Using actors as simulated patients in psychiatry

1 WHY SIMULATION?

There are a number of issues in using 'real' patients for training in psychiatry. It is difficult to encourage trainees to experiment and allow themselves to fail, especially in talking about sensitive issues such as traumagenic events, when the sensitivity is genuine. It can be burdensome to get permission to record patients: all recordings technically become part of the medical record and subject to very tight regulations about access, storage and disposal of the recordings. When working across different trusts with different policies on recordings and different Caldicott guardians, this can be a formidable obstacle.

In contrast, simulation allows a robust approach to experimentation: we explicitly encourage trainees to try things out 'because you're not going to break the actors'. Recordings are not subject to regulation as medical records and can be used much more freely.

2 STANDARDISATION OR SIMULATION?

Standardised patient scenarios are very tightly scripted and may have particular cues to be hit at particular points. The scenario is usually designed to run within strict time parameters. These types of scenarios are often associated with assessment of one type or another, for example exams or appointment interviews. They tend to run to the end whatever happens. In these kinds of situations reproducibility is important so that each candidate is getting a very similar experience, in order that the assessment is fair. These types of scenarios can sometimes lose some realism in the service of standardisation.

Simulated patient scenarios are less tightly scripted. Improvisation within the bounds of the script is permissible or encouraged; the trainees are sometimes allowed to stop and start the process if they don't understand something or feel they wish to 'rewind' a mistake. Sometimes the facilitator may ask the actor to 'turn the volume up or down' on a particular facet of their delivery to match the need of the individual trainee. In this kind of scenario, realism is more important than standardisation. The encounter is not about assessment: experimentation and mistakes are encouraged, with the aim of the training being for the trainee to maximise their learning.

Be clear before you plan your course whether you are using standardised or simulated patients, as the needs of the actors will be different and they will need different kinds of brief from you. Your actors may also need the distinction drawing as they may have had experience in one or other set up. These notes refer primarily to simulated patients.

3 WRITING SIMULATIONS

A balance needs to be struck between the actors' needs and the trainees needs.

The trainee needs the scenario to be realistic. This immediately closes off some scenarios that are difficult or impossible to play accurately. We think that most organic and most psychotic illnesses fall into this category, and so tend to avoid these diagnoses. What trainees often need to practice is emotional responsiveness - picking up on small verbal or non verbal cues in the interview.

Actors can be very good at providing these non-verbal cues if they are (a) given enough material to work off and (b) encouraged to improvise within the envelope of the scenario. In giving actors enough to work off, it is helpful to give them clear dilemmas in the scenario to allow multiple emotions, hard choices between courses of action reflecting different virtues, or out-and-out ambivalence.

Actors can generally fill in the blanks when the patient scenario is close to normal human experience (e.g. feeling anxious) but may need more detail about things that a lay person would not normally know (e.g. a history of unpleasant medication side effects may need to describe the side effects precisely).

Individual trainees within groups usually have very different learning needs and it is helpful if the scenario can incorporate some flex to allow the level of challenge to be increased or decreased. For example, one of our early scenarios is with the wife of a man with dementia thinking through whether to continue to look after him at home or whether to admit him to a nursing home. The scenario has the option (when directed by the facilitator) to add in that her husband has been violent towards her to the extent that she could be considered a vulnerable adult.

4 BRIEFING ACTORS

We suggest getting your scenarios to the acting agency in good time, particularly if the scenario is potentially emotionally difficult for the actor. We now also send some generic briefing notes (see appendix) with our

specific scenarios. We also ask actors to sign a release for recording. This is quite broad and permits us to use the recordings for audit and to generate teaching materials.

We ask our actors to arrive in good time before the teaching session is due to start to check in with them and make sure they understand what the key points are. We usually remind them that the individuals in the groups have different individual learning needs: we use the metaphor of 'turning the volume up or down' on aspects of the scenario for different trainees.

In simulation, it is important to give the actor permission to improvise. For facilitators, this is sometimes about letting go and having faith in the actor's ability and professionalism. We have sometimes been surprised by the direction that actors have taken but have not yet had actors take things in completely inappropriate directions. We suggest giving the actor explicit permission (and a plan) for more extreme actions e.g. saying if they feel like they would have walked out, to walk out, and to come straight back in for a debrief assuming that the scenario has ended.

5 DEBRIEFING ACTORS

There are two components to debriefing actors, debriefing to de-rôle and debriefing for trainee learning.

Actors are usually practised at de-rôling themselves, and may take precautionary steps to separate themselves from the characters they play such as items of costume symbolically different from their normal clothes. We have not usually needed to spend much time on this type of debriefing and have learned to trust the actors abilities in this aspect of their work. One of our scenarios has a paedophile character: we had a brief discussion with one actor about his feeling torn between a professional desire to be convincing and a revulsion about seeming a convincing paedophile. We do suggest to actors that if anything has been stirred up for them that we are available for a debrief, but we have not so far had this offer taken up.

Debriefing actors for trainee learning can be challenging. Kurtz *et al.* (2005) suggests asking actors to debrief 'in rôle, in neutral': i.e. the actor could say 'I was upset when you said x' but would let go of the feeling of upset before the debrief. Actors can give very useful feedback but this usually needs to be explicitly directed so that the feedback they give is within their area of expertise. General questions such as 'how do you think that went?' will often elicit rather general (and not very useful) answers. Specific questions such as 'what was going through your mind at that point?' can be helpful for the trainee to identify why a particular intervention worked or didn't work.

As part of the general debrief with the trainees, it is sometimes helpful to discuss the artifice in the simulation and in particular the difference with daily practice, with questions such as 'how was this different to the patients you see at work generally? How would you behave differently if this was for real?'

Notes for actors

SIMULATION

Research and feedback from trainees suggests there are some key differences between how simulated patients *vs*. real patients and doctors respond to each other. Some of these differences are to do with the situation: in a simulation, trainee doctors are often less stressed and have more time. This can lead to the situation where they use better interview technique in simulation than they use at work - i.e. lessons aren't generalised from the simulation to the workplace.

Some of the differences are to do with the way actors respond. In particular, it may be that some aspects of actor training work against accurate simulation. These notes are our attempt to unpick what we see as some key areas where this is the case.

STANDARDISATION OR SIMULATION?

Actors are used to play patients in broadly two types of scenario. Standardised patient scenarios are very tightly scripted and may have particular cues to be hit at particular points. The scenario is usually designed to run within strict time parameters. These types of scenarios are often associated with assessment of one type or another, for example exams or appointment interviews. They tend to run to the end whatever happens. In these kinds of situations reproducibility is important so that each candidate is getting a very similar experience, in order that the assessment is fair. These types of scenarios can sometimes lose some realism in the service of standardisation.

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In the Severn Deanery core training sessions, we aim for the second type of encounter, simulation. We are happy to take feedback from actors on any aspect of the brief that they think would make for a more realistic scenario for the trainees, and we actively encourage improvisation within the broad envelope of the scenario.

SOME PRACTICE NOTES

Silence and pauses

In real life, many people find silence in conversation quite difficult to tolerate and will speak to try to fill it. Leaving gaps or silences is a legitimate technique for psychiatrists as patients will often bring out important information following a silence.

Actors are often very comfortable with silence, possibly because in many forms of drama silence and pauses are an essential part of the pace and rhythm of a script: tolerating an unnatural silence has become second nature. Trainees sometimes observe that with simulated patients 'pauses don't work'.

Recommendation: try to re-find the awkwardness that most people have with silences and use this as a motivation to speak.

Power

In real life, there is often a power dynamic in medical consultations where the doctor 'holds all the cards'. Typically medical consultations are on the doctor's territory and on the doctor's terms. This is invariably unhelpful and patients can sometimes push back against this either actively or (more commonly) passively by agreeing with the doctor even when they either doubt what they have been told or have no intention of following the prescription offered. An important part of the training we are offering is to teach our trainees to lose the habit of speaking down to patients and instead for the doctor to do the work of levelling the relationship to one of equals. In real life, this is sometimes difficult because patients may have had many unsatisfactory consultations and bring powerful expectations that the current consultation won't be any different.

Actors providing training often come to teaching sessions with a very high degree of expertise in communication, albeit learned in a different field. In some aspects of communication they have a higher sensitivity to particular issues and a better vocabulary for describing them than the medical experts in the room. The trainees pick up on this and often tacitly treat the actors as faculty - like lecturers with power over them. This can change the power dynamic in the consultation such that it becomes less realistic.

Recommendation: (1) as a default approach, try to re-find the unpleasant feeling of being talked down to. Go into the interview alert to anything that makes you feel patronised, infantilised or dis-empowered and work off that feeling. If the doctor does talk to you as an equal and takes your concerns seriously, allow the expectation of condescension to slowly evaporate (2) give your feedback in role so that your own expertise is 'worn lightly'.

Questions
Perhaps related to the issue of power, recordings of consultations with real and standardised patients suggest that standardised patients are more free in asking questions. In real life patients are often intimidated by doctors and find it difficult to ask even questions they are burning to ask. The most important questions are also often mixed in with feelings of shame in one way or another and are difficult to ask even of a sensitive listener. A very common experience is the 'hand on the doorknob' phenomenon when the patient only plucks up the courage to ask a crucial question when he or she is practically out of the room and knows that it is their last chance.

It is the doctor's responsibility to find a way to make it easy for patients to ask questions.

Recommendation: consider whether shame is part of the dynamic for questions your character might want to ask and work off that feeling. If you feel uncomfortable about asking questions, don't ask them, but give this as feedback at the end of the role play.

Coherence
Feedback from trainees suggests that one of the differences between real and simulated patients is the clarity and coherence of how they tell their story. There are several possible reasons for this: the scenarios we have written are generally coherent stories. In addition, from the perspective of an actor, clarity is a distinct and desirable skill, and for skilled performers, may be something that has become trained and engrained into practice.

On the patient side, patients often seem incoherent in telling their stories for a variety of reasons: they may be anxious and dot around in their effort to get everything in; they may have difficulties making sense of what might seem to them to be a constellation of unrelated problems; they may have an explanation for their difficulties which is at odds with the doctors beliefs (sometimes patients fill in what they don't know with what can seem to others eccentric health beliefs, to which they become very attached, so their story has a coherence that isn't immediately visible to the doctor); or sometimes their condition can directly affect their ability to tell a clear, engaging and linear story. For example, people who have been sexually abused in childhood often don't develop a reliable 'safety compass' in interpersonal relationships and can misread cues. They may be highly sensitive to ambiguities, reading them as potential threats. Shame may lead them to pass over important aspects of their story, or even to be economical with the truth to protect their own sensitivities or self image.

Recommendation: consider looking for the parts of your brief that you might find puzzling or that don't make sense and work off that feeling. Consider how your character might respond to ambiguous communication from the doctor: in what direction are they likely to take unclear meanings?

Extremes
Some scenarios can run through to extreme endings. Sometimes actors will pull back from the extremes to 'keep the action on stage', as they might in a theatrical improvisation situation.

Recommendation: if your character is angry enough to storm out of the room, go for it! Come straight back in assuming the role play if over. Similarly, if the character would hit the doctor, raise your arm then end the role play.

DEBRIEFING

Some of the scenarios we give out involve situations which may connect with difficult or traumatic events in the actors life. If you finish the afternoon needing to debrief in any way or need a moment to put away particular thoughts, feelings or memories, let us know. If you need pointers for where you could talk about issues on an ongoing basis, let us know.