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Patient-Drama: A Literature Review of Simulated Patient Experiences in Medical Education and Training

Shelby Davis
sdavis34@lesley.edu

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Shelby Davis

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Angelle Cook, PhD, RDT-BCT

Abstract

Simulated patient experiences are commonly used in medical education and training. These experiences have the benefit of training students in real-world environments without risks to real patients. However, these forms of training can be expensive to implement. Additionally, there may be room to improve their effectiveness for training medical providers in humanistic skills like empathy and relationship building. These experiences can be considered dramatic encounters with the incorporation of dramatic elements like role, story, and improvisation. Given the intentional use of drama in these simulated patient experiences, it can be argued that the definition of drama therapy broadly applies to these experiences. This literature review examines simulated patient experiences through the lens of drama therapy. Four specific types of simulated patient experiences are examined- peer role play, peer simulation, standardized patient experiences, and clinical scenario drama. These experiences are examined using drama therapy's core processes. The presence of the core processes in these simulated patient experiences, along with their absence, is identified. Potential benefits of the intentional incorporation of drama therapy's core processes and associated interventions are suggested. Suggestions for future research examining the incorporation of drama therapy in simulated patient experiences are made, including research to deepen the understanding of drama therapy's core processes and research to solidify understanding of dramatic processes that influence learning outcomes in simulated patient experiences.

Keywords: standardized patient, drama therapy, simulated patient experience, core processes, medical simulation

Author Identity Statement: The author identifies as a straight, White, cisgender, chronically ill female.

Patient-Drama: A Literature Review of Simulated Patient Experiences in Medical Education and Training

In medical education and training, simulated patient experiences are often used as part of the training model. These simulated experiences are interactive and designed to reflect real experiences in healthcare to prepare students for practicing in a clinical environment (Dalwood et al., 2020). A survey of 90 medical schools and 64 teaching hospitals showed that all respondents utilize some form of simulation during medical students' education (Passiment et al., 2011). According to the Northern Ontario School of Medicine (2017), these experiences can be used to teach and assess interviewing skills, communication skills, and physical examinations. Many types of simulated patient experiences are used in medical education and training, including peer role play, peer simulation, standardized patient encounters, and clinical scenario dramas.

The greatest benefit of learning in a simulated environment is that "the student can experience and practice clinical medicine without jeopardizing the health or welfare of real, sick patients. The value is in the *experience* of working with a patient," (Wallace, 1997, p. 6). Additionally, studies have shown that these interactive experiences improve confidence in medical students' abilities to perform certain skills, like smoking cessation counseling, when compared to more traditional, lecture-based methods (Park et al., 2019). In certain forms of simulation, like peer simulation and clinical scenario dramas, students and trainees have the benefit of experiencing patient encounters through a role other than the health care provider. These simulations can assist in developing important skills like patient empathy, as students and trainees experience the medical encounter through a different lens (Dalwood et al., 2020).

While these simulated experiences can be valuable, they are not always easy to implement. Standardized patient encounters, involving actors trained to play patients, are a more commonly used form of simulation in medicine and are researched more often compared to other forms of simulation. They are also some of the most difficult forms of simulation to implement. Standardized patients require hours of training, and many programs aim to compensate their standardized patient actors well, which burden simulation programs (Hardee & Kasper, 2005). This can become a barrier to implementing effective simulation training, as many simulation programs have an operating budget of under $500,000 per year and may not have the ability to adequately train actors (Passiment et al., 2011). There is a lack of data on the effectiveness of other, more accessible, forms of simulation, like peer simulation, contributing to the difficulty in developing robust and effective simulation programs.

At their core, simulated patient experiences are dramatic encounters. These experiences ask participants to use dramatic elements like role, story, embodiment, and improvisation in the encounters. The use of these elements, along with goals of simulation like increasing self-esteem, empathy, and interpersonal skills, indicate an overlap between simulated patient experiences and drama therapy. Furthermore, drama therapy is an experiential and intentional use of drama and theatre to achieve therapeutic goals (North American Drama Therapy Association, 2022). One could argue that the definition of drama therapy also broadly describes simulated patient experiences in medical education and training.

This thesis will explore four types of simulated patient experiences- standardized patients, peer role play, peer simulation, and clinical scenario dramas- through the lens of drama therapy. It is this author's belief that, as dramatic encounters intended to achieve interpersonal goals, simulated patient experiences are aligned with drama therapeutic interventions.

Furthermore, this author believes that the medical simulation field would greatly benefit from the influence of drama therapy theory, research, and processes. A drama therapy lens may help to identify the potential of easier to implement forms of simulated patient experiences to be effective, or potentially more effective, ways to train medical professionals.

Additionally, drama therapy theory and research may aid in strengthening existing simulated patient experiences, making them even more effective and well-rounded teaching models. Of particular interest is using drama therapy theory and approaches to better train medical students in physician-patient communication and relationship building. A 2014 study (The Associated Press- NORC Center for Public Affairs Research, 2014) showed that Americans consider the doctor-patient relationship to be the greatest factor in determining what makes a high-quality doctor. Only 29% of respondents in this study stated that health outcomes or delivery of care were the most important factors of a high-quality physician. The study showed that patients consider quality doctors to be attentive, have good listening skills, and display a caring attitude.

Another piece of research (Orom et al., 2018) has also shown that, "quality of the relationship with the physician was associated with both greater perceived influence of physician treatment recommendations and whether patients chose a treatment that was recommended," (p. 590). Communication skills, empathy, and relationship building can all be taught, and are skills often addressed through drama therapy interventions (Jones, 2007; Mayor & Frydman, 2021). It may be valuable to understand how the addition of drama therapy practices may better teach these skills to medical students in a simulated environment in an effort in increase quality of care.

These simulated patient experiences will be examined using the core processes of drama therapy. Jones (2007) describes the core processes as elements that come together in drama therapy work and "describe the ways in which drama and theatre forms and processes can be therapeutic" (p. 81). In using the core processes, this author aims to connect simulated patient experiences and drama therapy, while also highlighting areas in which simulated patient experiences could be adjusted to align with (and theoretically produce the same effects as) drama therapy processes and interventions. Recommendations for further research will be presented in an effort to better achieve the goals of these simulated experiences.

This author wishes to acknowledge her identity as a chronically ill individual who has experienced medical trauma. This author understands that her traumatic experiences within the medical environment have shaped her view of the medical system and medical professionals. The author acknowledges her own beliefs that, if physicians were better trained in empathy and relationship building, her own quality of care may improve. While this author's research is motivated by her own experiences in the American healthcare system, she has made a conscious effort to explore both the strengths and weaknesses of simulated patient experiences, which are a large part of the initial and continued training of medical professionals.

Literature Review

The History of Simulated Patient Experiences

The concept of a simulated patient experience was developed by Howard S. Barrows, a neurologist and educator at the University of Southern California. Barrows was teaching third-year neurology clerks when, in 1963, he first used a simulated patient in his teaching. He published his experiences of developing this simulated patient and using it in his teaching the following year (Hardee & Kasper, 2005; Wallace, 1997).

Barrows' goal in developing this simulated patient was to find a way to assess a medical student's clinical skills fairly and accurately. Barrows found that students were not often rated as having subpar skills, as faculty rarely saw them interacting with actual patients. This led to the development of the first standardized patient case, Patty Dugger. It was in developing this first case that Barrows identified the necessity for a standardized patient to evaluate the interaction with medical students, leading to the use of checklists which the standardized patients could use to evaluate student performance (Wallace, 1997). This practice continues to be used today.

Throughout the 1970s, others were also using simulated experiences to teach and assess students. Paula Stillman began teaching interviewing skills using simulated mothers while she was pediatric clerkship director at the University of Arizona in Tucson. Here, she developed The Arizona Clinical Interview Rating Scale (ACIR), "the first behaviorally-anchored Likert scale to assess medical interviewing skills," (Wallace, 1997, p. 12). At the same time, Robert Kretzschmar created gynecology teaching associates, then known as professional patients, who would use their own bodies to instruct students to conduct pelvic exams. They also came to teach students how to communicate with patients while conducting pelvic exams (Wallace, 1997).

Not long after, the concept of standardized patients and simulated patient experiences became accepted as valuable parts of medical training and education. Simulation labs became more common in medical schools throughout the United States in the late 1980s, along with the use of a human-like manikin (Bartram, 2020). In 1991 and 1992, grants were awarded to aid the development of an exam for medical student that utilized standardized patients (Wallace, 1997). In 1993, the Medical Council of Canada was the first to incorporate a simulated patient encounter as part of the license exam (Wallace, 1997). In 1995, the Nation Board of Medical Examiners in the United States followed with the addition of a standardized patient exam to the

United States Medical Licensing Examination, Step 2 (Wallace, 1997). Now, other forms of simulation are regularly used including peer simulation and role play, clinical scenario dramas, and encounters that combine the use of patient actors and manikins.

The Evolution of Simulated Patient Experiences

At the start, standardized patients and other simulated patient experiences were created to teach and assess objective, clinical skills and behaviors. "So the birth of the standardized patient came out of a need for a more rigorous method to evaluate the clinical skills of third-year medical students," (Wallace, 1997, p. 9). Medical educators felt a need to see how medical students were interacting with patients to determine if they were ready to graduate from their programs. These days, simulated patient experiences continue to be used to teach and assess clinical skills like physical exams, pelvic exams, and other procedures. These experiences, however, are now regularly used to also teach and assess interview and communication skills (Northern Ontario School of Medicine, 2017). Additionally, simulated patient experiences have been used to teach medical students how to counsel patient for smoking cessation (Kameg et al., 2021), to affect nursing students' feelings toward psychiatric nursing (Long-Bellil et al., 2011), and to teach medical students specific skills for working with disabled patients (Park et al., 2019).

Simulated Patient Experiences as Dramatic Encounters

Simulated patient experiences have also evolved in their identity as dramatic encounters. When first conceived, resistance to standardized patients and simulated patient experiences came from them being, "criticized as too touchy-feely, too expensive, too 'Hollywood'," (Wallace, 1997, p. 6). Now, these simulated experiences seem to embrace their dramatic connections. Standardized patient programs audition and hire working actors to staff their facilities. These

actors are given instructions similar to any other acting job, including directions to stay in character, memorize their script, and be ready to improvise (Northern Ontario School of Medicine, 2017; Parry Center for Clinical Skills and Simulation, n.d.; UIUC College of Medicine, n.d.). Some programs even describe the room in which standardized patients will work as, "a temporary 'stage' upon which you perform," (Parry Center for Clinical Skills and Simulation, n.d., p. 10).

The close ties to drama are strongly seen in those simulated patient experiences other than standardized patient encounters. Literature on peer role play and peer simulation clearly acknowledge the encounters as a form of role play. This literature refers to all parts played in these encounters- patient, health care professional, witness- as 'roles' and stress the benefits of students experiencing each of these roles (Dalwood et al., 2020; Park et al., 2019). Furthermore, clinical scenario dramas are described to be more like performances than other forms of simulated patient experiences. Clinical scenario dramas include fully written scripts, casting of roles, a rehearsal period, and a more formal performance in front of audience members (Jiang et al., 2020). While medicine initially rejected any ties to drama, it is clear that the field of simulation has embraced its dramatic connections as it has evolved.

The Core Processes of Drama Therapy

Although the field of simulation has begun to embrace its dramatic nature, there does appear to be a gap in understanding how dramatic processes impact simulation outcomes. This author was unable to find literature examining the dramatic processes taking place in various simulated patient experiences and their impacts on learning outcomes. In the field of drama therapy, nine core processes are considered to be the "common factors across drama therapy interventions, regardless of specific approach," (Mayor & Frydman, 2021, p. 1). Applying an

understanding of these core processes to simulated patient experiences may allow for a greater understanding of how to leverage certain forms of simulation to achieve better and more specific learning outcomes, like greater patient empathy or increased communication skills.

The core processes of drama therapy were developed by drama therapist Phil Jones (Jones, 1991). Over the course of his publications, he collected descriptions of work from clinicians in the field and interviewed drama therapists about the work they were doing, as well as noted his own observations (Jones, 1991; Jones, 1996; Jones, 2007; Jones, 2008a; Jones, 2008b; Jones, 2009a; Jones 2009b; Jones 2014). Using this information, Jones was able to find common themes across the work being done and, from these themes, developed his core processes (Cassidy et al., 2014). These core processes "define how drama therapy is effective," and are considered to be "fundamental processes within all drama therapy," (Jones, 2008a, p. 271).

Jones' development of the core processes occurred over many years throughout many publications. Additionally, as the field of drama therapy has grown, additional research has contributed to the definitions and understandings of the core processes (Armstrong et al., 2015; Armstrong et al., 2016; Mayor & Frydman, 2021). In an effort to clarify the core processes, Mayor and Frydman (2021) presented aggregated definitions of the core processes from selected publications. The author has chosen to use these aggregated definitions in this thesis as they reflect the most current understandings of the core processes of drama therapy.

Dramatic Projection

Dramatic projection involves, "externalizing aspects of self, inner conflicts, or emotions onto tangible or intangible dramatic material," (Mayor & Frydman, 2021, p. 2). The projection may consist of issues or emotions being represented by objects like masks or puppets. Dramatic

projection also includes the projection of one's own experiences onto the roles they play, or themes explored in stories and scenes in a drama therapy session (Mayor & Frydman, 2021). Dramatic projection encourages the creation of new perspectives, "along with the opportunity for exploration and insight through the enactment of the projected material," (Jones, 2007, p. 84).

Playing

Within drama therapy, playing refers to the process of coming into a "flexible state with reality, including an altered sense of time, space, and everyday norms," (Mayor & Frydman, 2021, p. 2). This can lead to a more flexible relationship with ideas and consequences (Jones, 2007) and may encourage experimentation with relationships with self and others (Mayor & Frydman, 2021).

Mayor and Frydman (2021) note that playing, with its current definition, can be understood as, "a close, if not exact, stand in for drama therapy participation," (p. 8). They offer the concept of *heightened play* to provide a more specific definition that separates playing from the other core processes. Here, heightened play is considered to be an intentional state of elevated playfulness that requires less formal structure (Mayor & Frydman, 2021).

Role

Role describes "identifying, taking, or playing roles, which might include representing aspects of self, a real person, or a fictional character," (Mayor & Frydman, 2021, p. 2). Role taking in drama therapy is often used to build skills and explore situations from the client's own life (Mayor & Frydman, 2021). However, role can also be used to help individuals develop new ways of relating to others and to gain perspective as they experience a situation from another point of view (Jones, 2007).

Embodiment

Mayor and Frydman (2021) define embodiment as, "expressing inner thoughts, feelings or experiences through a heightened, altered physicality or intentional use of the body within a dramatic form," (p. 2). Embodiment is often used in drama therapy as a tool to promote self-regulation and focus; it is also used to assist clients in physically expressing and processing emotions (Mayor & Frydman, 2021). Given that the body is one of the primary ways in which human beings communicate with one another, embodied work in drama therapy may also help individuals communicate more effectively as they gain more experience in using their bodies (Jones, 2007).

Empathy & Distancing

As noted by Mayor & Frydman (2021), empathy and distancing are likely to be better understood as two individual processes. There are defined together in this section as they continue to be addressed together in the current literature.

Within drama therapy, we look to encourage an expression of empathy from the client toward a role, dramatic experience, or projective object (Mayor & Frydman, 2021). The ability to express empathy in the dramatic environment may have implications in the client's real-life experiences and relationships. "The development of an empathic response during dramatic work can help to encourage empathy towards others in life outside the dramatherapy group," (Jones, 2007, p. 95).

"Engaging in processes of distancing encourages clients to engage with thought and reflection," (Mayor & Frydman, 2021, p. 2). This can assist clients in their ability to balance cognitive and affective processes (Mayor & Frydman, 2021), and may also allow clients to develop new perspectives on themselves, others, and their experiences (Jones, 2007).

Active Witnessing

In drama therapy, the core process of active witnessing refers to both functioning as a witness, or audience, for another, and the act of being witnessed by another. The witnessing may be done by the client, group members, therapist, or invited guests if in a more formal performance setting (Mayor & Frydman, 2021). Active witnessing can aid in the processing of socio-emotional issues and is also used in drama therapy groups "to consolidate thinking and experience, and in some cases, convert that into action," (Mayor & Frydman, 2021, p. 7).

Life-Drama Connection

Life-drama connection refers to the process of exploring real-world experiences and narratives within a safe, dramatic environment (Mayor & Frydman, 2021). This connection may be a clear, direct representation of a client's world, but can also be indirect and metaphorical in nature (Jones, 2007). Life-drama connection is the primary process used to assist individuals in practicing and rehearsing new ways of responding to real-world situations (Mayor & Frydman, 2021). Jones (2007) refers to this connection as "intentional and essential to the process of change in drama therapy," (p. 118). "If the connection did not exist…the client would not be able to bring life experiences into the dramatherapy, nor would they be able to take the experiences within the dramatherapy into their life outside the session or group," (Jones, 2007, p. 118).

Transformation

The core process of transformation is defined as "creatively developing and rehearsing new capacities, including exploring new intra/interpersonal roles, desired shifts in cognition and affect, and transformational relationships with the therapist and/or group members," (Mayor & Frydman, 2021, p. 3). Transformations in drama therapy may include real-life events transformed into representations of the experiences; real-life people transformed into roles or characters; or objects transformed into the representation of some event, experience, person,

feeling, or other thing from the real world (Jones, 2007). The process of transformation may include an aspect of insight or reflection and may help clients find other ways of existing in the world (Mayor & Frydman, 2021).

Triangular Relationship

The core process of triangular relationship defines the dual function of dramatic action within drama therapy- "as both a container and active third factor of the therapy," (Mayor & Frydman, 2021, p. 3). Mayor and Frydman (2021) note that, with the current definition of triangular relationship, this core process is always taking place when drama therapy is happening, as the creation of a dramatic reality is necessary to the practice.

Since simulated patient experiences are dramatic encounters that are used with the intention of teaching humanistic skills like communication and empathy, it is likely that these core processes can be identified in a variety of simulated patient experiences. Certain core processes, however, may be amplified in certain simulated patient experiences given the design of the experience and the intended learning outcome. Identifying the presence of drama therapy's core processes in different simulated patient experiences may help identify why certain experiences are better for teaching specific skills and how to leverage these experiences depending on intended learning outcomes.

Simulated Patient Experiences

Peer Role Play

Peer role play models are the least formal of the simulated patient encounters examined in this thesis. In peer role play, students and trainees work in groups of at least three individuals rotating between the roles of health care professional, patient, and observer (Park et al., 2019). No actors or additional individuals take place in the simulated experience. Every student will

take on each of the three roles. In most peer role play experiences, each role play takes 15-20 minutes. This time consists of 10-15 minutes for the actual role play and approximately 5 minutes for feedback (Park et al., 2019; Schlegel et al., 2012).

The types of cases enacted during a peer role play vary. In some settings, groups are given the freedom to develop their own cases, including the patient's presenting complaint and general medical history. In other settings, groups are presented with cases to enact during the peer role play. In most peer role plays, the feedback given is based on checklists similar to those used in Objective Structured Clinical Examinations (OSCEs), which are common, standardized patient-based assessments used in medical schools (Park et al., 2019). These checklists contain criteria relevant to the material being taught, but often focus on observable behaviors and skills. These criteria may include making eye contact with the patient, explaining technical terms, and inviting the patient to ask questions (Park et al., 2019; Schlegel et al., 2012).

Peer Role Play Research. Research on the use of peer role play suggests that it can be effective in teaching material to students and increasing their self-confidence in certain clinical areas (Park et al., 2019).

A study conducted in Korea (Park et al., 2019) compared the effectiveness of a peer role-play model versus a standardized patient model in teaching medical students smoking cessation counseling skills. The standardized patient model had a trained actor portraying the same patient role, history, and presenting complaint for each student. The peer role play model had students in groups of three rotating between the roles of student, doctor, and observer, as is customary for these types of experiences. The students (N=113) were randomly assigned to either group. Students were evaluated beforehand using an interactive exam, along with a written test on

smoking cessation, and a Likert scale designed for this study to assess students' confidence level on the subject.

Students' test scores were compared pre-and post-intervention. Both groups showed significant improvement in knowledge and ability regarding smoking cessation (p <0.001 for both groups). Both groups also showed improvement in self-reported confidence levels and overall smoking-knowledge ($p < 0.001$ for both). The students in the standardized patient group, however, self-reported a larger gain in confidence than the peer role play group (p =0.01). This may be due to the fact that standardized patient encounters are designed to be more realistic, leaving students more familiar with a patient encounter which can lead to increased levels of confidence (Park et al., 2019). It is important to note that, "although students in the SP [standardized patient] module group felt more confident in smoking cessation counseling, however, this self-perceived confidence didn't impact on learning outcomes," (Park et al., 2019, p. 7).

Peer Simulation

Peer simulation is a simulated patient experience that combines elements of peer role plays and standardized patient programs. In peer simulations, students portray the roles of patients in the encounter, just as they would in peer role plays. In these experiences, however, they receive training in accurately portraying the patient roles and maintaining the character, much like standardized patients do in their training (Dalwood et al., 2020).

The method of a peer simulation is a true hybrid of peer role play and standardized patient experiences. Peer simulations begin with the development of cases and patient profiles, as patient profiles are for standardized patient encounters. Again, similar to the preparation process for standardized patients, students are exposed to these patient profiles and have an opportunity

to prepare for playing the role of the patient (Tengiz et al., 2022). The actual peer simulation encounter, however, is formatted much like a peer role play. Students rotate between the roles of patient, physician, and observer, having the opportunity to play each role. There is a feedback session held after each encounter where each participant reflects on the encounter (Tengiz et al., 2022).

Peer Simulation Research. Peer simulation holds a distinct advantage over the use of standardized patients as it shares the standardization of the patient roles but is significantly less expensive to implement and reduces the burden on instructors and faculty members (Tengiz et al., 2022). A review of 12 studies (Dalwood et al., 2020) including the use of peer simulation, discovered that there is no significant difference in the development of communication skills between students participating in peer simulation and those participating in standardized patient encounters. Additionally, some studies reviewed indicated that peer simulation led students to develop significantly higher levels of empathy when compared to other forms of learning (Dalwood et al., 2020).

Research from a medical school in Turkey (Tengiz et al., 2022) examined whether peer simulation can be effective in teaching patient-physician interviewing skills without the use of standardized patients. In this study, second-year students (N=50) rotated between the roles of physician, patient, and observer, participating in a simulated encounter based on a standard patient role developed for this study. The peer simulation encounters were video recorded, and the students rated each other using checklists created for this study (Tengiz et al., 2022).

In the physician role, students were rated as successful in their ability to start interviews with patients and implement nonverbal communication skills. Additionally, feedback from

students stated that being in the role of the observer positively contributed to their learning (Tengiz et al., 2022).

Standardized Patients

Standardized patients are specially trained actors used in medical education and training. "The role of an SP is to accurately and consistently portray the medical background, physical condition, and emotional state of a patient," (Parry Center for Clinical Skills and Simulation, n.d., p. 4). Standardized patient encounters are often one-on-one encounters between the standardized patient and the healthcare student. These encounters are often used to practice communication skills and non-invasive physical exams. They may be used to teach or assess skills. In recent years, standardized patient encounters have become more commonly used in assessing student skills through objective structured clinical examinations (OSCEs) (Long-Bellil et al., 2011).

Standardized patients are given a specific patient role to learn and rehearse before the encounter with the student. They are given information regarding the patient complaint, previous medical history, and any other important information that may be relevant to the learning experience (UIUC College of Medicine, n.d.). The standardized patients are typically given a checklist used to rate the students on the skills displayed during the encounter. During the encounter, students are observed by faculty and/or classmates through a two-way mirror or through camera recording. After the encounter, the student may receive verbal feedback from faculty, students, and/or the standardized patient, along with written feedback, depending on the nature of the encounter (Northern Ontario School of Medicine, 2017; UIUC College of Medicine, n.d.).

Standardized Patient Research. Standardized patients are one of the most commonly used forms of simulation used in medical education and training (Passiment et al., 2011). Thus, they are one of the most researched forms of simulation. The current research shows the effectiveness of standardized patient encounters to teach communication and clinical skills to health care professionals (Hardee & Kasper, 2005).

Researchers (Kenaga et al., 2021) at Wayne State University's Office of Graduate Medical Education examined the use of a standardized patient encounter to teach first- and second-year residents (*N*= 70) competencies for counseling patients on opioid medications. The competencies were coordinating patient care, working in interdisciplinary teams, and advocating for cost-effective care. This encounter was consistent with the common practices of standardized patient encounters previously described in this thesis. The role was kept consistent for each standardized patient encounter and the standardized patient rated each resident using a standardized instrument, the Kalamazoo Essential Elements Communication Checklist- Adapted (KEECC-A).

This study used the scores of the standardized patient encounters to predict scores on end-of-the-year clinical skills exams for both the first- and second-year residents. The study showed that the standardized patient experience predicted improved ability to coordinate patient care and work in interdisciplinary teams for second-year residents ($p < 0.001$ for both) during the evaluation at the end of the year. The study did not, however, show any predicted improvements for first-year residents ($p > 0.05$). There is an indication that overall experience played a part in seeing improvement for second-year residents and not first-year residents. Even still, the study shows an ability for standardized patient encounters to effectively teach skills to some medical students and for the students to retain that learning (Kenaga et al., 2021).

Clinical Scenario Dramas

Clinical scenario dramas are described in a single study from a medical school in China (Jiang et al., 2020). They are included in this thesis as they are a highly dramatic form, structured similarly to a performance. Thus, clinical scenario dramas, while new and relatively unknown, are a simulated patient experience of particular interest in this literature review.

Clinical scenario dramas utilize standardized scripts that explore real-life encounters between physicians and their patients. Students play the roles in the scenes, and receive coaching regarding the background, illness, and other important identifying information for the roles they will be playing during a rehearsal period (Jiang et al., 2020). Students not playing a role in the scene being performed are responsible for other aspects of the performance, including set design, sound design, lighting design, and observing rehearsals. The scripts for the clinical scenario dramas contain stage directions that provide flexibility in how the scenes are performed. The scenes may be performed in front of an audience on a traditional stage or in the round; complex stage lighting, including spotlights may be used; and set design may create a realistic setting, or be simplistic and only imply the setting for the scene (Jiang et al., 2020).

As the clinical scenario dramas are performed, the students' goal is to portray the reality of the clinical situation. Following the performance of the scene, there is a feedback session in which students can share what they learned from the roles that they played. Focus is given to the skills the "physician" used in the scene, how the "patient" felt during the interaction, and feedback from those observing (Jiang et al., 2020).

Clinical Scenario Drama Research. The single study from China (Jiang et al., 2020) describing clinical scenario dramas presents data collected from March 2009 to October 2018.

During this time, medical students (N= 727) participated in courses involving clinical scenario dramas, with 675 students responding to the self-rating questionnaire developed for this study.

When compared with evaluations conducted prior to the courses, students report significant improvements (p<0.05) in self-confidence in a variety of domains including relationship building, breaking bad news, and communicating with relatives (Jiang et al., 2020). Students also reported high satisfaction for clinical scenario dramas as a teaching method and preferred them to lectures. Finally, as a teaching method, "students felt that they could participate more actively, find solutions to problems, learn better in a team environment, gain insight from feedback and previous experiences," (p. 7).

With a detailed understanding of the structure of various simulated patient experiences, along with the research for these experiences, a drama therapeutic lens can be applied to these experiences. This detailed view sheds light on where drama therapy's core processes may be present in these experiences and how the core processes may influence the experiences and their outcomes.

Understanding Simulated Patient Experiences Through a Drama Therapy Lens

Presence of Core Processes in Simulated Patient Experiences

Although the four types of simulated patient experiences described above are not considered drama therapeutic interventions, they do clearly exhibit some of drama therapy's core processes.

While Jones (2007) considers the life-drama connection to be an essential component of change in drama therapy, it also appears to be essential in simulated patient experiences. As previously described, the connection between life and drama in drama therapy may be clear and direct, or indirect and metaphorical (Jones, 2007). In simulated patient experiences, the emphasis

is clearly on the importance of a direct connection between life and drama. Particularly in standardized patient encounters (Parry Center for Clinical Skills and Simulation, n.d.) and clinical scenario dramas (Jiang et al., 2020), the goal is to portray the clinical environment accurately and simulate the reality of a clinical interaction.

Just as Mayor and Frydman (2021) highlight that the core process of triangular relationship is always taking place within drama therapy, it also appears to be taking place in simulated patient experiences. The creation of a dramatic reality is necessary in these simulations; the dramatic reality is what distinguished simulated patient experiences from real-world encounters. Additionally, it could be argued that the dramatic reality of the simulated patient experience functions as a container for the learning taking place during the encounter, much as it functions as a container for the therapy in drama therapy (Mayor & Frydman 2021).

Finally, the core process of role is obvious throughout all four of the simulated patient experiences described above. Depending on the encounter, however, the use of role may vary. In standardized patient encounters, students only take on one role- physician. In these experiences, the goal is primarily skill building for the student, with a focus on communication and clinical skills (Long-Bellil et al., 2011). In peer role play (Park et al., 2019; Schlegel et al., 2012), peer simulation (Dalwood et al., 2020), and clinical scenario dramas (Jiang et al., 2020), students have the opportunity to also take on the role of the patient.

The Use of Role in Simulated Patient Experiences

The difference in the use of role among simulated patient experiences is of particular interest when viewing these experiences through the lens of drama therapy. As previously noted, in all simulated patient experiences described here, role is utilized. However, standardized

patient encounters differ from the others in that students only take on the role of physician and never take on the role of the patient (Long-Bellil et al., 2011).

Jones (2007) notes that roles can be used to help individuals gain new perspectives as they have experiences from another point of view. In the case of the standardized patient encounter, the student does not necessarily take on the role of another, but instead steps into a role of their own- a new part of themselves that they are rehearsing. While this certainly aids in skill building, as role taking can (Mayor & Frydman, 2021), there is not necessarily the opportunity to gain perspective from the role of the patient. The ability to understand the perspective of the patient may aid students in expressing empathy and building relationships with their real-world patients.

Expression of Empathy in Simulated Patient Experiences

All four of the simulated patient experiences described here allow for students to work toward the development of an empathic response. Within the dramatic encounter of the simulated patient experience, the students have the opportunity to practice the expression of empathy in the role of the physician, along with other skills. As Jones (2007) notes, the ability to communicate empathy in this dramatic encounter may help students express empathy for their real-world patients outside of the simulation environment.

However, the ability to take on the role of the patient as well as the observer in peer role play, peer simulation, and clinical scenario dramas could also strengthen students' ability to express empathy toward patients. In taking on the role of the patient, students have the opportunity to experience a physician's ability, or lack of ability, to express empathy. As previously noted, this experience may allow students to develop a new perspective (Jones, 2007), which could lead to a change in future behavior with real-world patients.

Additionally, the ability to take on the role of the observer may contribute to the development and expression of empathy in medical students. As previously mentioned, peer simulation research (Tengiz et al., 2022) has noted that students find the observer role valuable in their overall learning. In drama therapy, this observer role would be considered the active witness. In the core process of active witnessing, the student in the role of the observer has the opportunity to process the experience they have witnessed along with their own thoughts and feelings (Mayor & Frydman, 2021). As noted by Mayor and Frydman, there are cases in which this process of combining thoughts and experiences in the active witnessing can be converted into action. In the case of medical students, that may look like a change in the way they choose to interact with or relate to real-world patients, including an increased ability for empathic communication.

Core Processes Missing from Simulated Patient Experiences

Dramatic Projection. The argument could be made that the opportunity for dramatic projection naturally exists within simulated patient experiences. Students may, for example, project their own personal experiences onto the stories being explored in a clinical scenario drama. They may also project their personal emotions or internal conflicts onto roles existing in a standardized patient encounter, peer role play, or peer simulation.

That being said, there is no intentional use of dramatic projection in simulated patient experiences. The current literature does not describe the use of objects like masks or puppets in simulated patient encounters that would encourage intentional dramatic projection. Students may benefit from participating in object projection interventions as it provides distance from the topic being learned and explored. This distance, another core process of drama therapy, may also contribute to student development of new perspectives and understandings (Jones, 2007).

Additionally, while there is opportunity for students to project their own emotions and experiences onto the intangible dramatic material of the simulated patient experience, the literature does not describe an encouragement of this projection.

Playing. As previously mentioned, Mayor and Frydman (2021), note that as the core process of playing is currently understood, it can be considered a "stand in for drama therapy participation," (p. 8). In this sense, it could also be argued that play naturally exists within simulated patient experiences, as these experiences do have a flexible relationship with consequences (Jones, 2007) and encourage experimentation within the physician-patient relationship (Mayor & Frydman, 2021).

Mayor and Frydman's (2021) concept of *heightened play*, however, does not appear to be present in the four simulated patient experiences described here. Their definition of heightened play considers this to be an intentional state that has less formal structure and an elevated sense of playfulness. Much like dramatic projection, the literature does not describe intentional moments of playfulness in any of the simulated patient experiences explored in this thesis. Additionally, standardized patient encounters (Parry Center for Clinical Skills and Simulation, n.d.), peer simulation (Dalwood et al., 2020), and clinical scenario dramas (Jiang et al., 2020), all involve structured, standardized cases and scripts used by students, bringing a formal structure to the experience that would not be found in moments of heightened play.

Embodiment. The goals of simulated patient experiences often include teaching communication skills, including nonverbal communication skills (Hardee & Kasper, 2005; Tengiz et al., 2022). Peer simulation research (Tengiz et al., 2022) shows the success of peer simulation to teach students to implement nonverbal communication skills in patient interactions.

By stepping into a role in these dramatic, simulated patient experiences, students are embodied as they are using their physical bodies as part of the encounter However, as with dramatic projection and playing, there is no mention in the literature of intentional embodied work in simulated patient encounters. The literature does not make mention of connecting students back to their bodies either during these experiences or in processing these experiences. Additionally, body-based interventions like mirroring exercises are not seemingly used as a part of medical education and training. While the literature mentions teaching and assessing nonverbal communication skills, methods for teaching and assessing these skills are not mentioned, so it is not clear how the dramatic environment contributes to the learning of these body-based communication skills. More intentional incorporation of embodied interventions and physically-focused post-experience processing sessions may be beneficial in teaching nonverbal communication skills.

Based on this literature review, it is clear that simulated patient experiences used in medical education and training are truly dramatic encounters. Furthermore, these experiences do appear to align with the field of drama therapy. Simulated patient experiences intentionally use dramatic processes to teach communication and clinical skills, while drama therapy interventions intentionally use dramatic processes to achieve therapeutic goals (which may, at times, include the teaching of things like communication skills) (North American Drama Therapy Association, 2022).

Both the fields of drama therapy and medical simulation are young, with much research to be done within each field overall. Generally, there is a lack of drama therapy research regarding the core processes and their ability to facilitate client change. As the field works for

clearer, operationalized definitions of the core processes of drama therapy, it is likely that more research regarding the core processes will follow.

Similarly, research regarding simulated patient experiences is slim. The bulk of the existing research centers on standardized patient encounters, with less research speaking to peer role play and peer simulation. As previously mentioned, only one study (Jiang et al., 2020), exists describing the process of clinical scenario dramas and their use in one medical school in China. Generally, more research is needed to understand the specific mechanisms behind each of the different simulated patient experiences.

By bringing the fields of drama therapy and medical simulation together, more understanding can be gained as to how dramatic processes facilitate change. This understanding can then be applied to simulated patient experiences, with the hope of creating more effective training experiences capable of teaching humanistic skills along with clinical ones.

Discussion

This literature review highlights the potential mutual benefit of research understanding the integration of drama therapy and simulated patient experiences. The sheer volume of medical schools and training programs using some form of simulation to train students provides great access to individuals participating in dramatic encounters that could be used for drama therapy research. As noted in this thesis, many core processes of drama therapy are naturally present within the different types of simulated patient experiences. Furthermore, there are opportunities to introduce the other core processes into these experiences. This provides a wonderful opportunity to isolate the core processes in action to better understand their function in drama therapy interventions and how they contribute to the process of client change. Additionally, the

field of simulation stands to benefit from a better understanding of the dramatic processes at play in their simulated experiences.

More specific suggestions for research on the intersection of drama therapy and simulated patient experiences center on how drama therapy theory and understanding may impact the training of medical students and medical professionals. Data shows that patients consider doctor-patient relationships as the greatest factor in determining whether a patient is receiving high-quality care (The Associated Press- NORC Center for Public Affairs Research, 2014). As such, it is important to understand how the influence of drama therapy theory, processes, and intervention may contribute to better training in interpersonal and relationship-building skills.

As previously noted, there are significant differences between the four types of simulated patient experiences explored in this thesis. Of particular note are the differences in the roles students take on and the ability to participate in active witnessing, or the role of the observer. Future research could look to understand how taking on the role of the patient or the role of the observer contributes to a students' ability to express empathy with a patient.

One of the greatest difficulties in implementing simulated patient experiences in training programs is cost. As standardized patient programs are the most well-used of the simulated patient experiences, most programs look to implement these programs within their training. However, it is expensive to hire and train competent actors to play standardized patients; create simulation facilities that look like real clinical environments, including real medical equipment; and hire staff with the experience necessary to run such a program. There is some research comparing learning outcomes of different types of simulated patient experiences. Generally, this research suggests that there is little to no difference between standardized patient encounters and other simulated patient experiences when learning clinical skills and subject knowledge (Park et

al., 2019; Schlegel et al., 2012). There is, however, some research showing that students learning through standardized patient encounters feel more confident in the skills they have learned when compared to those learning through peer role plays (Park et al., 2019).

Drama therapy's involvement in implementing simulated patient experiences may help to decrease costs associated with these programs. Medical schools and teaching hospitals are likely to be connected to university programs and agencies hosting master's level counseling interns. The expansion of these programs to include a drama therapy intern, along with an experienced drama therapist to supervise, would allow for the implementation of drama therapy programs at a lower cost as, unfortunately, many master's level internships are unpaid. Further, research opportunities may help to bring simulated patient experiences to students at lower costs. Simulation programs could look to partner with drama therapists doing research in how the core processes of drama therapy facilitate change. In this case, drama therapists could focus on the use of lower cost simulated patient experiences, like peer role, peer simulation, and other forms not currently used in medical education and training. Furthermore, funding for this research could be obtained, ultimately offsetting higher cost simulated experiences like standardized patient experiences.

Future research should focus on the mechanisms at play in simulated patient experiences. By better understanding the mechanisms involved in skill building, developing empathy, and other learning that takes place in these experiences, they can be better leveraged and implemented in the learning environment. By identifying specific factors that contribute to the development of empathy, for example, researchers can look to bring those factors to other simulated patient experiences. Understanding the differences in each experience will aid in the development of stronger simulations and the targeted implementation of experiences based on

needs and learning goals. In this way, simulated patient experiences can truly become the ideal form of training for medical professionals.

It would also seem wise to explore other drama therapy interventions that may be helpful in the training of medical professionals. The field of medical simulation has become highly formal and standardized; this has led to the expectation that interactive forms of training must look like the types of simulated patient experiences discussed in this thesis. There may be room to research how smaller, more creative drama therapy interventions can contribute to skill development in medical students and medical professionals. For example, studies exploring the use of dramatic projection using puppets or masks in teaching medical professionals communication skills could be conducted. This research could identify interventions that are easy to implement, more cost-effective, and still as effective as the current standard for interactive forms of training. These less-standard interventions may have the additional benefit of preparing students for unexpected and atypical encounters in the actual clinical environment. Exposure to experiences that are not carbon-copies of the clinical environment may promote flexible thinking, creative problem-solving, and confidence in new, unfamiliar situations in students.

Finally, the recommendation to include drama therapists in the field of medical simulation seems clear. The current lack of drama therapists in the field of medical simulation prevents the field from truly leveraging the dramatic processes they are engaging in. Drama therapists' training in how dramatic processes lead to change and transformation should be of high interest to those working in medical simulation as they look to improve their training programs. The author believes that the inclusion of drama therapists in the field of medical

simulation is a necessary step to creating simulation programs that can effectively train clinicians that are capable of providing high-quality care for patients.

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THESIS APPROVAL FORM

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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Angelle V. Cook, PhD, RDT/BCT E-Signature 4/28/2021 1:41pm EST