PUMA-project
Failing in a safe learning environment - using theatre pedagogy to prepare junior doctors for difficult patient encounters

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Background

Difficult patient encounters due to communication problems are a common source of frustration in clinical medical work [(1)] [(2)]. Often, the challenges are due to different models of understanding health and disease or disparate value systems between patients and caregivers. These differences in turn may be related to differences in socioeconomic class, level of education, culture and religion. Another important cause is termed cognitive bias. This occurs when the caregiver's prejudices are activated, leading to unfounded assumptions regarding patients and their disease presentation.

An interesting venue of research has explored the value clashes that can arise when healthcare providers are expected – in the case of the Swedish healthcare system, explicitly so – to strive for an inclusive diversity where different or opposing values from the patient are expected to be tolerated. But because the caregivers also must follow directives to strengthen certain ideals, such as equality [(3)], these ambitions (diversity and equality) may in certain difficult patient encounters be in direct contradiction, leading to caregiver ethical stress. Ethical stress is defined as the reaction of a caregiver to a situation where it is impossible for her, due to external circumstances, to follow their inner 'moral compass' [(4)]. Common examples are when resources are not enough for optimal care (eg. caring for too many patients, lack of in-patient beds, long waiting times for appointments or surgeries) or, as in this case, when organizational demands (eg. strive for promoting equality) collide with conditions 'on the floor'. This is a very relevant topic to explore, considering the growing rates of work-related mental health problems and burnout among healthcare providers.

Difficult patient encounters and burnout

One of the cardinal signs of burnout is lack of empathy and projection of negative feelings onto patients. A legitimate medical concern, for example a patient complaining of recurrent pain, may be interpreted as a faulty character ("they just want pain medications/sick leave"). Likewise, a patient bursting into tears during the consultation may be implicitly characterized as "whimpy" or "manipulative", instead of eliciting expected empathetic responses. These negative caregiver reactions are even more pronounced in difficult patient encounters. This may, as burnout worsens,

spiral into feelings of guilt and a sense of professional or even personal failure for harboring these inappropriate feelings as a caregiver [(5)] [(6)]. This further deepens the moral injury for each difficult patient meeting. Discontented patients, who sense the lack of empathy, may be labeled by struggling caregivers as 'difficult patients', when in fact a grievance lies at the bottom of their discontent, which could have been addressed at an earlier stage. Reflective training on ones own feelings and supervised training in handling difficult encounters may thus alleviate and prevent burnout. However, these skills are not easily learned from textbooks or lectures, as they are more practical than theoretical in nature. Instead, an authentic case-based simulation training may be a valuable method to address this, but has not been studied sufficiently [(7)] [(8)].

The current model of 'cultural' communication and our suggestion

In contrast to the dearth of studies on simulation training in handling difficult patient encounters, there has been a large number of educational efforts, often in the shape of seminars or theme days, to address 'cultural' communication problems. Common terminology for addressing the challenges are 'intercultural competency', 'intercultural communication' and 'culture-sensitive communication' [(9)]. This discourse usually presents migrants and foreign-born patients as the major groups in need of this kind of communication. The terminology implies that the problems mainly lie in differences in culture, a concept difficult to define but in common usage often meaning ethnicity or country of origin [(10)]. This narrative may cause stereotypes of certain patient groups as in need of help or special communication solely based on their ethnicity or native country, which may overshadow the patients' individual needs [(11)]. Using analytical tools from the social sciences, such as WPR (What's the problem represented to be) [(12)], we can address the fundamental problem formulation ('it is part of their culture'), questioning the presumptions behind it rather than regarding the narrative as truth, in an objective sense.

In contrast, our starting point has been that other factors than culture (in the narrow sense of ethnicity or nationality) play a greater role in communication breakdown. Focusing on culture and culture-sensitive communication – while supposedly in the spirit of tolerance and diversity – runs the risk of presenting culture as the defining characteristic of people. Paradoxically, tolerance can lead to intolerant actions, as the notable sociologist Zygmunt Bauman proposed [(13)]. Culture can be labeled as something dichotomous and static, rather than a dynamic phenomenon with many nuances – even more so in the migrant populations of the world whom often belong to several cultures at once. Culture-sensitive communication, in turn, is often reduced to a checklist with certain questions that should be asked when a patient of a certain background is encountered [(10)]. This procedural approach to

communication risks alienating patients and creating an “us vs them”-understanding of other people.

The real danger lies in the fact that we as providers are made to believe that we represent a neutral, objective and (natural) scientific worldview, untainted by cultural expressions and subjective values. This often makes us blind to our own culture, but using a social constructivist approach, we can realize that our understanding of reality and normality shapes how we interact with people.

Modern medical culture

Modern-day medicine, as taught by Anglo-Saxon universities, is heavily based on the Cartesian dichotomy between body and mind. This concept played a crucial role in advancing scientific studies of the human body without enraging the church (until then, cadaver dissection were seen as sacrilege) in 17th century Europe [(14)]. Its influence has remained a powerful influence on how doctors view disease, setting an expectation that every ailment has a demonstrable cause.

However, in today’s medical practice, where many patients express symptoms of stress and lifestyle-related issues, a more holistic approach is often needed. Patients, as well as caregivers, may be frustrated when the examination cannot pinpoint a biochemical, verifiable cause for the symptoms (preferably with objective means such as blood tests or radiology). Further frustration can be evoked if any suggestion is made that the bodily symptoms may be caused by ailments of the soul – whether it be stress, partner violence or previous traumatic experiences. Our reliance on the natural sciences, whilst phenomenally fruitful when it comes to discernible organic disease, are an Achilles heel when it comes to ‘diseases of the soul’ – which are the area of the social sciences and the humanities. Interestingly, in many parts of the world this Cartesian division of body and mind does not exist.

More specifically, Swedish medical culture tends to be rationalistic, which sometimes causes its own sets of problems. Our rationalistic way of prescribing diagnostic tests and workups may clash with the patients’ thinking and values. For instance, not ordering any diagnostic tests (usually because the presenting symptoms are expected to resolve spontaneously) may be received by patients with great disappointment and is a common source of conflict in everyday clinical work. It is often seen by patients as their doctor ‘not believing’ in the severity of their symptoms, or more generally, a lack of caring. In contrast, many providers strive to avoid tests and medicines, knowing their side effects might harm their patient. The patient’s emotional approach (“more tests mean I get a better work-up and better care”) thus clashes with the provider’s rationalistic approach (“tests should not be ordered when they are not indicated, as they may cause my patients harm”).

In a similar vein, any practicing clinician can give a number of examples on 'clashing' with the patient for not wanting to prescribe antibiotics for a suspected viral infection. Here, the doctor may be seen by patients almost as an adversary, hindering them from getting what they need for their recovery, rather than a champion for their well-being. A vast array of factors play into this often repeated scenario. While some of these factors may be cultural, many are not.

As a final example, patient discontent may arise from previous experiences or unrealistic expectations on their providers, irrespective of nationality and culture. Most non-medical people have little insight in how the healthcare system is organized in their own country. For example, misunderstandings may arise regarding roles and division of tasks between different professions in healthcare. Nurses in Sweden today have far more advanced training and perform skills that in many other systems (as well as historically in Sweden itself) are done by doctors. Likewise, primary healthcare in Sweden performs workups and treatments that in most other systems are done by hospital specialists. Thus, a patient being followed up by a nurse for her diabetes or hypertension (commonplace in Sweden) may feel worry or a sense of being neglected for not seeing the doctor. A patient not being referred by her/his GP to the organ specialist at the local hospital may feel frustrated and fearful of not getting the correct treatment. No 'cultural-sensitive' communication is required to address the problems in these examples, only an astute clinician with strong fundamental communication skills and an interest in engaging the patient fully.

How to build reflecting and communication skills

Interestingly, the three clinical examples above constitute very commonplace causes of frustration in everyday clinical work – yet they are as often encountered with native Swedish patients as with patients of other nationalities, ethnicity, religion and thus, it would appear, culture. The clash at work here must span wider than country of origin. If we want to continue using the terms culture and culture clash, we must be open to including many other factors in them, and start critically appraising our own culture and its part in any clashes that occur. We need to better see ourselves from the viewpoint of the patients – a skill that often comes from a lifetime of experience, but a skill nevertheless, that can be honed and taught. Thereby, we can begin to see our own culture, in order to recognize its fallacies and truly master patient communication.

Our study aims at testing a case-based theatre pedagogical method for training in difficult patient encounters. The hypothesis is that this approach provides crucial benefits, as compared to traditional classroom or textbook teaching of ethics and communication. Importantly, participants are fully immersed in the challenging situation, rather than analyzing it from a distance. They get to experience high-

fidelity simulations of problems that they most likely will experience in a very near future, and hone their communication praxis.

This study is part of a larger research project [(15)].

Methods

The timeline below illustrates the workflow:

A qualitative, exploratory study was designed to test the feasibility and value of the new pedagogical method. In collaboration with an already existing research group at Uppsala University, an inter-professional group was set up. Its members consisted of four actors/theatre pedagogues (Adriana Aburto Essén, Johan Svensson, Francisco Sobrado and Gloria Tapia), a medical ethicist (Ulrik Kihlbom) and two clinical doctors (Birgitta Essén and Pouya Ghelichkhan). The group held regular meetings during the latter half of 2020, where consensus was reached that the most apt way of exploring the theatre pedagogical method would be interactive case-based workshops, where study participants would be immersed in the ethically challenging situations as active subjects, rather than discussing them from a distance (as would happen during ethics seminars in the medical curriculum). Several members of the group had previous experience in teaching through this method. Different combinations with traditional teaching methods (lectures, seminars) were discussed but finally dismissed in order to focus entirely on the workshops and the ensuing group discussions.

Cases

After deciding on the format, patient cases were collected. The clinicians in the workgroup reached out to colleagues asking for de-identified, written summaries on challenging patient encounters within the realm of sexual and reproductive health and rights (SRHR). More specifically, cases were asked for where language, cultural barriers or other communicative aspects of the case (rather than purely the medical aspects) presented challenges to optimal patient care or caused caregiver frustration.

The reason for choosing SRHR is that the field always has been ripe with ethical dilemmas, as many health issues here are intimately associated with fundamental questions regarding life and death. Also, SRHR continues to be a very politically, culturally and morally charged field, where many people have strong and often differing opinions. As there is a large immigrant population in Sweden, many of whom originate from countries with traditional views on sexuality and women's health, this field is also interesting because it acts as an arena for clashes between the healthcare providers' explicit mission to promote equality and their equally explicit mission to promote tolerance for differing views [(3)].

From the cases gathered, a total of 15 were analyzed and modified from a theatrical standpoint, with the help of the actors. This process involved introducing fictional elements to the original summaries, in order to make the protagonists more relatable and to ensure that the cases would contain the necessary dramatic tension for the actors to be able to portray the different characters involved.

Due to the restrictions and social distancing related to the ongoing COVID19-pandemic, the original cases had to be modified. A new case, taking place in a digital healthcare (or telehealth) setting, was set up. The case presentation is available as Appendix A. In summary, a recently immigrated mother is seeking care through a telehealth consultation for her 8-month old daughter. The child seems to have a simple viral respiratory tract infection and had been seen only a few days prior by an experienced nurse at a remote health care center in the North of Sweden. Since the travel distances to specialist care are very far in these parts of the region, it was felt that this added credibility to the premise that the 'doctor' could not solve the case by referring the child in to hospital. As the case unfolds, more and more layers of social complexity are added. The mother speaks neither Swedish nor English and relies upon her brother, who has lived in the country for a few years longer, to translate. The remaining family is in their native country. They do not have a car. They live in a cramped apartment, so the child's incessant crying is wreaking havoc upon their sleep and well-being.

Study population and recruitment

The level of clinical experience among the participants was seen as a key factor. Medical students very early in their studies were expected to have had too few real-life experiences with challenging patient encounters, therefore not being able to bring their own experiences to the workshops. Conversely, more senior doctors than internist level (eg. residents or specialists) were expected to have a more readyformed attitude and therefore be less open-minded to change their position. For these reasons, last-year medical students and interns were seen as the optimal target group.

Since the students and junior doctors were already engaged in full-time studies and clinical rotations, with their weekly hours strictly regulated by the university, the workshops had to be held outside of office hours and on a voluntary basis. Before each workshops, an invitation was sent out to the last year medical students at Uppsala University, as well as the junior interns at Uppsala Akademiska Hospital, with the aim of recruiting up to ten participants for each workshop.

This number was deemed to be optimal for our purposes. Too few participants would stifle the dialogue, especially considering that seven members of the workgroup would be present and we did not wish to outnumber the participants. Furthermore, too few participants in each workshop would make the pedagogical method unrealistic for future use as it would demand an inordinate number of teachers. On the other hand, too many participants would make a large proportion of the participants observers instead of being assigned active roles in the theatrical portions.

The participants were accepted on a “first come, first serve” basis, without any exclusion criteria.

Results

Workshops

An early, prototypical, three-hour workshop (labeled ‘pre-pilot’) was held in December of 2020. The purpose of this workshop was mainly to be an exploratory training session for our team and give us a better sense of direction for the main pilot workshop, which was planned for May of 2021.

The initial plan was to arrange two different prepilot workshops, labeled A and B, respectively. This would give us a greater variation in the pedagogical method. In prepilot A, the actors would portray the patient and relatives whereas the study participants would act as the patient and relatives in prepilot B, after being given a

manuscript and a short briefing by one of the theatre pedagogues. The assumption was that 'the act of acting' in prepilot B would provide an even deeper kinesthetic experience to the ethical and communicative issues at hand. However, we were not sure whether the participants would be able to act with sufficient credibility or whether the acting would be a distraction, perhaps adding an unintended comical undertone to the workshop, which would greatly damage the realistic learning environment we aimed to set up.

Participants to both prepilot workshops were recruited, all of them last-semester medical students (see Appendix B for recruitment letter). However, due to a worsening COVID19-situation in our country by late 2020, the university decided to ban almost all physical meetings and recommended personal distancing and masking for meetings that needed to be held. The physical workshops were thus cancelled and instead a digital workshop was held in December of 2020, with six of the original participants (five having dropped out when the physical workshops were cancelled). From the work-group, two theatre pedagogues (JS, AA), two actors (FS, GT), two doctors (PG, BE) and an ethicist (UK) participated.

The participants connected individually to a Zoom meeting where AA, acting as moderator for the workshop, welcomed them and presented the schedule. Except for the actors (GT, FS) who had their cameras off, all people present introduced themselves and their reason for participating. All participating students and juniors stated inadequate training in handling difficult patient encounters as the main reason for taking part.

Next, JS (acting as moderator for the theatrical section of the workshop) pasted the patient presentation for 'Case A' in the chat and asked one of the participants to read the information aloud. One of them was then assigned the role of doctor in the first half of the case. After 15 minutes, JS would freeze the scene and another participant, would take over the scenario where the first 'doctor' left off (the actors would continue on as if there had not been a change of doctor). All participants apart from the actors in the case and the 'doctor' had their cameras and microphones turned off.

The workshops unfolded in a similar pattern, with the students trying to establish trust with the 'patients' and the latter being purposefully evasive and only responding briefly to the students' heroic efforts at establishing a therapeutic alliance. For example, one of the workshops started with FS (actor) questioning the age and competence of the young doctor. His factual responses were met by *"Are you really a doctor?"*

In a similar vein, the actors would misunderstand expressions on purpose, with the aim of creating a level of uncertainty and making the participants extra mindful of how they expressed themselves. For example, at one of the workshops a junior doctor said that *"antibiotics wouldn't bite"* (ie. be effective), whereupon FS immediately retorted *"Bite?! What do you mean, bite?"*

At a given point 30 minutes into the simulation, JS stopped the role playing and had all participants turn their cameras back on. After thanking the active participants, he then led a short group discussion, making sure to involve the observing participants and the actors themselves. The 'doctors' received feedback from the actors and the observers on their communication styles and strategies, with the aim of making them conscious of their own verbal and non-verbal communication, rather than pointing out a 'correct' way of communicating. For instance, one of the 'doctors' leaned forward towards her screen, constantly nodding and smiling softly – exuding a very friendly and empathetic style of communication. Another doctor used rational thinking, striving to get the facts straight, answering succinctly to questions whilst using less facial expressions and validating statements than his peer. Both styles have advantages and disadvantages in different situations, obviously depending on the patient's medical status, their own communication style and preference.

While it was deemed important that the actors would be unknown before the role playing, including them in the discussion was perceived by both participants and teachers as a crucial part of the workshop. Valuable impressions from the actors was passed on to the participants, for example explaining their motivations, 'hidden agendas' and their feelings in given parts of the dialogue. At the same time, the 'doctors' could explain their reasoning and how they tried to reach beyond the obvious frustration and tension to build a therapeutic alliance (and their increasing desperation as their efforts invariably failed). A very interesting topic that came up in this segment was whether the 'doctor' should use softer, empathetic techniques or authority in this situation. As the participants had experience from health care in other parts of the world (where physicians often are authority figures), reflections could be made on the pros and cons of each approach, respectively.

The theatrical portion of the prepilot was then followed by a short break, before a more traditional, seminar-type group discussion ensued. In one of the workshops, we used another modified and de-identified patient case with a different kind of communication challenge was used. Here, a young woman sought care at a gynecology clinic for low abdominal pain. Her partner insisted on staying in the consultation room during history taking and exam, often answering symptom questions which were directed to the women. This scenario is expected to raise concerns for intimate partner violence. The participants were given four minutes to write down their own thoughts on how to handle this situation before sharing with

the group. This second case discussion was more similar to already existing medical ethics seminars but was still seen as a valuable addition to the more immersive first case. Here, the participants received concrete tips and ideas for how to de-escalate a tense situation. One of the participants remarked that it would be interesting to use this case for a physical workshop, where the presence of the partner in the physical room would be one of the major elements.

In another workshop, we used the following case for a similar group discussion. An elderly woman is diagnosed with terminal gynecological cancer, which can not be cured but only palliated with chemotherapy. As she does not speak Swedish herself, her adult children have represented her interests and even translated for her during previous consultations. Now, her children demand that the patient not be informed of her cancer diagnosis, as this would *'break her heart and scare her'*. Instead, the family wishes to take care of her according to what they think is best for her, and have her undergo chemotherapy without understanding her disease or the treatment. The case highlights the problems when the family's wishes are accommodated over the individual's rights as a patient (see discussion in background regarding tolerance and equality). However, as the discussion unfolded, participants quickly realized how difficult it is to assess the patient's true wishes, especially if family members are used as translators.

Evaluation

After 45 minutes of reflection on the actual cases, the workshop was concluded with a 30-minute discussion on the theatre pedagogical method, its feasibility and potential role in future medical education. Uniformly, all participants perceived that they had not had adequate training in handling difficult patient encounters during their medical education. All participants found the simulations challenging and rewarding, with a majority agreeing that this type of training should be a mandatory part of medical education. It was felt that the act of role playing, as well as observing an interaction, provided greater depth to the communication challenges as compared to standard teaching and case discussions. The patient interactions were experienced as realistic and stressful. Several of the participants remarked on the difficulties of overcoming the distance created by the tele-health setting. For instance, how they could not use non-verbal communication (eg. moving closer to the patient, placing a hand on a shoulder) to de-escalate the situation.

One of the concerns of the teachers' group was whether a digital workshop would allow for the learning and reflections sought. The participants allayed our concerns in this regard, even pointing out unexpected advantages. For example, the actors leaving the screen for brief periods when they were very upset (eg. arguing in a neighboring room) added an extra layer of tension which we had not expected. One

of the participants later remarked on this 'threat' of the patients hanging up on the doctor. In more general terms, many physicians are accustomed to the hospital environment which may feel like a second home, whereas most patients experience some nervosity and unease upon entering the clinical milieu. By removing both doctor and patient from this arena, the power dynamics between them also changed.

Reflections from the actors

Two of the actors wrote down their reflections upon concluding the third workshop. FS played the role of the concerned uncle in the case of the baby with a respiratory infection. JS had the role of moderator for the initial group discussion, as well as prompter for the actors during the role playing. Regarding the explicit purpose of the workshop and how they sometimes can inhibit the flow, FS wrote: *'The ambition to create a new platform for acting in combination with teaching was a challenge as the utilitarian ambition easily can become an obstacle. I have experienced that acting can give new insight on life but also has its own intrinsic entertainment value without distinguishing these aspects.'*

Sometimes the cases seemed too impossible to solve. We discussed whether the actors could reward steps in the right direction (eg. validation or other signs of empathy) with softening up or providing more information. JS wrote the *'...actor can meter out information and events during the process in order to control the participants using carrot/whip.'* On a similar note, FS remarked *'Like a rebus, where we lay out riddles for the student to solve. Make them ask even more existential questions to create trust. Challenge them to see how far outside their comfort zone they can go.'*

Even though an explicit goal was to provide the participants with tangible tools and techniques, some of the participants wished for even more detailed feedback. JS reflected on this point: *'Some participants* […] *remarked that it would have been valuable to receive more concrete, direct and detailed feedback (regarding body language, choice of strategy, etc). We conclude that the tele-health format hinders some of these ambitions, but for future work* [with a physical workshop] *this might have to be implemented in the ensuing reflection. Here, the teachers' group could divide different aspects to comment on between us beforehand.'* JS further developed his thoughts on how to provide concrete tools for future difficult patient encounters by suggesting that the workshops could *'...include a coaching session for the participants in proximity to the workshop. It could be about body language, tone of voice, body awareness, etc which we could explore using our competence as actors.'*

Follow-up questionnaire

The participants in all three workshops were contacted via email for follow-up questions (appendix C) in October of 2021, with 12 out of 14 responding (86%). By that time, all participants were working clinically as junior doctors or interns. Most responded that they occasionally thought of the themes brought up in the workshop in their work: *'It was instructive and I would have liked more training of this kind. I have also used some techniques that were mentioned in the workshop.'* Several replied that they thought about the workshop when they had challenging encounters with patients or demanding relatives. Four replied that they had not encountered similar cases in their work.

Another participant replied that *'The workshop still seems extreme in that there were so many difficult moments all at once (language, physical distance, etc) but when similar situations arise I feel that I more readily can identify them and thereby be more thoughtful around how I express myself.'* This goes in line with the aim of the workshop, which was to promote reflective skills, rather than teach a checklist approach to difficult patient encounters.

Universally, the actors were praised for their interpretation and making the situation very realistic. Three participants commented on the advantages of professional actors visa-vi role-playing against fellow students. One participant remarked that *'...I felt a stress surge* [while role-playing] *and performing under pressure is something I wish had been more integrated into the final parts of the medical education.'*

One of the medical students even wrote that the workshop was *'probably the single event during my education that I have thought of most since graduating, meaning it has made a huge impact, at least on me.'* Another commented that *'...I have started to reflect more on myself and how I could be more active in my role to achieve common understanding'* and yet another one that *'I am more focused on finding solutions now'.*

Three different participants asked for even more concrete feedback from the teachers and the actors (ie on the verbal and non-verbal communication of the 'doctors'), one of them explaining that *'otherwise we will not have better communication skills than before'.* One medical student claimed she had never received feedback on her communication during medical school.

Regarding the format, most comments were positive, for instance: *'Even though it was online you managed to make the situation feel very realistic.'* Or the following: *'Very good* [format]*. If there were to be a physical workshop it would be even better.'*

Discussion

The teachers' group was in agreement that the concept was feasible and a promising venue to explore further. The self-reported need for this type of training from the participants, along with their active engagement in the discussions strengthened our belief that we sometimes need to look outside the field of medicine – for instance to arts and the medical humanities – to find solutions for inherently human problems.

The interprofessional composition of the workgroup proved invaluable as we ventured into the domains of the medical humanities and medical ethics. The abilities of 'reading' the feelings of the people and the atmosphere in the room, of improvising and seeing one's own presence through the eyes of others are key abilities that many artists, especially actors, learn to master. Medical staff, on the other hand, are indoctrinated from a very junior level with a biochemical outlook on health and disease, whilst the communicative and psychosocial aspects of care are just expected to occur naturally. There is sometimes even a derogatory attitude towards the humanities which may be portrayed as a 'soft' or non-essential part of clinical medicine. Likewise, the presence of an ethicist (UK) in the group, with many years of experience teaching ethics to medical students, allowed us to identify and avoid pitfalls in designing the cases and provided the workshop participants clarity in ambiguous situations.

There is room for improvement when it comes to concrete tools and tips that the participants can facilitate in their everyday clinical rotations. One study has highlighted this point – if the participants are not guided in changing their communication style and strategy, the workshop may be perceived as a fun yet pointless exercise with unclear applicability to medicine [(8)]. From our experience, we conclude that a crucial part in enhancing feedback on the participants' verbal and non-verbal communication is to bring the actors into the discussion even more, as the students during the preceding role-playing have formed trust and empathy with the actors/patients.

A pitfall which we expected yet could not fully avoid was the fact that medical students, as well as doctors in general, have a tendency to focus on the medical issues. It was clear from observing the participants that many of them were concerned about potential missed medical diagnoses, which stole part of their attention. This could be seen when they switched back and forth between asking about the patients' feelings and their symptoms. It indicates an uncertainty regarding the medical status of the patient. We conclude that the framing of the case must make it even clearer that the purpose is to focus solely on communication and empathy. Hopefully, this may allow participants to move on from the medical aspects to engage fully with the communication aspects.

The major strength of the study is its innovative approach to pedagogy. In our experience, many teachers and students think of communication and empathy as a character trait (perhaps inborn) – one of our participants summarized this view as *'either you have it or you don't'.* Approaching patient communication as a skill which can be assessed, practiced and perfected, is a radical break with this thinking. Furthermore, it is well in line with new revisions to the Swedish medical education system. For instance, in the new, six-year medical program, emphasis is put on a set of so called EPA's (entrustable professional activities) and 'professional development', which include patient-centered care as a key goal for future clinicians. This presents an opportunity to promote communication as a skill among others.

When it comes to weaknesses, the non-randomized selection process, where participants applied on a voluntary basis, is almost certain to produce selection bias. The participants in this study likely are interested in questions regarding patient communication, medical ethics and possibly global health. We addressed this topic directly with the participants during the group discussion, where one of the medical students pointed out the paradox that "the students/doctors who need this kind of training the most are the most unlikely to register voluntarily for a workshop". This strengthened our belief that communication training and simulation need to be fundamental parts of the medical curriculum. The sample size is small, making any generalizations tentative.

This method is resource-intense due to the need for direct supervision and small groups in order to facilitate active participation by all. This, in turn, may prove an obstacle to implementing it as a mandatory part of standard medical education. On the flip side, any method that attempts to seriously address patient dissatisfaction (potentially leading to many visits to different providers) and the slow epidemic of provider burnout – two hugely costly ails of modern healthcare systems – should be taken seriously and judged on its merits rather than solely on its costs. All of our participants commented on the lack of similar training during their 5,5 years of medical education. Therefore, the method deserves further exploring and its value can easily be argued for.

The COVID19 pandemic presented some obvious challenges but surprisingly, also some unexpected advantages. The shift to a digital format made many theatre pedagogical tools unavailable to us, especially in the kinesthetic realm. Body language, stances, gestures and using stage props are a major part of an acting performance. Sitting by a screen may make participants more passive and hamper interactions. Besides, digital equipment has a tendency to fail at the most crucial moments. However, a digital meeting also made possible new techniques and provided some interesting shifts in perspective. To begin with, instead of the patient

coming to a doctor's office or hospital, she/he may be sitting in her/his own home, somewhat shifting the normal asymmetry of power. During the conversation, the actors would sometimes become increasingly frustrated, at times leaving their device and exiting the room. This literally 'left the doctor hanging', watching helplessly as their patient showed their frustrations in a very powerful way. Furthermore, they could receive live instructions from JS on their screen, with cues on what to say or how to behave differently in the scenario.

Furthermore, an increasing number of consultations are taking place digitally through telehealth (a controversial topic in itself). This makes the concept of a digital workshop more realistic than it would have been only ten or even five years ago. Fortunately, one of the theatre pedagogues (JS), had experience teaching in a digital format. This was encouraging and helped provide the project an interesting new direction, instead of it being halted by the pandemic.

Further studies need to examine the potential of theatre pedagogy to address communication challenges and caregiver frustration. While the improvisational element in the workshops makes it difficult to compare the specific content of the workshops to other, similar ventures, the general approach of the theatre pedagogical method may be tried in a variety of training settings in health care.

With all that said, no amount of simulation and theatre can replace clinical rotations with direct feedback from a mentor. What the theatre pedagogical method *can* provide, that even a patient encounter cannot, is the ability to freeze the scenario, try different approaches and communication tools – even in encounters where both patient and provider are maximally stressed and frustrated. This type of 'stress inoculation' or high-acuity simulation is used extensively for medical conditions. Optimally, real-life encounters can be woven into the theatre pedagogical workshops, to enhance learning from true cases. Seen in that light, our method can be seen as a complimentary method to provide a training forum where learners can 'fail safely', and a fulcrum around which a dialogue about difficult and frustrating patient encounters can take place.

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Appendix A

EXCERPT FROM MEDICAL CHART — Äcksby primary health care center

Date and time: 2020-12-16, 10.15 AM

Provider: Alice Söderblom, registered nurse

Patient: Paloma Perez Gonzales, 8 months of age.

Background: Downs syndrome, suspected prenatally, confirmed at birth. Normal pregnancy and delivery. No cardiac abnormalities detected, echo normal. Vaccinated according to programme. Normal growth chart and follow-up at BVC.

Social: mother has sole custody, arrived to Sweden in 2019, staying with the uncle of the child in a small apartment in Äcksby. Biological father resides in Chile, no contact.

Complaints: returns with mother because of ongoing upper respiratory tract symptoms since 4d. Presented 2d ago with similar symptoms. Rhinitis, dry cough, poor sleep. Bothered by congested nose when she breastfeeds but normal feeding pattern otherwise. Urinates and defecates normally. Mother and uncle concerned.

Exam: somewhat irritable but good eye contact, coos and plays occasionally. Normal tone, fontanelle palpated normal. Rhinorrhea with clear mucus. Resp rate 28/min. Lungs clear with minor crackles bilaterally. No intercostal retractions. Saturation 99% on room air. Heart normal on auscultation, heart rate 172/min RR. Capillary refill time 2 sec. Ears: difficult to see tympanic membrane due to ear wax bilat. Abdomen soft and non-tender. Temp 37,8. Capillary CRP 12.

Assessment: viral respiratory infection, no concerning findings or signs. Discharged home, return precautions given if she were to deteriorate.

Diagnosis: B34.9 Viral infection, otherwise not specified

Appendix B

välkomna till...

WORKSHOP I

BEMÖTANDE & KOMMUNIKATION!

Hej läkarstudenter!

Jag är snart färdig specialist i Akutsjukvård med särskilt intresse för pedagogik. Mitt vetenskapliga ST-arbete handlar om hur läkarstudenter kan förberedas inför patientmöten där det är svårt att kommunicera med patienter och anhöriga. Arbetet är del av ett större pedagogiskt utvecklingsprojekt som en forskargrupp vid Uppsala universitet bedriver.

Ofta handlar problemen om att vi som vårdgivare har en annan syn på hälsa och sjukdom än patienterna, vilket i sin tur kan bero på skillnader i exempelvis utbildning, klass, kultur och religion. Dessutom kan våra fördomar aktiveras på olika sätt och leda till felaktiga slutsatser (olika former av *bias*). Låsningar kan uppstå som är svåra att lösa utan de rätta verktygen – ni har säkert själva stött på sådana situationer.

Vi anordnar nu digitala workshops vid två tillfällen där vi kommer att simulera kommunikativt svåra patientfall. Skådespelare och teaterpedagoger kommer att gestalta eller vägleda er i att agera patienter/anhöriga/vårdgivare. Etiker är med som stöd i efterföljande diskussioner. Jag närvarar som kliniskt stöd och observatör.

- A) Måndag 2021-05-17 kl 17.30 – 20.30
- B) Måndag 2021-05-24 kl 17.30 – 20.30

Ni får träna på kommunikation och bemötande i en trygg miljö. Ni kommer att få feedback på hur ni kommunicerar (verbalt och icke-verbalt) och delta i lärorika reflektioner i grupp. Workshopen testades HT20 och fick goda omdömen av de T11-studenter som deltog.

Skriv till mig om ni är intresserade av att delta. Ange vilket datum. Först till kvarn.

Mvh
Pouya Ghelichkhan, pouya.ghelichkhan@akademiska.se

Handledare: Birgitta Essén, överläkare på KK Akademiska, professor i internationell kvinno-mödrahälsovård på IMCH, Institutionen för kvinnors och barns hälsa

Appendix C

Hej!

Du deltog i vår workshop om patientkommunikation och -bemötande den **dd-mm-yyyy**.

Tack för det!

Vi som arbetar med projektet vill gärna vet om workshopen har varit till nytta eller om du har reflekterat över det vi diskuterade då. Därför vore vi mycket tacksamma om du tog dig tid att fundera igenom och svara på följande frågor. Du får gärna ge så konkreta exempel som möjligt i svaren.

- **1. Har du tänkt på workshopen och dess innehåll vid senare tillfällen?**
- **2. Har du efter workshopen stött på fall som har påmint dig om den?**
- **3. Tänker du annorlunda kring kommunikationssvårigheter idag jämfört med när du deltog?**
- **4. Hur ser du på den teaterpedagogiska metoden vi testade? Mer specifikt: vilka delar var bäst och finns det delar som kan förbättras?**
- **5. Andra tankar kring projektet och workshopen?**