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Teaching Communication Skills Using Role-Play: An Experience-Based Guide for Educators

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Abstract

Teaching advanced communication skills requires educators who are not only excellent communicators themselves but have the ability to deconstruct the components of the interaction and develop a cognitive approach that can be used across a variety of learners, diverse content, and under different time constraints while helping the learner develop the skill of self-reflection in a 'safe' and effective learning environment. The use of role-play in small groups is an important method to help learners cultivate the skills required to engage in nuanced, often difficult conversations with seriously ill patients. To be effective, educators utilizing role-play must help learners set realistic goals and know when and how to provide feedback to the learners in a way that allows a deepening of skills and a promotion of self-awareness. The challenge is to do this in a manner that does not cause too much anxiety for the learner. In this article we outline an approach to teaching communication skills to advanced learners through the use of different types of role-play, feedback, and debriefing.

Introduction

Developing excellent communication skills is uniquely important for clinicians specializing in palliative care because many of the benefits of palliative care are only realized when clinicians can create discussions that are patient-centered, medically realistic, and therapeutic.[1] These advances will only be sustained if educators can develop methods for teaching communication that are more effective and far-reaching than what has typically occurred in graduate medical education. While there is certainly a need for communication skills at the medical student level, there is an urgent need for palliative care to develop faculty who can teach communication skills at a sophisticated level, for palliative medicine fellows and other palliative care clinicians.

A challenge in teaching communication skills at a sophisticated level is that being a master communicator oneself does not translate into the ability to teach advanced communication skills to trainees. Clinicians with expert communication skills are often revered for the "magic" that they are able to create in nuanced interactions with patients and families. Expertise of this kind develops with years of deliberate practice that includes self-reflection and openness to real, sometimes difficult, feedback. Fortunately, we know that experts are made and not born[2] and that numerous studies have shown that communication skills can be taught and that this type of teaching results in behavior change that persists over time. This magic is, in fact, a set of well-honed skills that involves listening actively, identifying and responding to affect, and the ability to manage one's own affect while discussing difficult topics.[3–14] To assist trainees in the cultivation of this kind of expertise educators must to possess a set of skills beyond their own personal ability to communicate and, even beyond the skills typically required to teach biomedical content. Teaching communication skills requires the educator to deconstruct the components of the interaction and develop a cognitive approach that can be used across a variety of learners, diverse content, and under different time constraints while helping the learner develop the skill of self-reflection in a "safe" and effective learning environment.

Thus, in this article we focus on the process of teaching communication skills in small groups through the use of role-play. The rationale for focusing on role-play is that the most rigorously conducted studies of communication skills that demonstrate behavior change used this method.[3–14]

Designing a Small Group Communication Skills Learning Session

Designing an effective communication skills learning experience requires attention to several things prior to the session. These include a preliminary needs assessment of the individuals in the group, the choice of communication

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content, and the creation of an effective, 'safe' learning environment. Table 1 presents an example of this approach with a group of palliative care fellows.

The educator's knowledge of the group: An informal, targeted needs assessment

Several characteristics of the group and the individual learners are likely to influence the learning environment and the challenges the educator may face in teaching the group. An informal, targeted needs assessment done prior to the session can be very helpful in the design. Several simple questions can be posed to the person with the most knowledge of the group of learners and/or to the learners themselves, e.g., What are the topics already covered in this curriculum? What are the learners struggling with currently?

Choose communication content that learners recognize and find compelling

By communication content, we mean the topic focus for the session and the discrete skills that will be practiced. For example, a session might be designed to focus on a communication approach such as Ask-Tell-Ask[15] when discussing prognosis, with a subfocus on specific skills such as: assessing patient perception of illness, or recognizing and responding to patients' emotional cues.

In general, we find that it is important to design sessions addressing the issues the learners are currently grappling with in order to build on their sense of urgency to master the task. It is also important to give them a set of guiding principles or a cognitive approach that they can replicate e.g. Ask-Tell-Ask. Learners can also benefit from short reading assignments before the session to develop a beginning understanding of the cognitive approach that will be presented at the session and the skills that will practiced.

Planning for a small group learning environment that is "safe" and effective

Because communication skill building requires risk taking on the part of the learner (e.g., trying out new behaviors in front of a group) the development of a safe learning environment by the educator is critically important.[16,17] For an educator facilitating a group of early learners, episodic groups, or groups with little knowledge of one another, the most important aim for the educator is to establish and maintain a learning environment in which participation is valued, feedback is justified and constructive, the awkwardness of learning process is normalized, and does not highlight deficiencies or embarrass learners publicly. These aspects of a constructive learning environment are often summarized as "safety."

Table 1. Designing a Session for Palliative Care Fellows: The Pre-Work

Brief needs assessment

Who are the learners in the group and how well do they know one another?

Five learners who have just started fellowship 2 months earlier. Three came directly from internal medicine residency, one from 10 years of oncology practice, and one from an anesthesia residency and interventional pain fellowship. The group is just getting to know one another.

What experience do they have with communication sessions?

This is the third communication teaching session in a series of 10 for this group. They have already had sessions on breaking bad news and family meetings.

What experience do they have with role-play?

All have role-played before. Several very much dislike this teaching approach and found it difficult to be engaged in a recent communication session.

What communication issues are they struggling with currently?

One states she was recently fired by a patient when responding to questions of prognosis. Two other members of the group state they are also struggling with discussions of prognosis and worry they too will be fired by a patient. The remainder of the group is having difficulty managing patient emotions such as sadness and anger.

Choosing the content

Because the needs assessment revealed learners struggling with discussion of prognosis and attending to intense affect, discussing prognosis was chosen. The goals for session included teaching the cognitive approach of Ask-Tell-Ask and helping fellows identify and respond to affect.

Planning for an effective and "safe" learning environment

Because it is a group of early learners with a fair amount of resistance to role-play, we chose a demonstration role-play to start the session with a faculty playing the role of "patient" to portray intense patient affect. The educator's goal was to allow the fellows to see faculty modeling the Ask-Tell-Ask approach, risk-taking, self-reflection, and techniques to respond to patient affect.

Design of session and role-play to address educational goals

In order help learners develop some comfort with the material prior to session, articles were provided to be read in advance describing the Ask-Tell-Ask cognitive approach. A demonstration role-play with another faculty member was chosen to start the session. This would be followed by a "hot seat" role-play in which the faculty would portray a 50-year-old patient with pancreatic cancer who asked his palliative care fellow "Doc, how much time do I have?" who was known to be emotional in the setting of discussions of prognosis and the other was the role of clinician who modeled the Ask-Tell-Ask cognitive approach and attended to the patient affect.

In the "hot-seat" role play, the fellow was instructed to portray the clinician. Prior to the session, the faculty practiced options for responding to learners' reticence to role-play and how to ensure small successes for the fellow.

Role-plays can be constructed in several ways, all of which have different strengths that can influence the safety and efficacy of the group. Group size is a practical consideration. For a group of 4–8 learners, using a single role-play with a faculty facilitator who solicits feedback and input from the group can be very successful because most or all of the learners can take an active role at some point, while not feeling pressured to speak when they have little to say. The simplest version of this is the demonstration role-play, which is an observed role-play in which an educator and a "patient" engage in a communication encounter that can then be deconstructed with the small group. Learners can be assigned specific roles for observation, e.g., attending to nonverbal cues, patient emotions. This tact can allow for discussion of the cognitive approach and identification of affect. It engenders the least amount of anxiety for the learners but can still be engaging and interactive for the group. It is a good choice for early learners, a group that has not worked together before, or a group known to be resistant to role-play.

A version of intermediate complexity is the dyad or triad role-play, in which learners pair up and practice simultaneously, with the facilitator giving instructions and keeping time. The third person in the triad can give feedback to the clinician, which involves the learners, but often results in feedback that is less specific and less effective than what the educator would give. This approach is favored when the communication skill is not too challenging and the educator would like all members to have the opportunity to practice discrete skills.

A more complex version is the "hot seat" role-play using the entire group, in which one learner talks to the "patient" in front of the small group, facilitated by the educator. This approach is the most anxiety provoking for learners, but if done skillfully can result in vivid learning. It allows deep skill building for one or two learners and promotes observational skills in the rest of the group. This approach requires the educator to have sophisticated skills in managing the learner and the role-play. Done poorly, this approach can result in a muddled experience with unclear learning points or, at its worst, become demoralizing for the learner.

Designing the role-play to highlight the chosen communication approach

Inventing a role-play on the spot is something that works only for highly experienced educators. In the 4–8 person group mentioned earlier, our first choice for playing a patient would be another faculty member, clinician, or trained simulated patient, because we often find that inexperienced learners cannot recreate a patient's perspective well enough to react spontaneously to the clinician talking to them, that is, they do not have acting skills. Even for another faculty member, clinician, or simulated patient, the educator should be prepared to create a character sketch that includes a name, some personal history, a disease history, and the clinical details of the visit. Ideally, the educator would also rehearse the "patient" in order to make clear how the patient should respond when the targeted communication skills are performed well, and how to respond when the communication skills are not performed or performed poorly.

Our second choice would be to have learners play patients. In this case we think a one-page handout giving information about the patient and clinical situation, and how the patient will respond to good or poor skills is extremely helpful. It is useful to caution "patients," whether they are other faculty, actors, or learners, that they should not play an "impossible" patient—having a learner try new skills and find the patient completely unresponsive gives the unintended lesson that communication skills are not worth learning.

Running a Communication Session

Effective facilitation of small group communication teaching requires attention to several issues during the session. These include engaging the group, a brief overview of cognitive approach, allowing discussion of discomfort with role-play, and assisting the individual learner in personal goal setting for the role-play. The most challenging role for the educator during the session is to monitor the role-play, deciding when to intervene, and concluding with feedback and debriefing. Table 2 presents this approach with a group of palliative care fellows.

Do a warm-up to get the group engaged

Choose a question that every learner can answer, to orient them to the content, and perhaps even give you insight into their own skill level. For example, "What happened the last time you had to discuss prognosis?" gives the educator a sense of the learner's observational skills, their self-assessment, and their sense of what seems challenging.

Brief didactic

A very brief overview of the cognitive approach to a communication challenge helps ensure everyone has a similar understanding of the content. If the group has been asked to read about the approach prior to the session, the facilitator can ask the group to generate the steps in the approach and fill in any pieces the group may have missed.

Setting up the role-play

Despite the value of using role-play in communication skills training, its use can be an unwelcome part of a session for many learners—often because they have experienced poorly facilitated role-play in the past. Well-facilitated role-plays begin with a clear discussion of the ground rules. These include confidentiality in the group, that time-outs will be used to highlight points for discussion, and that the learner can call a time-out at anytime to ask the group or facilitator for guidance. We have learned from our colleague Bob Arnold that it is important to open with a discussion of how role-play can be a useful teaching tool and, yet, is often challenging for learners. Asking "What do you hate about role-play?" and acknowledging that role-play can feel contrived and anxiety provoking at times can help learners more readily engage.

Engage the learner in setting a goal for her own learning

Adult learning theory suggests, that learners have a background experience and self-knowledge that they bring to the encounter and that the role of the educator is to act as a guide to the learners to deepen and develop connections with the skills and content.[16–18]

Table 2. Running a Communication Session: Facilitation in the Moment

The warm-up: "What experiences have you had discussing prognosis with patients?"

In response to the educator's question, most fellows readily answered that they often feel uncomfortable that they will take away the patient's hope when they provide prognostic data. They also stated that they have tried the Ask-Tell-Ask approach but some think they did it incorrectly because patient was still so upset.

After the warm-up, the group appeared engaged and to have some understanding of the approach but with also a great deal of concern about dealing with patient affect and balancing hope with the medical realities.

Brief didactic

The facilitator asked the group to describe what they knew about the Ask-Tell-Ask technique. In response, one learner was able to generate several aspects of the approach. The facilitator reviewed the Ask-Tell-Ask approach and provided a demonstration role-play with another faculty member.

Setting up the role-play

The facilitator started by asking, "What do you hate about role-play?" All but a few members of the group engaged in this discussion without prompting. When called on, the quiet members of the group stated that they were very worried about doing role-play and didn't feel ready to perform a role-play in front of the group. The one learner from an anesthesia residency stated that she has had very little experience with communication teaching.

Next the educators described the structure and ground rules for the "hot seat" role-play and asked for volunteers.

Engage the learner in setting a goal

One of the learners with the most experience with communication training came forward. When asked "What do you want to work on?" he replied "I want to get more comfortable giving information about prognosis and not to take away hope, or make a patient cry." The educator explored the learner's expectations and opened it up to the group. When the group was asked about those goals, one said "Can you do that? I mean can you tell anyone they will die and expect they won't be sad?" After about a 5-minute discussion facilitated by the educators about these goals, the learner had the insight that emotion often accompanies prognostic disclosure and that a more helpful goal could be to practice tolerating the patient's sadness.

Monitor the role-play as it unfolds

The fellow used the Ask-Tell-Ask approach to get a sense of the patient's understanding of their illness and prognosis. The patient quickly became sad and the fellow started to become restless and appeared anxious. The educator used a time-out and asked the learner. "How is it going?" to which the learner replied, "I haven't even given any prognostic information and the patient is already sad. How can I give them any news?" The educator opened the discussion up to the "patient" who stated that the reason she felt comfortable being sad was because the fellow had done a nice job of being empathic and attentively listening.

The educator asked the learner to try one technique to tolerate the patient's sadness. The learner had a difficult time generating an idea. The educator asked permission to open the discussion up to the group. One learner stated, "I try to remain silent but it is really hard so I have learned I have to consciously try by counting to ten before I think about responding." The learner in the "hot-seat" chose to use silence and to manage his own discomfort as the goal of the encounter. The educator reinforced this goal as an essential one for skilled communicators to learn and normalized the learner's difficulty with the use of silence and tolerance of affect as a developmental milestone for those learning advanced communication skills.

The role-play resumed and the learner used empathic statements and silence effectively and began providing small amounts of prognostic information to the patient.

Conclude with feedback and debriefing

The educator asked the fellow "What was that like for you?," to which the fellow replied, "It so hard to just sit there when the person is sad. I did it though. He then asked the "patient" how his approach felt. The patient was able to provide feedback about which specific statements were helpful. The educator asked the fellow, "What emotion were you aware were coming up in you during this encounter?" The fellow stated "I don't really know. I just feel badly." The educator asked permission from the learner in the hot-seat to engage the group in the discussion. One of the group members stated she felt anxious and helpless when the patient was upset. The educator asked the learner in the hot seat if that seemed to ring true for him as well, to which he stated "Are you saying that it is normal that patients feel this way and it my job to figure out how to deal with my emotions?" This allowed the educator to agree and engage the group in further discussion about managing our own emotions. The educator praised the fellow's willingness to take a risk and struggle in front of the group.

In a demonstration role-play, the learners can identify areas in which they would like to strengthen their observation skills, e.g., nonverbal communication, In dyad role-plays and in a hot-seat role-play, asking the learner to choose just one thing to work on today is a way to focus learner commitment.[13] The learner can then focus on this one aspect of communication skills that allows for deeper learning. It also provides a frame for the group's discussion of the encounter and for feedback from the facilitator. Several questions can help the learner with this goal setting: "Where do you get stuck? What do you want to work on today? What will success look like for you today?"

Monitor the role-play as it unfolds

For a demonstration role-play, the educator needs to stop the role-play with enough time for a debriefing to occur, and must remember that the learning occurs as much in the debriefing as in the observation. For dyad or triad role plays, the educator needs to remain available to make sure the dyads and triads are

actually proceeding by answering questions that inevitably arise about the case. For the hot-seat role-play, the educator's role is more complex and requires balancing attention between the learner in the hot seat and the observing group. The facilitator must watch the learner in the hot seat to track the conversation and may need to assist the learner in calling time-out. Sometimes learners, especially early ones or those with little experience with role-play, may not time-out. In this case, it is important for the facilitator to step in to time-out the encounter.

As educators we watch the learner in the hot seat for signs they are cognitively stuck or emotionally uncomfortable. We would decide to call time-out after letting the learner attempt an approach and struggle for a short period of time. Some time-outs are informed by the learner's self-identified goals. If, for example, the learner has chosen to practice tolerating affect and trying not to "fix" the problem, then a good place to time-out might be a time when the learner exhibits either the skill of tolerating intense affect or, conversely, a time when the learner offered up solutions rather than sitting with the patient's affect. Both provide opportunities for reflection. At this point the educator has the option to continue the current approach if things are going well or to encourage the learner to try another approach. This approach is often referred to as the "rewind," in which the learner and the patient are instructed to rewind to the point in the role-play where the learner would like to try a different approach. The learner may have their own ideas about another approach or the educator can ask the group for suggestions if the learner is not sure. These moments of pause in the encounter provide an opportunity for the learner to reflect and promote self-awareness. They also allow for a "mid-course" correction and the opportunity for the learner to try a different tact, with possibly better results. It is the facilitator's job to ensure some small successes for the learner.

Conclude the encounter with feedback and debriefing

Trainees crave genuine feedback based on direct observation.[20] Facilitators have the opportunity to provide this during and at the close of a teaching encounter in front of the group and, if necessary, privately at a later time.

Because learners often present multiple opportunities that an educator could use as a teaching point, educators frequently find themselves needing to decide on which observed behavior to provide feedback. A general approach is first to ask the learner what they would like feedback on and then to ask for a self-assessment. The second step is to provide feedback on the learning goal that was negotiated at the beginning of the encounter. This will increase the likelihood that the learner will be able to hear and integrate the feedback. After all, they are getting feedback on the actual skill they wanted to work on. The final step is to engage the learner in a discussion about what one or two things went particularly well and in what areas they might consider trying a different approach next time. This kind of real-time goal-directed feedback can be very powerful as it summarizes and consolidates the learning from the session.

An area deserving special emphasis in debriefing is learner self-reflection and self-awareness

A facilitator can use pauses in the role-play as opportunities to promote self-reflection of the experience.[14–17] It is customary to turn first to the learner in the "hot seat" to allow him or her to provide a self-assessment. A variety of questions can be posed to the learner at this point that can help get a better sense of the learner's understanding of the dynamics in the role-play. "What were you thinking here?" or "Where you hoping to go with this?" can be helpful in understanding the learner's developmental stage. Questions can also be posed to the group: "What did you notice about the patient's response in the encounter so far?" or "What did you like about the approach?" or "Were there any things that you were wondering about in the approach?" and "Can you give some suggestions for next steps?" This is also an opportunity for the facilitator to get a better sense of a learner's opportunities for growth and to praise the learner's willingness to take risks in their learning. Many early learners have not developed the skills to recognize their own affect. We find that asking "What emotions of your own are you aware of right now?" can be helpful to orient the learner to his or her own feelings. The anxiety about not achieving a change in goals of care with a patient can color the communication with the patient and damage rapport. Identification of these feelings is an important first step in managing these complexities in communication with patients with life-threatening illness.[21,22]

A second area deserving special attention in debriefing is in learning to observe and respond to patient emotions

Learners who trained in fields other than psychiatry typically receive little teaching regarding identification and response to patient affect. Educators can promote a deeper awareness of affect by pausing during the role-play and inquiring to the learner: "What affect do you recognize in the patient right now?" and "What are the options for responding to it?" This can be an opportunity for the facilitator to express his or her own assessment of the affect and empathize with the learner about the challenges of sitting with intense affect.

One common misconception held by early learners is that patient emotion is an indicator of a job poorly done. We have witnessed learners set the following goal; "I want to be skilled enough to talk about prognosis without making the person sad." Early learners will often believe that they have "made a patient cry" because if they were more skilled they would be able to inform a patient of a poor prognosis without "causing" emotional pain. Learners must understand that patient emotion needs to be uncoupled from their own self-evaluation. Emotion is a normal part of patient coping and this type of general concept can be reenforced during the debriefing.

Finally, remind learners about what you observed that "worked" in the role play—when were moments that you thought represented good, or even great, communication? Learners often experiment with different approaches in communication teaching sessions yet fail to see how a new approach promoted a deeper, skilled encounter with the patient. Explicit deconstruction of the approach both by the facilitator and by the group can provide important learning for the person in the "hot seat" so those approaches can be replicated or modified.

Reflect On Your Teaching Successes (and Failures)

Just like our learners striving to become better communicators we, as educators, will find some of our approaches to be

more effective than others. Becoming a skilled educator of advanced communication skills requires hours of practice and willingness to try new approaches. Educators benefit from their own practice of self-reflection and solicitation of observation and feedback from colleagues and trainees because it engages us more deeply in our own teaching and learning.

Conclusion

A core skill in palliative medicine is the ability to interact with patients in nuanced, difficult conversation using a language that is genuine and individualized to the clinician. As educators, we have the task of helping the learners develop this language in an effective learning environment. The keys to successful teaching of this type include: assessment of the learner: assessment of the group; the educator's ability to create a safe learning environment; the educator's ability to provide constructive, goal-directed feedback; and cultivating the ability of the learners to reflect on the processes of communication. If, as educators, we invite trainees to take a risk in their communication and repay them with deep learning, we have succeeded.

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