their clinical rotations. This might include behaviors such as making eye contact in establishing rapport or inquiring as to a patient's current knowledge about their medical situation before giving them information.

In a subsequent exercise, she asks learners to reflect on "bad news" conversations that they observed to have been challenging. An example might be the difficulty in responding when the patient or family became tearful or have reacted to the bad news by demanding a second opinion. Each pair would then communicate this to the group. Through dyadic warm-ups, group members share information about one another's experiences around the topic of the exercise and continue to build the involvement of individual members of the group necessary for a successful role-play. Warm-ups also allow the instructor to map to the learners' experiences and to identify communications that challenge these learners and are most salient to them.[37–40]

After the warm-up, the instructor will usually have several cases or situations from which to select a role-play with teaching potential. These might include, for example, "what to do when a patient gets emotional" or "how to begin a bad news discussion." Because it was the group members who identified potential scenarios, they are more likely to feel some ownership of it.

STAGE 5: SETTING UP THE ROLE-PLAY

Selecting Characters

Role-plays are a form of enactment wherein group members take the role of characters in the enactment. Creating roles differs from the approach of creating scripts for learners to adopt. Scripts are widely used in highly structured technical simulations because they can allow instructors to program behaviors in the simulation, which trigger teamwork and other challenges. However, in teaching interpersonal skills, we and others have found that scripts, rather than facilitating the role taking, can inhibit it.[5] Learners given scripts are expected to "drop into roles" automatically. This "role demand" is uncomfortable and often "dreaded" because learners simply do not know what to do or are unable to be spontaneous in the role of another whose character they have assumed. As an alternative to scripting, it is easier for learners who already have some experience in seeing "bad news" conversations, to actively participate in creating characters, once a scenario is selected.[41]

Thus, our instructor places chairs in the center of the group and asks the question "who would likely be participating in this conversation?" Thus, she guides them in the creation of the scenario as they "make up" the characters in the scenario, assigning them characteristics, such as age, sex, relationship to other characters, and so on. The more attributes the group assigns to the characters, the more salient they become. The instructor then asks a group member to each "hold" the place of each participant in the role-play (in this case, we might imagine a patient and their spouse) by coming up and sitting in a chair in the center of the circle. In this way, role creation taps into the creative imagination of the group. It enhances a sense of community in the learners and allows them to take more "ownership" of the cases.

Deepening the Role of Characters Through "Doubling"

Doubling serves to enrich the roles of characters because it addresses that which is felt but often is unspoken. The method is as follows: once a character is created, our instructor addresses the group, "raise your hand if you can imagine what this person might be thinking or feeling." Those that raise their hand are asked to physically come up and stand behind the chair occupied by the learner playing that character and to speak in the first person, stating, as that person, what they can imagine he or she might be feeling or thinking. Doubling thus allows anyone in the group to offer the words that come to them as if they were a voice-over or "alter ego." The point is to bring hidden emotions and unspoken thoughts to the surface because only then can they can be acknowledged and addressed.[33,42] The person doubled can adopt any of the suggestions by a double and incorporate them into his or her role.

In the case of our bad news scenario, most learners can imagine what it is like to give or receive bad news, either from their personal experiences or from having been in clinical situations where they have observed unfavorable medical information being communicated. In teaching learners how to prepare for giving bad news, the instructor might choose initially to double the doctor who is disclosing the negative information. This gives voice to the doctor's unexpressed feelings such as "I wish I did not have to do this" or "I hope they don't cry." This experience can normalize the fact that doctors have feelings also and that recognizing them is part of the preparation for giving bad news.[33,43] The instructor would use doubling at other times during an enactment to probe patient reactions to receiving bad news (see subsequent section) or to explore solutions to difficult questions, for example, when seeking to understand the unexpressed concerns behind the family member's question, "Does this mean he's going to die?" The instructor can also themselves be a double, and this is very useful because they can bring their own considerable experience into it.

Revealing hidden emotions deepens group connections by articulating what many group members might be thinking but not saying. The fact that emotional elements are introduced as part of the challenges of giving bad news serves to enhance the learning experience.[32,42,44,45]

STAGE 6: CONDUCTING THE ROLE-PLAY

Ideally, at least several hours should be allowed for a role-play, although we have done brief didactic role-plays that lasted only an hour. Typically, the role-play sessions we conduct last for 3 hours. This is just long enough for an instructor to set up the role-play, debrief, and leave some time for learners to practice. The simulation environment evolves from the roles developed in the scenarios. The interaction of the roles, both directed by specific tasks (such as breaking bad news) and undertaken by participants on their own, give further life to the environment.

There are a number of variations as to how role-plays might unfold, depending on the goal of the role-play. When dealing with specific skills such as the steps of SPIKES, an instructor might choose to demonstrate an interview, with one of the learners taking the role of the patient and stopping to reflect with the learners on the skill that was demonstrated. He or she can ask group members to double for the doctor in the scene or double for the patient or family members at various times during the enactment. For those who double, it can create an empathic understanding of how the doctor, patient, or family member might feel in such a situation. It also keeps group members engaged, a critical aspect of group teaching.

In another version of role-play, different students might take on the role of the patient. This can help them experience how various expressions feel to them. Students might then assume the doctor's role to try out different techniques. In complex role-plays, several students might take on the roles of family members, social workers, or patient advocates, shifting roles at certain points in the role-play to garner the perspective of a different professional. When learners participate in a role-play, learning itself becomes more salient for them. The instructor can also use the technique of "what-ifs" asking those in roles to be angry or sad or to ask a difficult question such as "Am I going to die?" She would again use doubling to uncover feelings and then brainstorming with the group as how to respond. Examples of how role-plays unfold are described elsewhere.[3,4,46]

USING ROLE-REVERSAL

In Shakespeare's play Julius Caesar, Brutus says "the eye sees not itself but through reflection." Moreno found that one of the most powerful techniques for understanding the perspective of others is role reversal. While the act of doubling is designed to reveal unspoken thoughts and feelings, in role reversal, one character actually exchanges roles with another to explore the impact of a conversation from the position of the other. Thus, in our scenario, a medical student who, in trying to give bad news, gives it very bluntly is reversed into the role of the patient. He can then hear his or her own words reproduced by his colleague who has now reversed into the role of the doctor. Role reversal serves to train empathy as well as to correct and change perspective in a problem situation.[23] When one has been "warmed up" and is able to be spontaneous, both doubling and role reversal can be accomplished.

Role-plays can be especially valuable when learners reverse roles with one of their own "difficult" patients. In our experience, learners are often eager to show the group a challenging patient they have encountered, perhaps as a way of validating their own unpleasant or stressful interaction with that patient. In setting this up, the instructor will guide a learner in actually stepping into the role of their own "difficult" patient by having them tell the group whom they "are" (eg, their illness, demographics).[18,19] The instructor has the learner explain the story of the encounter and asks the learner to "show" the group—by playing the role of the patient—what actually happened in the interview and what made it difficult. The instructor, in facilitating this role shift, may probe underlying feelings by having the learner in the role of their patient double themselves or ask group members to double. She then invites the group to reflect on strategies that might address the dilemma. Students in the group then move into the interview chair where they can try out different strategies. An example of a successful strategy would be acknowledging the frustration of an angry patient whose appointment was unexpectedly cancelled. Other students try to address emotions and/or difficult questions by using different strategies, such as making other empathic responses, or less successful ones, such as providing premature reassurance.[45] The student in the role of the patient can experience what strategies used by their colleagues had "worked for them." The instructor can stop the action and make teaching points from the readings or can have the group suggest different strategies. The student, who was once in the role of a patient, can reverse into the role of interviewer (now having the perspective of the patient) to try out strategies that he experienced as working for him or her in the patient role.

STAGE 7: GROUP PROCESSING

At the end of an enactment, the instructor first "de-roles" role-players simply by asking them to say who they are (their actual name) and who they are not (their characters name). Some facilitators actually ask the person who is playing a role to physically "shake off" the role. To de-role allows learners playing different characters to let go of that role and to segue back in to their more authentic self. The instructor then debriefs by asking group members to share what it was like to be in the various roles that they took[47] or to tell how the role-play enactment affected them.[40] Sharing is different from intellectualization. It is not just talking about concepts but a bit more personal. For example, a student in the role of a nurse may talk about his or her frustration when a patient's concerns were dismissed by a doctor who recommended ineffectively with simple reassurance. A student in the role of the doctor giving bad news may talk about the helplessness that they felt when several family members got emotional. Sharing them reinforces the insights attained by assuming different roles. By empathically connecting with both the patient and the doctor's attitudes and feelings, learners can have transformative experiences where they adopt effective skills in discussing bad news.[3] Finally, a summary of take home points by our instructor further reinforces key learning experiences they might have had and sets the stage for the consolidation of learning as they themselves become bearers of bad news.[46]

SKILLS PRACTICE

Although we have not included it as a specific phase, in many of our workshops, we leave time for learners to practice in small groups of 2s or 3s. In the case of the student example in this article, we might ask one student to make up a role for themselves as a person or family member who has to get bad news, to explain the role to a learner colleague and to have the colleague practice giving bad news using the steps of SPIKES. A third learner can observe and give feedback, and then each learner switches roles to practice.

ROLE-PLAY AND ADULT LEARNING THEORY

Role-plays using action methods are anchored in adult learning theory. Knowles et al[48] contributed important principles that have been widely accepted as a guide to understanding learners' attitudes and motivations. He felt that for learners to learn, there must be an effective learning climate where learners feel safe and comfortable expressing themselves. Knowles et al also emphasized learner involvement in the development of curricular content, making learning challenging, problem centered, and practical. He saw the role of teachers as providing basic knowledge, modeling skills, and promoting guided practice with corrective feedback. He also encouraged structuring the opportunity for learners to reflect on their learning, thus allowing them to acquire confidence in their skills. As Fanning and Gaba[49] have concluded, adults learn best when they are engaged in the process, participate, play a role, and experience not only concrete events in a cognitive fashion but also transactional events in an emotional fashion.

We have applied these learning principles to the role-play methodology discussed in this article. A safe environment is created by establishing confidentiality and gradually warming learners up to the task. Learners are guided to generate the scenarios to be enacted. They thus approximate the clinical tasks that they find most challenging. This motivates them to take ownership of the tasks. Modeling and discussion followed by practice allow learners to "try out" different techniques. Finally, stepping into the role of different characters through doubling and role reversal actively engages learners and allows them to practice empathy.

The action methods described in this article present an opportunity to enhance role-plays through creating spontaneity and empathy in learners. By simulating real-life enactments, they allow the learner to feel immersed in the simulation, suspend belief, and manage the situation as if it were real.[32] They are especially useful for teaching how to recognize, explore, and respond to underlying emotions and attitudes in challenging conversations,[46] a competency that learners struggle with.[50–52] Moreover, it is important for learners to recognize that patient and family emotions are not "baggage" but are the gateway to important issues and concerns and important data in determining behavior.[44] Methods for revealing hidden emotions and attitudes would also seem important given the data that show that empathy diminishes during the course of medical training and that physicians may be overcautious and uncomfortable in exploring patients' psychosocial situations, their feelings, and beliefs.[52] Not only are the methods described useful in helping make communications more authentic and empathic, but also patients deeply appreciate it when doctors or other health care professionals make this effort.[16]

SOME APPLICATIONS OF ROLE-PLAY

When interacting with a nonhuman simulator, students may be warmed up to the task by interacting with the simulator, listening to normal and abnormal heart and lung sounds, palpating the pulses, and locating the medical equipment in the room to be able to manage the patient.[28]

Another way that role-play can be used is for training in teamwork, by helping team members empathize with the role predicament of their fellow team members. Role-playing other team member's roles can create insight into each other's views, challenges, or perceptions. For example, in learning teamwork in the surgical suite, an anesthesiologist taking the role of a surgeon or of a scrub nurse when an adverse event occurs may gain new perspectives on the role of the other.[53] If a problem were noticed in the procedure, would they feel that they could speak up more as a doctor or as a nurse? Does status affect the way that something is heard and accepted or how something is said? What information and support do they need from the others?

Teamwork is also a key strategy in patient care, and partnering with the patient and family is a key element of patient-centered care. Action methods promote understanding of the concerns of the patient and help learners understand the different roles of members of the medical team and try out different communication strategies.

Case-based role-play is being more and more used as a training tool in medical education, and a number of guidelines exist for instructors. However, the role-play enhancements that we describe have not found their way into medicine to a great extent as a way for training medical students, nurses, and other learners to be competent communicators. Some of these techniques, such as doubling and warm-ups, can be adopted easily by teachers.[51] A number of articles[18,19,22–24,54] books,[4,23,35] manuals,[21,46] and video[55] give and show examples.

Hands-on training in these methods is held at the annual meeting of the American Association of Group Psychotherapy and Psychodrama and by such groups as the Hudson Valley Psychodrama Institute.

In conclusion, we feel that action methods described earlier can be a powerful addition to simulations especially in teaching communication skills and conflict resolution. Their use in technical simulations and teamwork training however are areas that offer promise but have yet to be explored. We hope that this article stimulates interest in their further application.

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