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The Act of Dialogue: exploring the dialogue of role play simulations as a vehicle for learning clinical communication skills.

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Abstract

Clinical simulations in a skills laboratory setting are used to explore role-play as a context for experiential and reflective learning. The impact on the quality of learning by using simulated patients who are skilled in both acting and facilitating is explored. A sample of dialogue provides rich data for analysing this environment as a context for situated learning. Furthermore, we use reflective dialogue between tutor and simulated patient to debate evidence of scaffolding the integration of new knowledge and skills for effective practice. Although clinical communication skills are the focus of learning in this example, the benefits may be generalised to a range of contexts where the learning outcomes include the development of more effective behaviours.

Key words: actor, clinical simulations, communication skills, dialogue, experiential learning, facilitation, feedback, health professions, reflective practitioner, role-play, simulated patients, situated learning

What we have to learn to do, we learn by doing

Aristotle (384-322 B.C.)

As professionals involved in the teaching and learning of communication skills we became interested in the transfer of learning from the Higher Education setting into work-based placements. Through our continuing dialogue, informed by the perspectives of both actor and tutor, we began to interrogate the vehicle of role play as a teaching and learning tool. Role-play including the use of simulated patients is often used as a methodology in health education to practise clinical communication skills, providing a bridge between theory and practice. "Simulated patients have been used successfully in communication teaching, evaluation and research since their first introduction in the 1960s" (Kurtz et al. 2005: 88). Barrows (1987) identifies that the role of the patient is taken by either a professional or amateur actor or a trained member of the community without formal acting training. Useful learning outcomes can also be achieved through students taking turns to play clients, however the effectiveness is often compromised for a number of possible reasons. Students may find it difficult, for example, to maintain a credible role, either through getting embarrassed at having to 'perform' or being sidetracked into the safer space of theoretical discourse. For those students who do maintain their role, they may misjudge the level of challenge that will facilitate learning, and are typically too helpful, reducing the need for the learner to practise new, more effective behaviours. The value of simulated patients is supported by Kurtz et al. who cite evidence that:

Simulated patients are realistic patient substitutes – research demonstrates that students, residents and practising physicians cannot distinguish between real and well trained simulated patients (2005: 89).

To date there is little research into using simulations in the training of speech and language therapists, although Syder's study using actors with students reported its benefit to supplement learning in NHS placements (Syder, 1996). Simulations are also considered as a valuable tool for reflective learning in the training of speech and language therapy clinical educators (Stoneham, 2000). Clinical educators view filmed student-client simulations, and then participate in reflective discourse with the actor playing the role of student. Our aim here is to explore strategies to maximise the potential learning, to provide a high challenge-low risk environment in which the students are safe to experiment with strategies and behaviours. We also explore the interdisciplinary dialogue between the tutor and simulated patient and the value this adds to student learning.

This paper explores the theory and practice that informs the dialogue occurring within a clinical simulation. The structure of this paper first records the hybrid and interdisciplinary theories that inform this work. Whilst role-play and the use of simulated patients is extensively researched in clinical education settings, our paper draws on the role-play and simulation that is used in other contexts, and incorporates perspectives from the field of Applied Drama. Our aim here is to present a truly interdisciplinary account of this work. This review is followed by a case study drawn from our recent practice. Extracts from a transcript of a case study are used to illustrate our dialogue. Through this process we explore the potential for role-play simulations as a rich space for heuristic learning, where the learning is scaffolded through dialogue and skills practice.

What is role-play?

Role-play provides specific benefits as a learning tool. Johnson & Johnson state that "role-playing is a vital

training tool for mastering new skills" (2000: 60). In this learning context, they identify the four qualities of role plays as:

1. Experience the situation concretely.
2. Identify effective and ineffective behaviour.
3. Gain insight into this behaviour.
4. Practice the skills required to manage the situation constructively.

Johnson and Johnson's model mirrors generic experiential learning models, such as Kolb (Smith, 2001: 2). Within role-play, *concrete experience* provides evidence on which to *reflect*. From this analysis *general principles* can be formed which aim to predict how the learning can be transferred to other contexts, or taken back into the practice setting.

The use of skilled actors can enhance the quality of learning by providing consistent, credible performances and a commitment to the reality of the role play. The actor training methods which can be used to achieve this credibility can be traced back to the rise of naturalism which arose as a reaction against the declamatory style of theatrical performance dominant in the late 19th Century. Playwrights produced work striving for an illusion of realism, notably Ibsen, Chekhov and Strindberg (Styan 2006). Whilst a realistic style of acting is the prevailing style of performance in the west today, it would have seemed surprising and innovative to audiences at the turn of the 20th Century. It was these developments which led actor and director Konstantin Stanislavsky to develop the first systematic actor training system (Benedetti 2004). His techniques explore the interrelationship between the actor's body, imagination and emotions as key to the creation of 'realistic' acting, and his work has been a foundation

stone of many actor training systems since (Merlin 2001).

In a role-play context, the illusion of realism can help the learner to reflect on the links between the strategies they explored in the simulation with those that will be effective in a real clinical setting. It is then only a further step to imagine that skills successfully rehearsed in the 'as if' world of the role play could be replicated in the real world.

Role-play as experiential education

Acting in this context has its own particular meaning, as learning outcomes have primacy over the actor's performance. Whilst conventional acting techniques are used, such as creating the illusion of emotion and the portrayal of character traits, the actor has a dual role of both maintaining the credibility of the role and contributing to an effective learning encounter. The actor is working to balance a truthful performance that also serves the pedagogical aims. The work therefore shares common ground with the technique of teacher in role (Ackroyd 2001). In practice the actor may accentuate certain behaviours to highlight their impact. Using Johnson & Johnson's model of role-play, we can describe an example:

1. Concrete experience: In a role-play where the learner is developing their use of open questions, the actor may respond to closed questions by answering only 'yes' or 'no'.
2. The learner can reflect on the experience to identify effective and ineffective behaviour.
3. Through dialogue, the learner gains insight into the impact of using open questions to encourage their client to tell more of their story.
4. Through this experience the learner is able to take their new learning back into the

practice situation to experiment with more effective behaviours.

Actors who are also skilled in giving educational feedback are an integral part of this learning process. This form of experiential learning thus involves a:

direct encounter with the phenomena being studied rather than merely thinking about the encounter, or only considering the possibility of doing something about it. (Borzak 1981: 9)

The model is still, perhaps, unsatisfactory: skills development and behavioural change are complex processes, and therefore it is likely that other elements will affect the learning process. Albert Bandura's work on Social Cognitive Theory and Self Efficacy (1986) may help to explain an individual's ability to learn new behaviours. Simulation and drama mirror the learning process identified by Bandura. His Social Cognitive Theory defines a series of interactive steps through which new behaviours can be acquired through exploration and testing. Correctly facilitated rehearsal of behaviours in a group setting can build self efficacy and also support vicarious learning through peer observation. Baim, Brookes and Mountford, of Geese Theatre, identify Bandura's work as an "important conceptual framework for helping participants to develop new skills in a conscious and structured way" (2002: 19). Bandura identified the interrelationship between environmental, behavioural and personal factors. He named this interrelationship a *triadic reciprocity*. These factors together influence self efficacy beliefs, which can be defined as:

people's judgements of their capabilities to execute and organise courses of action required to attain designated types of performances. It is not concerned with the skills one has but with the judgements of what one can do with whatever skills one possesses. (Bandura, 1986, p94).

Central steps in Bandura's model for building self efficacy are *rehearsal*, *incremental challenge*, *reflection* and *vicarious learning*. These stages and attributes to build self-efficacy can be present during a well-designed role-play exercise, and are explored below.

The link between *rehearsal* and the continued replication of behaviours in real encounters is not straightforward. Role-play provides a space to learn new skills. For these skills to continue to grow outside the training room requires the learner to be sufficiently motivated to continue to develop their use. It may be that the learner requires more support and is not yet ready to have such a potentially difficult conversation in the real world. This is not to suggest that the role play has not been worthwhile as new insights may have been gained through the experience.

Whilst the performance of rehearsed skills in the real world may be problematic, there is evidence which demonstrates that experiential learning is more memorable than other learning methods. Edgar Dale's research (2001: 108) finds that active, experiential methods lead to greater recall of what was learnt, with the simulation of real events being rated as almost as effective a method of learning as actual experience. Role-play can provide learners with *incremental challenge* so that they are not overwhelmed, but instead steadily build confidence in using new skills. In practice this may mean that the role-play actor will dynamically adjust the level of challenge to find a characterisation that provides an acceptable level of difficulty.

Self reflection enables individuals to explore their own thinking and to potentially alter their behaviour. Role-play can provide an individual with new perspectives

on which to reflect, which may in turn lead to action. In a group role-play activity, the tutor's and actor's feedback is supplemented by the peer observers' perspectives. In addition, peer observers' own practice is developed through *Vicarious Learning*. Witnessing their peer's performance provides evidence for their own reflection.

Despite the frequent citation of Bandura's theories by applied dramatists (Baim, Brookes & Mountford 2002) and although there is widespread evidence in support of his work, it is not without its critics. Thompson questions "the deferred promise of rehearsal" (2006: 47), arguing that "we do not simplistically store total interactions for later display" (2006: 47). Perhaps it is simply not credible that a lifetime of behaviours can be altered through a few workshops. Whilst the evidence for Bandura's principles as a model of social development may be sound, it is questionable that an intervention can generate lasting change when it has limited time in which to achieve its results. We don't expect an actor to perform a role on stage without adequate rehearsal, but do we really imagine people can learn to perform a new behaviour with just a few hours practice? For these reasons it therefore seems likely that in the case of role-play the tool does not, on its own, achieve behaviour change, and it may be helpful to look to other social and cultural learning paradigms.

Quay (2003) explores the limitations of a social constructionism paradigm in taking account of learning in experiential education. He highlights the need to analyse the learning within the existing social context, beyond that occurring within the individual alone. Although reflection-on-action strategies such as group debriefs are rooted in social constructionism, situated learning theory may be more helpful in explaining the learning occurring through active adaptation in the

existing social and cultural context. The learner is connected with the world created through their participation. This challenges the need to step in and step out of experience in order to reflect on it, assumed in reflective models such as that of Kolb described above (in Smith, 2001). Instead, a more holistic learning theory offers a perspective in which the transfer of knowledge is not simply transported in the mind of the individual. As an embedded part of the whole context, transfer of learning becomes more intuitive as the learner moves from more peripheral to fully developed participation. Bradley & Postlethwaite (2000) identify the importance of this situated learning paradigm in clinical skills laboratories. Role-play simulations are designed to help medical students construct new understanding of their interactions with patients. The role-play is not presented as a facsimile of the real context, instead providing its own reality in which the student is invited to construct their own interpretation. When in the real clinical context, the student is then able to further reflect and compare their own experiences and behaviours, constructing a new understanding of clinical skills. Key to situational learning is the role of tutors in scaffolding behaviours for effective participation, discussed in more depth below.

Experiential and Reflective Learning in Professional Practice

Kember et al. (2001) point out that professional practice is often 'messy' and too complex to apply simply defined technical skills. The Health Professions Council (HPC) have attempted to account for this complexity in training programmes, stating that integration of theory and practice must be central to the curriculum to enable safe and effective practice, and that "delivery of the programme must assist autonomous and reflective thinking" (HPC Standards of Education and Training, 2004: 5). Through exploring

these complexities within a simulated situation, students are enabled to learn that there is no one right way to act. Through feedback from the client, the student can develop self-confidence that personal qualities and attributes such as honesty, genuineness, presence and empathy are perceived as competent, rather than their application of technical skills alone. These interpersonal skills are recognised standards of proficiency for engaging service users in working collaboratively to meet their needs (HPC Standards of Proficiency 2007). Viewed within Schön's model of professional practice, this competent ability to act draws not only on intuitive knowledge, but also on the ability to both "reflect –in-action" and "reflect-on-action" (Schön 1993). Within the simulated activity, learning to reflect-in-action enables the student to develop their "online" decision-making using immediate information. The students learn to be mindful of more unconscious aspects of behaviour and to become more aware of deeper levels of professional competence, identified by Williamson as self-knowledge, interpersonal skills, values and beliefs (Williamson 2001).

For this reflexive activity role-play is well suited due to its flexibility and responsiveness. Within clinical simulations, the use of a "stop-start-rewind" format, where the role play can be stopped and started at any point as required, provides space for learners to explore their ability to both reflect-in-action and reflect-on-action. Within a "gap" that is created between stimulus and response in the therapist-client dialogue, the student is encouraged to pay absolute attention to the client's behaviours and to notice their own emotional state and experiencing. This gap becomes an infinite space to make decisions about behavioural change based on both internal and external factors. Deeper exploration of values and beliefs can be facilitated by the tutor and/or the actor,

encouraging the student to integrate new learning with their own knowledge and skill base.

It is worth exploring some concepts from facilitation and coaching within this context.

Facilitation and Coaching

The notion of the facilitator as a change agent is now well-documented in terms of purpose, role, skills and attributes (Harvey et al. 2001; Thomas 2008). Thomas conceptualised a set of continua in the education of facilitators that separates technical skills-based approaches; critical, political approaches; and intentional, person-centred approaches. Within clinical simulations, both actor and tutor have a responsibility to use intentional person-centred facilitation of the student's learning. The facilitator's own growth and journey towards self-acceptance is emphasised in Carl Rogers' person-centred notion of 'beings in becoming' (1989). With the intention that learning outcomes for the group and the individual will be met effectively, the tutor facilitates learning from outside the interaction between student and simulated patient, taking control of the overall structure and process of the experiential activity. With the intention that the same learning outcomes for the group and the individual will be met effectively, the actor facilitates learning from both inside and outside the interaction, taking a unique perspective from within the student-led interview, and contributing to the rich dialogue when stepping out of their client role. The qualities of facilitation that maximise learning will apply to both tutor and actor. Intentional facilitation recognises the deeper learning that can arise as part of this interpersonal transactive process between facilitator and student (Itin 1999, cited in Thomas 2004), enhanced by the personal qualities and presence of the facilitator. Within the clinical simulations it can be argued that the deepest learning arises not only from

the interpersonal transactive process between facilitator and student, but also between tutor and actor as co-facilitators of the students' learning, and within the whole group.

Ringer (2002) suggests a subjectivist perspective in which the facilitator develops presence through a conscious awareness of their own subjectivity which is then used to influence rather than control. Through paying close attention to their own feelings, thoughts and actions, facilitators are in a better position to use their influence to support the achievement of the learning goals. Incorporating elements of a solution-focussed coaching approach, the facilitator can promote an environment of 'respectful curiosity' and discovery, in which the learners' own resources are held as strengths (Jackson & McKergow 2002; Burns 2005). Thomas (2008) describes humility as a key factor in effective facilitation, in that being real is more important than being perfect or right. The facilitator enters into a collaborative learning space, and their presence is a powerful vehicle for noticing behaviours, and for supporting change.

Thomas also emphasizes the importance of respecting the other's limits, boundaries and choices. Within role-play simulations, these concepts become widened to include the tutor and actor as co-facilitators of equal status, creating a group learning environment through close dialogue.

It may be helpful to examine the nature of scaffolding dialogue further in enabling reflection-in-action that has behavioural change as its goal. Without focussed coaching conversations to scaffold this reflection learning is more reliant on the student's ability to identify areas for behavioural change. *Critical* incidents for reflection may be less likely to be highlighted by the learner if they perceive the experience as one of

mental or physical discomfort (Gray 2007) In clinical simulations, such discomfort can become the focus of the student's attention and strategies to avoid the anxiety thus become a priority over the client's needs. Gray's discussion of the reflective tools of facilitation from a management perspective highlights the importance of "proactive critical reflectivity" in which assumptions and beliefs are "surfaced and critiqued" to link reflection and action (Gray 2007: 497). The more autonomous reflector will stop the interaction to initiate dialogue themselves. Where this doesn't happen, both tutor and actor can be proactive in facilitating the surfacing of values, beliefs and behaviours within critical incidents that the student might otherwise avoid, perceiving them as 'mistakes'. The tutor may call a "stop-start" or from within the interaction the actor may challenge the student's reflection-in-action by choosing to make more explicit the potentially hidden impact of the student's behaviours. The tutor is also therefore aware of the actor's behaviours in sensing an appropriate point at which dialogue from outside the interaction might enable productive critical analysis. The quality of this dialogue will therefore depend to a large extent on the scaffolding of a more courageous examination of behaviours than the student might initially wish. Coaching conversations can be used to focus the student's attention on what is actually happening and to probe the beliefs and assumptions that inform this. Scott (2002) outlines four important goals of such real conversations as: interrogating reality, provoking learning, tackling tough issues and enriching relationships. The powerful shift in behaviour that can be achieved within this framework enrich the learning beyond a reflective feedback models such as Pendleton's Rules (Kurtz et al. 2005). New perspectives, gained through feedback on the impact of behaviour, can provide insights into the learner's blind self (Luft & Ingham 1955), enabling the student

to make informed choices about behavioural change. Coaching conversations can sit within reflective feedback models which may more usefully summarise the learning goals formulated from the whole experiential activity.

Mirroring desired behaviours

The analogous nature of the relationship between facilitator and learner within health education is worth exploration. Milan et al provide an excellent model to emphasise that the relationship between facilitator-student mirrors that of the clinician-patient (Milan, Parish, & Reichgott 2006; see also Makoul 2001). The processes of building comfort and trust, managing emotion, maintaining objectivity and the function of stimulating behavioural change is seen by Milan et al. as the intention within both environments. Furthermore, they emphasise several other key clinical communication skills that are also embedded in effective educational feedback: a partnership for joint problem-solving; respect for the learner's values and choices; and support for efforts at correction. Through skilful facilitation, educational feedback of both tutor and actor within the clinical simulations provides the invaluable scaffolding of effective clinical skills. Sensitivity to the learner's stage of readiness to change behaviour can be supported through group discussion and through focussing the learner on the impact for the client, within a relationship that also has behavioural change as its goal.

Our exploration has explored the three way dialogic process occurring within the role-play. This interaction is shown in Fig. 1

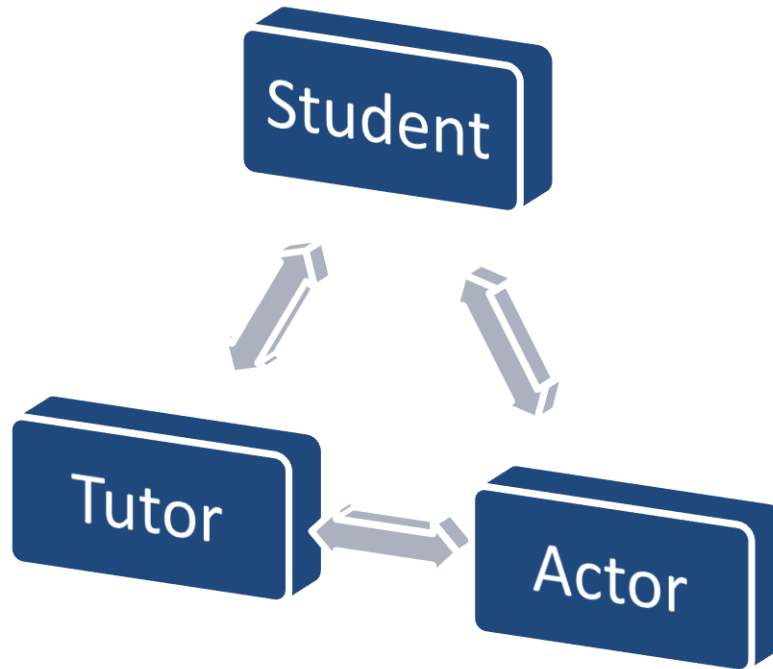


Fig. 1 The three way dialogic process occurring within the role-play

Having mapped the main theories that inform this work, we'll now explore the application of these theories in practice.

Theory into Practice

Our aim is to use the following extracts to explore the intuitive interventions of tutor and actor. The examples record our reflective dialogue as we investigate judgements that are made in the moment as to which aspects of the interaction to spotlight to facilitate the student's learning. The efficacy of using an actor as a simulated patient to explore and practice clinical communication skills is well documented (Kurtz et al. 2005: 89) and is not the focus of our analysis here. It is a given that a safe, student focussed learning environment has been established in which the student sets their own learning goals for each interaction with the simulated patient. In addition, strengths and development needs are defined through the well established mechanism of Pendleton's rules

(Kurtz et al. 2005: 110), taking account of participant, observer and simulated patient feedback.

Transcripts were made from a DVD recording of a role play activity within a clinical communication skills module. This role play took place with a second year speech and language therapy student in a small group setting. The student brief, provided in advance, specified the following simulated situation:

One week ago James had a stroke and his speech is severely impaired. You are on placement and have been asked to meet with James, to develop competence in interacting with clients who have had a stroke and in gathering information.

Students were required to formulate their own learning goal within the brief of developing competencies in interacting with clients and gathering information. These goals were shared with the group

at the start of the session and reviewed with each by an actor.

interaction. The simulated patient, James, was played

The DVD transcript extracts are reproduced in *italics*. Our reflective dialogue, which was recorded whilst reviewing the work, is in **bold** text. Gillie Stoneham is the tutor, and Richard Feltham is the actor playing the simulated patient James.

Extract 1: Here the student had already built rapport, and asked James about his concerns.

James: W....Whhh...When....when... (PAUSE)

Student: When will you be able to speak?

James: (PAUSE) When speak?

Student: (PAUSE) Well, I'm here to help to assess you and we'll see where we can go from there. And we can devise some therapy to help you through it. It might take some time. But we'll work on it at much as we can if that's a concern to you. OK?

Tutor: Shall we just stop you there – so how are you feeling?

Gillie: Decisions to stop the role-play can be based both on noticing the student's uncertainty about their own interventions and also on picking up signals from the actor highlighting the impact of the communication.

Student: Nervous! (warm laughter from the group)

Tutor: Yeah Ok...

Gillie: Encouraging students to express emotions in this safe space can enable them to acknowledge fear and anxiety and manage their feelings. By drawing attention to what is happening the student then has an opportunity to explore potential barriers to progress. The aim is to help the student to match their own behaviours to achieving the goal of the interaction. The dialogue in these situations often explores how to address the client's needs and look at how the students own emotional needs can present a barrier. In this example I noticed that the student's words were not congruent with their non-verbal signals. The student was 'performing' what she believed a therapist should say to help at this point, drawing on technical skills to solve what she saw as the problem, but not reflecting in the moment on the meaning of the dialogue in a more congruent way. Interactive skills such as client centred congruence and empathy are harder to measure, but just as important in clinical decision making. The student must combine both to be professionally competent.

Student: Ummm – I think I kind of lost my track a bit.

Tutor: Despite that, despite the fact that you're nervous and you feel you're losing your way a bit, what are you managing to do well?

Gillie: Stopping the process can be useful to reinforce what the student is doing well so that they develop conscious competence in managing the interaction more effectively. I asked the student to identify their strengths, in order to re-orientate their behaviours from deeper professional values, such as congruence and empathy.

Student: I think I'm getting him to use the communication that he's got, and listen to him, and give him a chance to speak, and hear his concerns and make note of them....

Extract 2: Having explored strengths, the student decided they wanted to 'rewind' their response to the above client concerns. Inviting feedback from the actor at this point can inform the student's decisions regarding new, more effective, behaviours. Here we explore how the actor can provide feedback in character regarding how the patient is feeling or thinking, or can drop the role and enter the dialogue.

Tutor: Let's just check out with James how that was as a response.

Actor (James): (The actor steps out of role) As a response James had no idea what that meant, in any meaningful way, and so I was coming back to the question 'when will I speak again, around the whole question of coming to terms with what's happened and what might happen. It's a challenge isn't it to find the form of words that is both truthful and as reassuring as you can be to James without giving false reassurance?

Richard: I had a clear trigger from you, Gillie, that the issue of empathy was worth exploring further. What I wanted to do was share with the student how my character felt and what he needed, so that the student could appreciate the implications of her behaviours. As the simulated patient I decided that providing feedback in role would have limited the information that would forward the student's learning, as the character had already expressed their concerns. By dropping the role and reflecting on how I experienced the situation, I supported the student learning need of developing honesty and empathy. By coming out of role I am able to articulate the challenge that the moment presents in the form of a question for the student to reflect upon. The authenticity underpinning the challenge coming from the actor, as opposed to the tutor or peers, can add greater impact to the student's motivation for positive change

Gillie: This authenticity is an example of mirroring behaviours that we want the learner to replicate in the workplace. Reflecting on this, I also notice the value of Socratic dialogue, how an appropriate level of probing question can model the value of surfacing and critiquing a critical incident. Our intention is that the student will question their preconceptions of what they should say and begin to explore deeper values and beliefs that result in desired behaviours.

Extract 3: As a result of critiquing this incident, further dialogue around honesty enabled the student to access their inner resources based on their own values and beliefs.

Tutor: When Richard from behind James' character had just talked about 'what's the truthful answer'... if you are going to talk to someone.... who has had this whole life changing thing happen, then you have to be prepared for 'I just want to know when I'll be able to speak'

Student: Yes.

Tutor: Now in truth?

Student: Probably not ever going to regain his speech as it was.

Tutor: As a second year speech and language therapy student what do you know in truth, about, what he's just asked?

Student: (PAUSE) What do you mean – about when?

Tutor: What would be the truthful answer? If I said to you when is he going to get his speech back?

Student: (TENTATIVE) ...He's...not...?

Tutor: You don't know that – that's not the truth...Nobody can say whether he is or he isn't.

Student: No..

Tutor: What's the truth?

Student: We don't know.

Tutor: 'I' don't know.

Student: I don't know. (NODS)

Gillie: It's important to encourage the student to own their responses.

Tutor: So the truth is you don't know. And actually there is something about being honest and truthful with our clients, because they will pick up when you're not being honest actually what are you finding difficult?

Student: Is it OK to say 'I don't know'?

Tutor: Let's try it!

Student: Ok..yes (NODS)

Gillie: We could have carried this on as an intellectual discussion, but the role play provides a space to rehearse difficult conversations and bridges the gap between theory and practice. At this point the student was encouraged to take a risk and experiment. The student chose to re-enter the role play and practiced bringing honesty into her professional role.

Richard: Since honesty was the goal, I chose to respond in a way that valued the student's new and more effective behaviours. I'll use my judgement to offer an appropriate and bespoke level of challenge, dependant on the student's level of skill. I am holding a mirror to their practice. I'm encouraging students to learn to use their judgement in the moment, recognising that each interaction is unique and another client may respond differently. The key learning point is the student can only make their best judgement in the real situation, rather than there being a right or wrong formula in clinical communication skills.

Gillie: Students will take their experience of this critically reflective process into their clinical practice and will, as a consequence, be more effective communicators.

Conclusion

We have begun to explore the value of simulations from interdisciplinary perspectives. Here we have investigated qualities and skills of facilitation, coaching and acting that contribute to simulations as highly effective vehicles for learning clinical communication skills. More traditional reflective feedback models can be enhanced by dialogic techniques that aim to surface hidden dialogues. With the student's learning as central to the process, new insights can potentially accelerate further learning in the workplace.

We have explored the methodology in the context of a clinical skills laboratory. Using actors to facilitate learning in this way, however, is equally transferable to other contexts.

Tell me, and I will forget.

Show me, and I may remember.

Involve me, and I will understand.

Confucius (450 BC)

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