

# ROLE-PLAY AS A TEACHING METHODOLOGY

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## INTRODUCTION

Within language teaching, it is probably fair to say that role-play is used relatively little and that where it is used it is considered essentially as a fun activity, and one which has psychological and tactical benefits — Friday afternoon's reward for a good week's work — as well as having the additional virtue and justification that it offers practice in the development of fluency. It is probably also fair to say that it is almost always centred on language, perhaps particularly on highly constrained bits of language — such as handling basic service encounters; buying a ticket at a train station and so forth — and very seldom attempts to go beyond language to look in any detail at the dynamics of the situation which underpins it.

Role-play as a technique is, however, potentially very much richer than this. Treating it merely as a way of breaking up the lesson and cementing bonds between the students as they share the endeavour, or as a resource for fluency as students discover that they can indeed master the strings of alien sounds and words which are required of them is a mistake. To limit it by restricting it to the study and practice of language alone, is to miss opportunities. It is at its most powerful when it is concerned with realistic, serious, complex and ambivalent professional situations. This paper reports on role-play work of this latter kind undertaken at the University of Birmingham Medical School, and proposes procedures for its successful implementation in other environments.

## ROLE-PLAY AT BIRMINGHAM UNIVERSITY MEDICAL SCHOOL

All medical undergraduates at the University of Birmingham undertake role-play work, whose main emphasis is on consultation skills, in four of the five years of their undergraduate career. For this work, students are typically divided into very small groups of around four with each student role-playing the part of the doctor and consulting with a professional role-player who takes the part of the patient. Role-plays last about 10 minutes — real consultations in UK last on average 6-8 minutes — and the subsequent feedback about a further 20 minutes. Thus a group of four will attempt one and observe three role-plays in the space of 2 hours or so. The student role-plays the consultation in full (it is not broken down into its constituent elements) and feedback is designed primarily to invite reflection on the attitudinal principles involved, and

thus from the particular example build up inductively to general statements. Feedback is free ranging, typically led either by the role-player patient or more usually by a facilitator who is a member of staff.

Some people who use medical role play follow what are known as «Pendleton's Rules», a somewhat stilted but very courteous way of ensuring that feedback is supportive rather than destructive. These rules are listed at Appendix 1. Our experience is that it is very much better to create a friendly and supportive environment beforehand, one in which the rules would be seen as paying a laughably over-elaborate amount of attention to people's feelings. However, there is no doubt that if students find the experience daunting, or do not know each other well, there is a lot to be said for a more formal procedure. (Note that almost all of these students are native speakers of English. The detailed procedure outlined below is an adaptation of the methodology we use for a non-native speaker environment). Each student will attempt between two and six role-plays per year. This perhaps does not look like many, but role-play is an extremely powerful resource which is best used sparingly: and students will have the opportunity to watch classmates undertake three to four times as many.

Finally in this section, a word about our role-players. We have built up a group of about 30 of all ages from 6 months to 75 years, who come from all walks of life. Many are professional actors, others have a background in health services or in counselling or are merely patients who want to assist in the process of medical education. Actors who are at the prima donna end of the spectrum are useless, principally because they insist on acting. Our golden rule is «whatever you do, don't act». A great deal of acting is about making a judicious and deliberate choice of emotions to show an audience, rather than simply letting things happen: and actors, trained to learn and repeat a script, do not always have the first rate improvisational skills which this kind of work demands. Moreover actors are trained not to interrupt each other, and this can give an extremely false «feel» to the interaction.

The other skill which is of vital importance to the role-player is an ability to offer articulate and intelligent feedback. All our role-players attend training sessions, sit in on other role-players and work with the video material which is available as a preparation for their work with us. Our experience is that it is easy to recruit role-players if the working environment is right. If there is an environment where significant and often powerful interactions are taking place people will volunteer their services. However, if you have any funds available to support an activity of this kind, it is best to spend it on role-players of the highest quality.

The central ethos of the work we undertake is to offer undergraduates an opportunity to practise in a safe environment and in difficult circumstances, skills which they will need to have as part of their professional life, and also to offer them the opportunity to introspect and reflect in some depth and with some subtlety on the professional role of the doctor as it pertains to the particular scenarios which they are undertaking.

## **SURFACE SKILLS**

We make an important distinction between surface skills and the deeper attitudes which they reflect. Unusually for role-play work in medical education, and in ELT, we focus most of our attention on attitudinal issues such as are described below, and work on surface skills only insofar as they are a resource for expressing appropriate attitude. We concentrate therefore on helping students to select and deploy surface skills, as a way of doing this, rather than as ends in themselves.

We try to develop therefore a flexible range of consultation styles with respect to such matters as relative formality or informality, depending on what is perceived as appropriate for the patient. Thus, to take an evidently necessary example, we invite students to make choices about the cognitive level at which explanations should be pitched, and the words in which they should be realised — how far can patients from different backgrounds make sense of technical lexis, for instance. To some extent it is clearly possible to localise these styles in surface phenomena; thus we encourage students to reflect on the use they make of their posture — do they echo that of their patient, say — their position relative to the patient (near or distant, behind a desk or side by side, etc.), eye contact and so forth. At the language level we invite native speakers to reflect on their use of key terms. Some of these are obvious — uses of words like «dead», or «die»; words associated with cancer such as «abnormal cells», «lump», «growth», «tumour», «cancer», and the like. Some areas here, such as expressions of doubt, certainty and worry are less obvious but repay consideration as well.

For such language matters we are able to draw on the data base of over one million words of real doctor/patient consultations which the Department of General Practice has built up over the last two years. Thus, unsurprisingly perhaps, we have no examples in the database of a doctor using a word like «death», «die», «dying» directly to a patient. Less predictably, because doctors very rarely declare themselves to be «worried» about patients, a phrase like «I'm a bit worried about .....» strikes with great force.

## ATTITUDE

This type of analysis, however, and the sort of analysis which considers such matters as eye contact and body language, seem to us to be of relevance only in so far as they mirror or fail to mirror the attitudinal base from which the student is working. Our role play activity exists to put some pressure on the student's attitudes about his/her profession and patients. Thus, is the student's ethical base sound? Does she/he have an appropriately humanistic attitude towards patients? Is there evidence that the patient is being treated at the psychological and social as well as at the biomedical level? We have very little evidence of a deficit at the level of skills occurring where attitudes are broadly right.

Role-plays are developed with an eye to a number of different kinds of difficulty. They may be ethically difficult, that is, they may present the doctor with an ethical dilemma to which there may or may not be a solution, to where the doctor's ethical principles are likely to be at variance with, or disgusted by, those of the patient. (Scenario 1 in Appendix 2 is an example). Some of the scenarios are *experientially* difficult — most medical students are young and middle class and have little experience of dealing for example, with the elderly and the poor (Scenario 2) and some scenarios are *psychologically* difficult, that is psychologically difficult for the student (Scenario 3) — and so on.

## A POSSIBLE PROCEDURE FOR THE ESP CLASSROOM

(Note: a summary of «Rules for Successful Role-play» is at Appendix 3).

This procedure is designed for use in classes at a broadly intermediate or better level of English who have a good reason — typically a well defined professional aim — for undertaking role-play. It should be remembered that role-play has the power to be a very emotive and

challenging resource and it is probably best to use it occasionally. If the additional difficulties of funding such a course arise, and of finding sufficient space to run small groups concurrently, then it can be used profitably as little as once a year. It is not, however, an «end of term» activity. If it is to be done well, it must be prepared properly and carried through with conviction.

It will be seen that the procedure outlined breaks down into seven Tasks. All of these tasks, except the role-play itself, may appropriately be undertaken in the native language. Many can therefore, if preferred, be given as homework so that classroom contact time is reserved for the target language.

### **Task 1**

In class, or prior to class, a number of different potential scenarios are read. The teacher will have the situation very briefly outlined — not more than 8 to 10 lines and perhaps less — and the class will discuss, either together or in small groups, which scenario or scenarios they wish to attempt. The written description may well be in English, but the group discussion, except with very advanced students, is probably better done in the native language. The purpose of this task is to focus the students' mind not only on personal preferences, but on identifying relevance for their particular situation, and also identifying what each scenario is really «about». In particular, what set of attitudes will it require of them?

### **Task 2**

If small groups have not already been assigned, they should be assigned now. 4 to 6 is ideal but larger groups work well. It is the task of the group at this stage to identify a *group leader* whose function will be to collate and report back on the experiences of the group. The group should also identify who will undertake the scenario or scenarios. In addition, if no professional role-player is available, the group should also identify who is to undertake the lay role(s). As with the previous task this one, which will last only 1-2 minutes, may well be undertaken in the native language.

### **Task 3**

Each small group will identify what additional information they need — additional, that is, to the teacher's brief written description mentioned above — in order to carry out the role-play. This may lead to the teacher being asked questions about the scenario, and the rule of the game here is that once the teacher has declared something to be the case, it is the case. Experience suggests that it is better to handle the question of information in this way, rather than by providing an entirely exhaustive scenario beforehand, of a complexity which will tax the student's memory. Moreover the effort of identifying what additional information is necessary is a way of helping the student to separate the important from the trivial. Once more, a native language task.

### **Task 4**

Also in the native language, except with very advanced groups, all those playing the same professional role from different groups should meet, and (as appropriate) all those playing the

same lay role should meet either together or together with the teacher to identify the language they need to express the attitudes they wish to convey. Thus for example, if the role play is about a complaint, «lay» students will want to focus on the language of anger, the «professional» students will want to focus on the language of conciliation and negotiation: or so one would hope.

### **Task 5**

This task is the role-play. A role-play should not last more than 10 minutes unless it is going extremely well and profitably for the whole group. This means that scenarios will be chosen which will run their natural course within this period of time. As far as medicine is concerned, there is the advantage mentioned above, that the normal length of the consultation in the UK is around 6 to 8 minutes. The more difficult scenarios that we offer naturally take somewhat longer, but not a great deal longer. Remember that the scenario should be designed to be short in its execution, but inexhaustible in its potential for feedback.

It is much better, because more authentic, to run the role-play through from beginning to end without interruptions to correct language or for any other reason. If a student makes a clear mistake, giving the wrong piece of information, for example — she/he is not allowed to stop the role-play and return to a point before the mistake is made. Students must dig themselves out of holes of their own creation. However, where the class has limited English, it may be advisable to break the role-play down further into constituent parts, probably functionally labelled, such as «Greeting», «Statement of Problem», etc.

### **Task 6**

The group leader will now lead the feedback session. Group leaders are ideally self-selecting, but the teacher will be well advised to keep an eye on the level of tact which particular individuals are capable of mastering. It is not the group leader's task to offer feedback, rather to invite and explore feedback from other people. Feedback must be broadly supportive, but at the same time truthful. We have found that students are almost never destructive. If they are well briefed before the start of this sort of activity, they will understand both the need for a positive approach and also how devastating a criticism can be. Once more, one would expect this activity to take place in the native language.

### **Task 7**

The group leader should now report back to the class in either English or the native language.

It is obvious that the time taken for each task and the amount of time spent in the native language will vary from situation to situation as teacher and student preferences dictate.

Finally, role-play is part of the general movement towards reflective and independent learning. It is absolutely essential, therefore, that all the students involved should have a very clear and explicit idea of the purposes of the role-play activity. They should clearly understand that it is serious, and that the focus of attention is on the attitudes they display.



### Appendix 1

«Pendleton's Rules» are named for David Pendleton, a major figure in doctor-patient communication during the 1980s. In fact they echo rules common in other spheres.

It is better if an environment can be created which makes these rules unnecessary — they can easily make feedback stilted and vacuous. However, they are worth bearing in mind if you fear problems.

- Participant says «what was done well», then
- Observers say «what was done well», then
- Participant says «what could have been done differently», then
- Observers say «what could have been done differently»

### Appendix 2

#### A LONELY ALCOHOLIC WOMAN

##### Notes for Participant

You are a GP trainee, on your first day in the practice. Your next patient is Vera Wallace. She is registered with the practice but to your annoyance, you note that the receptionists have been unable to find her notes. There is no computer, either.

##### Notes for Role-player

You are Vera Wallace, a 72 year old unhappily married alcoholic. You have come to the surgery today because it's on the way to Safeways and you fancy a chat. Besides, you've heard that there's a new young doctor down there and you want to check him/her out. You attend the surgery for all sorts of minor ailments, but generally because you're not happy with your lot. The staff know you well, and have developed the knack of gently humouring you when you're feeling belligerent. However, this new doctor may not know quite how to take you.

Today, you've been at the vodka all morning. Don't be too OTT but let the student know you are under the influence of alcohol. Your main problem is headaches (almost certainly alcohol induced) — you have been coming to the doctors for years with these, and even managed to get a brain scan two years ago (it was normal). The student will be told that your notes have been lost, and so will not know this. Why not ask for another brain scan? Your other problems are that your husband keeps accusing you of «things». Don't be more specific and perhaps get a bit stropky if he/she tries to pin you down as to what these things are. You also feel tired all the time and want a tonic; be as vague and confused as you like.

The student may want to end the consultation by examining you next door. Don't let him opt out too early — «While I'm here doctor etc». In a sense, you are controlling this consultation, which may make the student feel quite uncomfortable.

#### SUSPECTED CHILD ABUSE

##### Notes for the Participant

You are a child psychiatrist. An 8 year old girl, Melanie Bloxom, has been referred to you with a six-month history of nocturnal enuresis and behavioural difficulties which include physical/verbal aggression, disobedience and stealing, and a deterioration in her school performance.

The social services have recently become involved as the GP strongly suspects the father of child sexual abuse, although there hasn't been a disclosure of this to him, George Bloxom, who you will be seeing today.

You were hoping that Melanie would attend the appointment too with her father, but apparently she is ill and has stayed at home with her mother. Your task is to assess whether any sexual abuse has indeed been going on, and to try to arrange a future appointment to see Melanie herself.

##### Notes for Role-player

You are Mr. George Bloxom, a 30 year old businessman. Your daughter Melanie aged 8 years has been referred to the child psychiatry services with [a six month history of] behavioural difficulties, e.g. aggression, stealing, disobedience, nocturnal enuresis (bedwetting) and a deterioration of her school performance. Melanie was supposed to attend with you today, but you've told them that she is 'ill and at home with her mother'.

Your GP has also contacted social services about the case because he strongly suspects child sexual abuse. You aren't aware of this but you have indeed been sexually abusing your daughter. You attend the appointment to see

the child psychiatrist thinking that you are just going to be discussing your daughter's development and school and why she's not getting on very well and why she's behaving badly, but the child psychiatrist will be aware of your GP's suspicion of sexual abuse, and so she/he is likely to take a history probing into these matters.

When she/he does you will get very upset/angry, as well as very defensive. You will go into the 'attack' as it were asking the psychiatrist what the hell right she/he has asking you this type of question. Get quite terse and angry — refuse to answer anything that you think is of a personal nature about your relationship with Melanie. Actually question the qualifications and experience of the psychiatrist: threaten to report him to her, threaten to call the police, take it to court, in fact anything you like, but DON'T give in or admit to abusing your daughter. The scenario may well end with you storming out or getting very angry or shifting the conversation onto the child and refusing to talk about yourself at all.

### BREAST CANCER

#### Notes for the participant

Mary Spencer is 32, married with two young children. Six months ago she found a lump in her breast and went to her GP.

The GP told her it was probably nothing to worry about, but asked her to keep an eye on things and to return two months later. She did this, and on her return was referred for tests. These showed a negative FNA and mammogram, and her surgeon, Mr Symonds, also advised her that there was «probably nothing too serious happening». It was therefore a further three months before she returned to the hospital, during which time her lump increased in size. This time the FNA and mammogram were positive.

She therefore had, ten days later, a wide local excision of a poorly differentiated tumour, 3.5cms in size.

At present, 5/10 nodes are positive, and all staging investigations are clear.

Mrs Spencer has now been referred to you for her future management. You have spoken to Mr Symonds, who has warned you that she is extremely bitter about the delay in her treatment, and what she perceives as the false reassurance she was given.

#### Notes for role-player

You are Mary Spencer, aged 32, married with two young children, aged 7 and 5. You are a secretary.

You discovered a lump in your breast six months ago and immediately went to see your GP. You take health issues seriously, particularly since the birth of your children, and were anxious to have things attended to as soon as possible. Your GP however told you that there was nothing to worry about. He suggested you «keep an eye on things» and return in any case two months later.

You did this, and were referred to the hospital, where you spoke to a surgeon, Mr Symonds. He did a fine needle aspiration and a mammogram, which were negative, and appeared to feel you had no need to concern yourself. You had been quite anxious until this stage, but Mr Symonds' words and manner put you very much at ease.

You went back to the hospital three months later, aware that the lump had grown a little in the interim but still not unduly worried. When your tests were repeated, however, they were positive. This was a considerable shock to you, and the first time you considered the possibility that you were very ill.

Ten days later, you had an operation to remove the lump, and you understand that the operation itself was successful. You were advised that your breast would therefore look a little different following the operation, as would your upper arm. You have since been told that «all the diseased tissue has been taken out, and there's no evidence of any disease anywhere else».

You have now been referred to see an oncologist to discuss the next step. You are very angry with the time delays that you have faced, and the false reassurance you were given.

You have a great many questions which need answering — both «Why has this happened?» and «What are my chances?»

### Appendix 3

#### RULES FOR SUCCESSFUL ROLE PLAY

- 1) Take it seriously or don't do it.
- 2) Whatever you do, don't act
- 3) If you have any funds, spend them on recruiting role-players
- 4) Role plays are about solving problems, not just using language
- 5) be careful with feedback

