A guide to using role plays in registrar teaching

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A variety of interactive teaching methods are described by the term 'role play'. These techniques tend be underutilised[1,2] despite their application to communication skills training.[3] This article provides guidelines for planning, delivery and evaluation of training sessions[4] utilising role play. I use a case study of a motivational interviewing workshop for general practice registrars to explore this topic.

Planning and delivery

A drug and alcohol workshop has been offered to basic registrars since 1998 in the New England Area Rural Training Unit. The main learning objectives are to:

- gain understanding of the cycle of change model, and
- develop skills in motivational interviewing.

Registrars are instructed using lectures, video and role plays in developing different approaches to patients presenting with different stages of the cycle of change model from precontemplation, contemplation, action and relapse.[5] Cases reflect stages of the model. General practice registrars are divided into groups of three where they alternate between the role of doctor, patient and observer. Facilitators (author and drug and alcohol nurses) move between the groups to assist. After 10 minutes, the small group comes out of role and each member of the trio discusses the case and their performance. A detailed patient case history given to the role playing patient is reviewed by the role playing doctor and observer. One smaller group reports back to the class.

I have found using icebreaker games, planning a mixture of learning modalities, or promoting the role play as a mock clinical exam useful in overcoming registrar reluctance to participate. Registrar safety is important. Group rules are developed to ensure confidentiality of any disclosures made in the group. Registrars can become immersed in a distressing role. Debriefing following each case is conducted by the facilitators. Support may be required and planned, especially when a registrar identifies with a traumatic patient role.

Evaluation

A five point Likert scale was used to evaluate segments of the workshop. Comments were also analysed qualitatively for content and themes.

A total of 30 general practice registrars attended this workshop in 2000–2003. Twenty-one evaluations were received. The response rate was 21/30 (70%). Eighty-six percent of registrars agreed the role plays were useful to their training. Registrars rated the lecture and role play components equally favourably (p=0.63) (*Table 1*). In rank order, the most favourable aspects of the workshop were: learning skills in interviewing and counselling, role plays, case discussion with a GP, and saying no to unreasonable requests.

Discussion

Most registrars valued role play in my workshops, rating it on par with other teaching modalities. This finding is contrary to previous findings about some medical students' negative rating of role play in learning.[2]

Educators increasingly recognise the value of this educational tool,[3] but evidence about its impact on influencing clinical practice behaviour is mixed. Knowles et al[6] found video role play with feedback improved performance during undergraduate objective structured clinical exams. Others have found no difference in results between role plays and lectures.[7] More research into the effectiveness of the different forms of role play influence on doctors' behaviour is needed. A major limitation of evaluations – done at the conclusion of workshops – is that there is no means to measure what proportion of regis-

Table 1. Registrar evaluation of motivational interviewing workshop

How useful was this session to your GP training?

1=strongly disagree, 2=disagree, 3 neither agree or disagree, 4=agree, 5=strongly agree

Session	1	2	3	4	5
Lecture*			1	14	5
Video*				17	13
Role play		1	2	12	6

N=21, * includes 1 missing data

There was no statistical difference for the numbers of registrars agreeing that lectures or role plays was useful compared those that did not agree or had a neutral response. (Fisher's exact 2 tailed test p=0.63 as some cells <5)

trars integrated these skills into their work.

Group size, venue, time, and cost need to be considered in planning role plays. Two common role play formats are: using small group trios or the use of actors with predetermined scripts. These methods have pros and cons. Registrars performing a role play may lack the fidelity that an actor can bring to a patient role. They may also be embarrassed by the subject matter or performing in front of their peers.[1,2] Actors playing a patient increase costs and realism. I have found higher numbers per facilitator (1:12–15) are possible in triads, as all registrars have a role to engage interest. I find a group of no more than 1:8 is preferable using an actor to maximise participation. When using an actor, I rotate the doctor role at random, use time outs, rewind the consultation using different approaches, and ask the group for input to maintain interest. Registrars who exhibit performance anxiety or require remediation may benefit from role play on an individual basis.

Patients can be used to teach physical examination,[8] however, their use in teaching counselling is limited by ethical issues. A distressed patient can be harmed by novice interviewers.[8,9] Role play allows learning opportunities when patients are reluctant to engage learners. Being able to have 'time outs', 'rewinds' and asking the patient and doctor their inner thoughts during a consult are powerful teaching tools, not available consulting a real patient.

Implications of this study for general practice

- Role play is a useful tool in teaching communication skills.
- Safety is important in role plays. Group rules need to be developed to ensure there is confidentiality for any disclosure participants make in their group.
- More research into the effectiveness of the different forms of role play influence on doctors' behaviour is needed.

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References

1. Brodaty H. Teaching interviewing skills in the medical teacher. Cox K, Ewan C, eds. 2nd edn. Churchill Livingstone: Melbourne, 1988.
2. Stevenson K, Sander P. Medical students are from Mars: business and psychology students are from Venus, university teachers are from Pluto? Med Teacher 2002;24:27–31.
3. The Royal Australian College of General Practitioners. Companion to the training program curriculum. Melbourne: The Royal Australian College of General Practitioners, 1999.
4. Fraser J. How to plan, deliver and evaluate a training session. Aust Fam Physician 2004;33:453–455.
5. Prochaska J, Di Clemente C. Towards a comprehensive model of change. In: Miller W, Heath N, eds. Treating addictive behaviour. New York: Plenum, 1986;3–27.
6. Knowles C, Kinchington F, Erwin J, Peters B. A randomised controlled trial of the effectiveness of combining video role play with traditional methods of delivering undergraduate medical education. Sex Trans Infect 2001;77:376–380.
7. Taverner D, Dodding C, White J. Comparison of methods for teaching clinical skills in assessing and managing drug seeking patients. Med Educ 2000;34:285–291.
8. Wykurz G. Developing the role of patients as teachers: literature review. BMJ 2002;325:818–821.
9. Sayer M, Bowman D, Evans D, Weissier A, Wood D. Use of patients in professional medical examinations: current UK practice and the ethicolegal implications for medical education. BMJ 2002;324:404–407.

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