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WEB PAPER

Medical students on the stage: An experimental performative method for the development of relational skills

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Abstract

Background: Development of therapeutic relational skills is a relatively neglected area of medical education. Conventional teaching techniques are mostly unsuitable for the realization of experience-based learning.

Aims: To develop a training method which enables lived self-experiences of the therapeutic relationship in class. To help students understand that illness and the doctor–patient relationship are integrated in the network of life histories and other relationships.

Methods: Our Integrated Performative Action Method is based on the elaboration of a short story of an illness in a student group. Through the 5 phases of the process, students write their own version of the story, build up characters, scenarios and enact the play. We have tested the method with 6 groups of students ($n = 70$) in a 10-week course. Video-recordings and minutes of sessions were analysed by two independent observers.

Results: Through elaborating the characters and playing the roles, students could speak about their own problems and act out feelings in the name of the characters. All groups had strong involvement throughout the process.

Conclusions: The method helps to experience the ways in which therapeutic relationships and professional identities are constructed, reflected upon and communicated in a group of medical students.

Introduction

Numerous studies have indicated that doctor–patient communication and the therapeutic relationship are primary factors of patients' satisfaction with treatment (Beach & Inui 2006; Dent & Harden 2009). Education of interpersonal-communicative skills has been embedded into most of the medical curricula across countries. However, the majority of these courses are stressing the *techniques of communication*, instead of a real focus on *improving interpersonal skills*. As a result, a lopsided doctor–patient relationship is constructed. The curricula are organized around the question of '*How should the professional communicate with the patient?* instead of '*How does their relationship function?* With a curriculum dominated by a focus on the techniques of communication, we are taking the risk of overshadowing significant features of interpersonal relationships, i.e. the process-like nature of interactions, the inner world of the relationship and experiences are neglected. Teaching *techniques* of communication can be easily realized without any background experience of students, even in the absence of any real-world experience of the concrete interpersonal-communicative settings of the medical profession. This might be a reason for the existing bias of favouring *techniques of communications* over the development of relational skills. These curricula accommodate the fact that most students lack experience with patients and do not have their own cases. Thus, the question arises whether we can find educational methods that are capable of substituting students' lack of professional experience, in order to aim our educational focus on interpersonal skills.

Practice points

- Relational and interpersonal skill development is a neglected area of medical education.
- We need group teaching methods which enable lived experiences of the therapeutic relationship.
- The Integrated Performative Action Method makes self-experiences possible through elaborating stories and playing roles, without demanding personal transparency.
- Students can learn that illness and the therapeutic relationship are interdependent, and integrated in a wider network of personal histories and relationships.
- The method enables students to identify with different roles, which also contributes to the development of empathy and the prevention of early burnout.

Professional socialization already begins as early as medical students enter a training program, even in the absence of any guidance or orientation about their professional roles (Stern 2000; Beagan 2001; Van De Camp et al. 2006). If a training program fails to provide guidance and support for professional socialization in a systematic way, it may significantly narrow

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the possibilities of improving interpersonal skills, or may even prevent it later on. A number of recent studies have highlighted that the incidence of *burn-out* has become alarmingly frequent among students of the helping professions – especially among medical students (Dahlin & Runeson 2007). A primary factor of burn-out is related to students' disillusionment provoked by the absence of 'human' and 'practical' elements in their initial training years. In other words, they were disappointed because the *principle of interaction* was neglected in the curricula. There have been important advances in the research of the development of the therapeutic role and also some improvements have been achieved in educational practices. However, studies that incorporate investigation of the *developmental process* of *interpersonal skills*, and related *self-experiences*, are still rare (Pitkala & Mantyranta 2003; Lumma-Sellenthin 2009). The unelaborated and/or disordered intersubjective experiences of the future professionals might also play a relevant role in constructing and recycling this dichotomy.

Considering these issues, new methods in the education of interpersonal skills are needed. These should be applied in the preclinical years of medical training or in the early phases of the various training programs for other health sciences students. Moreover, these new methods should be adaptable to any phase of training and should enable the integration of the two aspects of interpersonal skills: the professional aspect and the one emerging from the process of socialization. Thus, it would succeed in realizing Michael Balint's (1957) principle of '*rapport as a therapeutic factor*'. The often cited maxim of medical education – 'Cure the sick person, not the disease!' – encapsulates a profound difficulty. We have to face the challenge of transmitting to students the appropriate attitude that could fulfil the ideal of a person-centred therapist.

The specific methods we have met in teaching doctor–patient communication at various medical schools have not proved as fully adequate for the experience-based learning of the complex process of doctor–patient interaction. *Case study discussions* are more suitable for cognitive analyses, *spontaneous role-play* is hindered by fears of performing in front of peers, *empathy labs'* encounter exercises are suitable only for acquiring fragments of the professional role and *film-screening* often evokes passivity among the group members.

In our own approach to develop a training method for improving interpersonal professional skills we set the following major objectives:

(1) Create self-experiences for students in their early phase of training to enable them to identify themselves with both roles in the therapeutic relationship – doctor and patient – in a voluntary way that is free from anxiety.
(2) Integrate students' own feelings and problems in action, through projection and the improvement of their skills to establish rapport.
(3) Incorporate the process of 'unconscious learning', wherein implicit interpersonal knowledge becomes perceptible and accessible to be used by the professional in the future to generate rapport when searching and finding meeting points with his/her patients.
(4) Follow the principle that the therapeutic relationship is a narrative integrated into the web of other stories. The patient's and doctor's life histories, the stories of their own relationships, their earlier illness narratives and the social and cultural representations related to the given symptom, can all be present in this narrative web.
(5) Improve students' skills of thinking in terms of life histories and enable them to situate the disease within the patient's life world.

Method

The structure of the training method

Our method was a combination of drama-therapy, bibliotherapy and the *Bálint group*.

The *Bálint group*, as a case discussion group, focuses on the physician–patient relationship, and organizes its meetings weekly or biweekly (Balint 1957). Group members are supported by an experienced expert who helps them in recognizing and discussing their feelings about their problematic personal cases. *Drama-therapy* is a method of planned/projected emotional training (Slade 1995). The secure atmosphere provided by the group enables members to experience a potential failure without having its burden of consequences. This provides a way of experiencing trauma without being traumatized, to experience harm without being harmed, to grieve without grief: this is the essence of dramatic experience. *Bibliotherapy* uses the healing effect of reading, and applies narratives as medicines (Matharu et al. 2010). This method has to be supported by a carefully chosen literary piece in order to improve the adaptive capability of a person, to offer potential solutions to her personal problems.

The case story

Developing our educational method, we needed a short story serving as a common projective surface for group members. In order to find a proper story that adequately fitted our objectives, we used four criteria. First, it should contain a narrative on a doctor–patient relationship, a story of an illness. Second, the story should not contain any precise, professional diagnosis. Third, it should involve several, but just roughly sketched characters. And fourth, the story should be neutral – almost 'boring'.

The short story that best fitted to our above mentioned criteria was Nagy's (1937) *The patient*, which can be simply summarized as follows. (1) An elderly couple arrives at a hospital reception to visit their adult granddaughter (Ilonka, the protagonist of the story). (2) A worried husband asks questions from the head of the hospital department about his wife's (Ilonka's) operation. (3) A female patient (Ilonka) after an operation complains to her roommate that her relatives fail to care about her.

Phases of group activity

The group's activity is structured by five phases. First, we start with *sensitivity training*. This is built up from short warm-up

games that support trust, nonverbal communication, empathy and conscious reflection on establishing/upholding connections with group members. Second, the group *familiarizes with the story*, reads the short story and with some guidance and instruction from the facilitator (teacher), group members put their feelings into words. This phase involves *script writing* as well. Doing this, the group members are elaborating together significant details of the story. How old are the characters involved? What are their occupations? What is the protagonist's diagnosis? After they finish these details, they work on the basic story by broadening it out along time and space, and completing it according to their imaginations. The third phase is *character construction*. The short story's characters and their personal life histories are worked out together by the students, as each life period is narrated by a different group member. Moreover, the group might imagine a given character's inner feelings and fantasies, e.g. her most important wish, her greatest fear and the nature of her sorrow. The fourth phase begins with *casting*, where each member writes down his or her conception about the proper casting of the play with group members as actors. The final step is *performing the play*. Group members act out the story created by the group. At the end of the course, two parallel paths of life – the doctor's and her patient's – are brought to life on stage.

Subjects and measurement tools

We tested our method in six groups, at two Universities. We announced optional credit courses in two consecutive semesters for fourth-year students, four groups for medical students ($n = 46$, University of Debrecen) in their first clinical year, and two for psychology majors (University of Szeged, $n = 24$). Groups had a 2-h meeting weekly for a 10-week period.

We measured students' expectations and outcomes by a questionnaire distributed before and after the course. This consisted of 16 items assessing the student's satisfaction in 4 dimensions: *cognitive* (e.g. 'I would like to improve my knowledge about the rules of communication'), *emotional* (e.g. 'I would like to improve my ability to recognize my own emotions'), *communication* (e.g. 'I would like to improve my nonverbal communication skills.') and *career orientation* (e.g. 'I hope to get help for building up my identity as a doctor').

Significant events of the group process were video recorded. These were the six scenes created by the groups and the final full version brought on stage by the students. Facilitators took minutes throughout the whole course, including notes about their own experiences. Video-recordings and facilitator notes were content-analysed by independent psychologists according to the criteria of involvement, activity level, dynamics and content of scripts and plays.

We have also undertaken a reliability study about our short story, using a questionnaire with 334 participants.

Results and discussion

Our reliability study proved that the selected short story met the criteria we determined and evoked similar associations about diagnosis, illness, and also about patient's and doctor's characteristics in the sample of medical and psychology students. A detailed analysis of this study is summarized in Csörsz et al. (2010).

Sensitivity games

In the first phase of the course, the sensitivity games were effective. Students enjoyed playing, and the groups worked in a friendly and relaxed atmosphere.

Preparations for dramatization

In the second phase, where they first interacted with the story, we focused on familiarization with it, and some initial preparations for its dramatization. The text served as a *projective surface* which helped students to construct their own concepts about the illness narrative and the development of the healing process. This was supported by specific exercises and group dynamics. All four groups actualized the text by situating the story into current situations, choosing present-day occupations for the characters, and placing the interpersonal relationships into the everyday life of contemporary health care institutions. Similarly, as a sign of their involvement, the psychologist groups created and built into the script a psychologist character. The psychologist appeared as a model of identification. The situation of the doctor–patient relationship within the short story served as a stimulus that initiated their demand to live through experiences in direct actions and motions.

During the first meeting of the second phase, when they started to work on the literary text, all groups showed uncertainties about their professional identity. Group members gave accounts of feelings of loneliness, misunderstanding, defencelessness and uncertainty in the health care setting. They recalled personal stories about their existential insecurity as well as professional uncertainties. They all agreed that the story would happen in the same way today. They treated the story as an actual scenario happening here and now, and localized it into a provincial hospital's surgical department.

Script writing

In the second meeting of the second phase, we started script writing, to construct a full scenario consisting of several scenes. All groups created six scenes instead of the original three of the short story. Below we give examples from one medical student group's scenarios.

Scene 1. The day before entering the hospital.
The protagonist wakes up with colic pain. The previous night she had had an unsatisfying sexual intercourse with her husband. He is not really caring about her complaints though these kinds of mornings are quite frequent. Without any comments the husband leaves for his workplace. At this moment her mother calls the woman. The protagonist complains that her husband does not care about her at all. Following her mother's advice she calls the ambulance, preparing herself for a hospital stay; she also collects her make-up.

Scene 2. An elderly couple arrives at the hospital to visit their hospitalized granddaughter.
This scene was the favourite of the group. The two characters arrive at the reception desk hand in hand, asking kindly for the room number of their granddaughter. The group was generally touched by this. A typical comment: 'Affecting, heart-warming couple, showing a firm attitude, it is nice'.
Scene 3. A husband asks for information about his wife's operation from the head of the hospital department.
Frequent opinion among group members was that the scene represented a typical interaction between the doctor and the patient's relatives: 'The physician is rude, rhetorical, insensitive'. 'The physician is just focusing on how to get out from the interaction'. 'The husband is too weak, overly uncertain in the situation. He should have asked about some facts'. An interesting comment from a student: 'Basic health care knowledge should be incorporated into primary schools' curricula'.
Scene 4. After the operation.
In order to construct the scene after the operation, the group focused on the question: '*What might be in the woman's mind after waking up from anasthetic?*'. The group answered this question in a group monologue exercise, creating monologues like 'I feel alone. How do I look? I should put on make-up before my husband arrives', etc. Consequently, numerous self-experiences were intensively invoked, such as personal childhood experiences in hospital settings, e.g. tonsillectomy. Their experiences with secondary illness gain came to the fore.
Scene 5. The protagonist complains to her roommate about her relatives neglecting.
Group members regarded this scene as being rather lively. 'The roommate is a talkative, playful teenager who falls in love with her doctor. The two roommates are competing in attractiveness: who can win the doctor's attention?'
Scene 6. Back at home again.
The scene invokes rather pessimistic feelings regarding the woman's capacity to change her life. At this point, we applied the *Flash Forwards* technique from drama pedagogy, where students imagine the woman's life 1 day, 1 year and 10 years after the hospital events. A frequently emerged opinion among the groups was that her life would continue as usual, she would not change her life. Disputes with her husband would get more frequent, which leads to their divorce at the end.

Character construction

This third phase takes place in the sixth and seventh sessions. In the sixth session, the group should work out the details of their characters: age, occupation, diagnosis, external and internal characteristics.

After finishing the construction of their characters, we attempted to direct the group's focus on the relationship between the couple: 'What do you think is the most frequent and typical situation that most adequately describes their relationship?' Then, we moved on to an exercise called *Statue Building*, where each member chose a partner and built a statue representing the imagined relationship. Then we asked the 'couples' to tell directly to each other those sentences that have never been said in their relationship. Examples of these sentences from the patient (wife): '*You never pay any attention to me! Be a man! I often feel so lonely and you do not understand me!*'. On the husband's side we had the following sentences: '*Stop it, I cannot bear it any longer! What else could have I done? I just do not understand what is your problem with me!*'

According to our experiences with the groups this is emotionally a particularly demanding exercise. Thus, it is of utmost importance to pay enough attention to, and leave enough time at the end of these games to consider and discuss within the group all the emerging emotions and experiences of group members.

Our groups created quite similar characters, detailed in Tables 1 and 2. Comparing the characters constructed by the psychology students and the physicians in training groups, we found some interesting similarities. The age and personality features of the main characters were very similar, and also the imagined disease aetiology was described as psychosomatic by both groups; marital conflict was the main factor. Interestingly, diagnoses provided by medical students were less concrete and differentiated, whereas psychology students suggested quite concrete diagnoses. For all medical student groups, the character of the doctor was a person in his 50s, an authoritarian, achievement-oriented and tired man.

Casting and performing the play

Casting was done individually by group members, where everybody made remarks and suggestions for the person, who should play the characters that they had elaborated together. Suggestions were discussed for settling a final agreement on casting. The main characters should be played by several members (2–3) in order to see variations of the same setting. Everybody brought costumes, typical clothes corresponding to

Table 1. Characteristics of patient.

Medical students	Psychology students
33-year-old housewife	33–34 years old secretary
Egocentric	Unstable
Hysterical	Distrustful
Unhappy	Worried
Irritating	Negativistic
Unpleasant	Makes martyr of herself
Diagnosis: non-differentiated gynaecological problem	Diagnosis: gastric ulcer

Table 2. Characteristics of doctor.

Medical students	Psychology students
50-year-old man	45–48 years old woman
Wise	Determined
Formal	Helpful
Calm	Achievement-oriented
Lives only for work	Authoritarian
Disdainful	
Tired	

the characters and settings. Afterwards, students worked out the concrete dialogues in a concise style and the related nonverbal behaviours as well. At this stage, it seems advisable to leave enough space for spontaneity, as it might make visible and even malleable the students' interpersonal skills. At the final session, we brought the whole story on stage. The facilitator remained in the background, while the group functioned both as audience and actors of the play. At the end, the whole group became the audience, as they watched the video-recorded version of their full play. This was a cathartic experience for all participants.

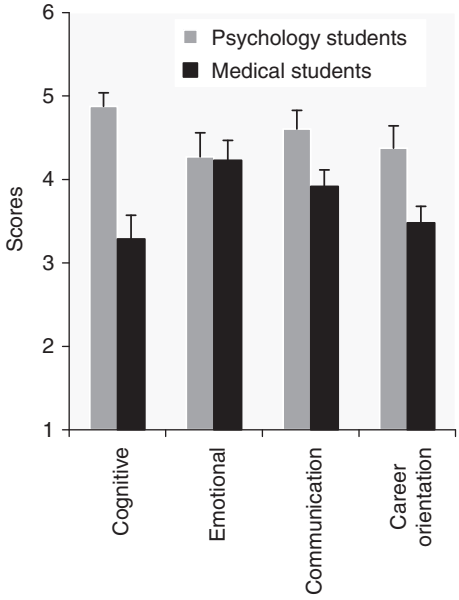

Figure 1. Expectations of medical ($n=46$) and psychology ($n=24$) students before the training measured in four dimensions on a 6-point Likert scale.

As we can see in Figure 1, medical students' overall expectations were lower than psychology majors. It may reflect the fact that medical students, being relatively unfamiliar with such a type of interactive course, had a more sceptical attitude. At the same time, it is remarkable that their expectations were the lowest in the cognitive, and the highest in the emotional dimension, which suggests that they might be overloaded by the (cognitive) curriculum, and missed the emotional, more 'humane' part of education.

The questionnaire which was taken at the end of the course can also prove that our educational method can help mainly professional socialization of medical students, but it can be effective in solving their emotional and communication problems as well (Figure 2).

Conclusion

According to our first experiences, the training provides its effects on two levels. It has an impact on a declarative, conscious, verbal level ('What I do, what I say'), and also on a more indirect, interpersonal level (How I do, whom I tell it). The latter is more significant in our case, because the improvement of nonverbal skills and the meaning construction/meaning interpretation capacity are equally important requirements in the everyday work of the healing professionals (Argelander 1976).

The performative action is a significant moment in the developmental process of professional interpersonal skills because it opens a space of engagement equally determined by the doctor's and the patient's role and also creates a perspective for recognizing other students' role play and enables self-reflections. Thus, group participation ensures that students receive continuous feedback from others about their behavioural acts, as constitutive elements of the therapeutic role-set. Considering the various recorded scenes, the feedback from 'the patient', and the continuous comments from

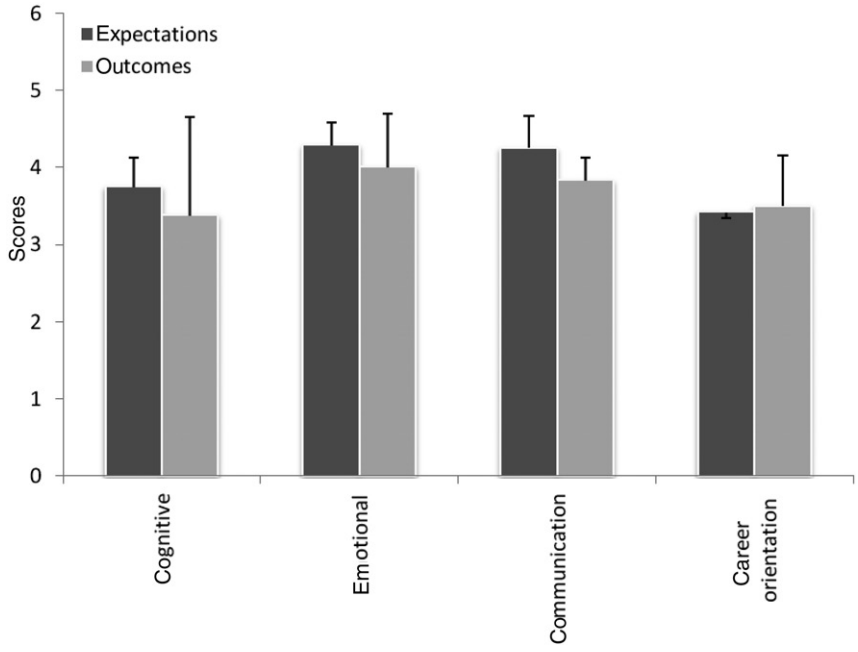

Figure 2. Comparison of medical students' ($n=46$) expectations and outcomes in four dimensions on a 6-point Likert scale.

others, all serve to improve participants' self-knowledge and the development of their emphatic skills.

One of the main advantages of this type of training compared to other educational methods is that neither the illness nor the therapeutic relationship appears as isolated entities, but in their complexity, as they are embedded in their 'natural' environment. The history of the patient, the illness and the relationship evolves in front of the students. It helps the students to understand that all symptoms and patient behaviours have their antecedents and meaning in the patient's life history, which is on the other hand connected to the interaction network of other people. They can also learn through their lived experiences that the therapeutic relationship also has a history, dynamics and an interpersonal context.

Through talking about the characters and playing the roles, distancing is possible which enables students to speak about their own problems and act out feelings in the name of the characters. In this way, self-experience of different roles and anxiety-free identification becomes possible which can also strengthen the empathic skills of patients. The fact that own feelings are integrated in action may also have beneficial effects on the elaboration of hidden conflicts and anxieties about professional identity. It may help students to prevent early burn-out, and support a more confident and healthy way of professional socialization.

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