

**The empathetic physician: using process drama to facilitate the training of empathy
skills in healthcare education**

by

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Declaration

Hereby I, Louise Schweickerdt, declare that this dissertation is my own, unaided work. In instances where someone else's work was used (whether via internet, printed or any other source) reference was made and due acknowledgement was given.

This dissertation has not been submitted in whole or in part for any degree or examination purposes at any other university.

It is submitted in fulfilment of the requirements for the Masters of Drama at the University of Pretoria.

Louise Schweickerdt

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Abstract

Introduction

This study used elements of process drama to explore and facilitate training of empathy skills in medical students. To do so, a training session through role-play was introduced, which was evaluated through qualitative reflections and pre- and post-training ratings.

Background and Objectives

Research has proven that students of medicine lose their empathy during the course of study. Introducing an aspect of humanities into medical training is advocated as a sensible way for medical students to retain and develop the empathy they inherently possessed at the time they enrolled. However, no study has been done before to explore the qualitative effect on empathy when introducing an aspect of humanities into their training. The objective of this study was to explore the qualitative effect on retaining or acquiring of skills in empathy when students partake in a training session of role-play.

Process drama and empathy were studied and described from a theoretical point of view by reviewing both the internal (psychological) as well as external (aspects of process drama) mechanisms that enable these processes to occur. These formed the framework that constructed the context in which this study was situated.

Methods

The research was designed to take place in four phases. Phase 1 included the review of scholarship relating to empathy in healthcare and healthcare training. It also investigated how process drama may enable metaxis to take place, allowing for reflection following the oscillation between the two worlds of real life and the world of the role that was entered into. Phase two established levels of empathy among eight fifth-year medical students by making use of the Jefferson Scale of Physician Empathy (JPSE) student version (S-version). This phase obtained themes extracted from student reflections on empathy in themselves, their peers and other Healthcare Practitioners (HCPs) regarding empathy. Phase three comprised a training session through introducing elements of applied drama, specifically role-play. The training was followed by a post-training exploration of empathy using the JPSE (S-version) as well as qualitative reflection. The reflection sheets were analysed qualitatively, while the JPSE (S-version) was

analysed descriptively by making use of data transference. Phase 4 compared pre- and post-training data by using a mixed-method approach through a convergent parallel design.

Findings

Eight, fifth year medical students were engaged in a training session of role-play during which they were ascribed the opportunity to portray both the role of the HCP and the patient. The training session of role-play opened up the possibility of entering the sphere of metaxis where the participants found themselves in both the real as well as the fictional worlds at the same time.

Following the training through role-play, qualitative findings showed that the participants felt more confident in themselves with regard to becoming the kind of HCPs they would like to be. They also felt less threatened and more capable to display empathy towards their patients. According to the post-training themes that were extracted, empathy had a positive qualitative effect by which patients trusted the participants more and shared more personal information, which allowed for improved diagnostic practice and adherence to treatment. The participants further stated that patients were also less likely of trying to take advantage of the students as had been the case before partaking in the training.

The quantitative results showed an improvement in empathy in five and a decline in three of the eight participants. During the training session of role-play, participants became aware of where they lack in an empathetic engagement between themselves as HCPs and patient. This rendered them more critical concerning their levels of empathy and they scrutinised more when completing the JSPE (S-version) during the post-production phase of the research. The decline in empathy could thus partly be ascribed to a more acute awareness – or the lack thereof in the participants themselves - of what an empathetic connection between HCPs and patients entail.

Conclusion

Comparing both qualitative data and quantitative pre- and post-training scores through a mixed method convergent parallel design indicated the positive qualitative effect that partaking in role-play had on the training of empathy in medical students. This study suggests that using humanities in medical education may sensibly be investigated further.

Table of Contents

Chapter 1: Introduction.....	1
1.1. Background.....	1
1.2. Research project.....	8
1.2.1. Positioning this study through a broad overview of prior research	8
1.2.2. Applied Theatre (AT) and empathy in healthcare.....	8
1.2.3. Placing this study in context: The medical curriculum at Sefako Makgatho Health Sciences University (SMU).....	16
1.2.4. My position as researcher in the study	17
1.3. Research question	18
1.4. Research objectives	18
1.5. Research Approach.....	19
1.5.1. Mixed-method methodological approach	19
1.5.2. The mixed method convergent parallel design.....	21
1.5.3. Participant profile.....	22
1.5.4. The Jefferson Scale of Physician Empathy (JSPE).....	24
1.5.5. Reflection questions	25
1.5.6. Outline of the training session	26
1.6. Ethical considerations	29
1.7. Breakdown of chapters.....	30
1.8. The significance of the study.....	31
1.9. Chapter conclusion.....	31
Chapter 2: Empathy and healthcare.....	33
2.1. Chapter introduction	33
2.2. Empathy: a clarification of the concept	33
2.2.1. Jaspers and the lack of empathy	36
2.2.2. Neuron-mirroring and empathy	40
2.3. Chapter conclusion.....	42
Chapter 3: Stepping into the shoes of another	43
3.1. Chapter introduction	43
3.2. Applied Theatre (AT): a frame	43
3.2.1. Process drama	44
3.2.2. Role-play	47
3.2.3. Mantle of the Expert (MoE).....	52
3.3 Strategies used to facilitate MoE approach in the applied drama strategy of role-play.....	54

3.4. Role-play within a contextual structure	57
3.4.1. The status of the facilitator in process drama.....	59
3.5. En/derolment.....	60
3.6. Chapter conclusion.....	61
Chapter 4: The empathetic physician	62
4.1. Chapter introduction	62
4.2. Data gathering and analysis	62
4.2.1. Introductory session	62
4.2.2. Session one.....	63
4.3. Substructure.....	65
4.3.1. Theme extraction: pre-training.....	65
4.3.2. Results JSPE	70
4.3.3. The training session of role-play: preparation	71
4.4 Structure	72
4.4.1. Outline of the training session	72
4.4.2. Setting the space.....	80
4.4.3. Introduction.....	80
4.4.4. Scenario development.....	82
4.4.5. Enrolling	87
4.5. Training session: role-play.....	95
4.6. Superstructure.....	99
4.6.1. Role-play session one	100
4.6.2. Role-play session two.....	104
4.6.3. Role-play session three	107
4.6.4. Role-play session four	109
4.6.5. Exchanging of DVD	112
4.6.6. Role-play session five.....	113
4.6.7. Role-play session six.....	115
4.6.8. Role Play session seven.....	118
4.6.9. Role-play session eight	120
4.7. Role-play and after	124
4.7.1. Theme extraction: post-training	126
4.7.2. JSPE (S-Version) results.....	128
4.8. Implementation of the mixed method parallel convergent design.....	129
4.9. Chapter conclusion.....	131

Chapter 5: Conclusion.....	133
5.1. Chapter introduction	133
5.2. Research objectives	133
5.3. Findings	135
5.4. Limitations.....	138
5.5. Bias.....	140
5.6. Recommendations for future research.....	140
5.7. Conclusion	140
List of References	142
Appendix A: Permission to use the JSPE	149
Appendix B: Example of the JSPE (S-version).....	150
Appendix C: Informed letters of consent.....	152
Appendix D: First set of reflection questions	157
Appendix E: Third set of reflection questions	159
Appendix F: Application for ethical clearance - Ethics committee (UP).....	160
Appendix G: Letter of approval – Ethics Committee (UP).....	172
Appendix H: Letter of approval – SMU Research Ethics Committee	173
Appendix I: Letter from resident psychologist.....	174
Appendix J: Strategies to be employed during role-play.....	175

List of Figures

Figure 1. The convergent parallel design (Subedi 2016:[sp]).....	22
Figure 2. A contextual structure for drama planning (Morgan & Saxton 1985:217).....	58

List of Tables

Table 1. Themes - pre-training	66
Table 2. The pre-training outcomes.....	71
Table 3. Time allowance equation.....	74
Table 4. Outline of the role-play session	75
Table 5. Themes: post-training.....	126
Table 6. JSPE (S-version) results	129

Chapter 1: Introduction

1.1. Background

If health is about adaption, understanding and acceptance, then the arts may be more potent than anything medicine has to offer (Brodzinski 2010:11).

This study aims to explore the qualitative effect of role-play on the empathy levels of eight fifth year medical students at a South African university. The study is broadly positioned in the domain of the medical humanities¹. I will use elements of a mode of Applied Theatre, namely process drama, as a method of establishing the qualitative effect of role-play on the empathy levels of medical students.

The study will make use of a pre- and post-training scoring, preceding and following a training session through the process drama strategy of role-play. The quantitative effect of role-play will be explored through the process of data transference and compared by using the Jefferson Scale of Physician Empathy (JSPE) student version (S-version). The qualitative data will be established through theme extraction preceding and following participants' reflection on the role-play explorations.

The basis that this study rests upon is the empathetic connection (or the lack thereof) between the Healthcare Practitioner (HCP) and patient². The term Healthcare Practitioner will be used with reference to any professional working in the medical field albeit as practitioner or lecturer irrespective of specific discipline. Apart from the sessions of role-play where the participants referred to HCPs as "doctors" and in cases where I quote sources directly, for the purpose of this study, all Healthcare Practitioners will be referred to as HCP.

Empathy in healthcare is a topic that has been receiving increasing attention in recent years (Geist 2013; McClean 2014; Viall [sa]; Suttie 2015; Zulueta 2013). Empathy stands out as

¹ For more detail on the medical humanities in/and South Africa, see Reid, S. 2014. The 'medical humanities' in health sciences education in South Africa. *South African Medical Journal*. 104(2):109-110.

² The word "patient" has historical as well as traditional connotations. Allied health professions have taken to using the term "client" as, generally, a patient is regarded as someone who suffers and needs compassionate care and there is less need of dependency in someone who is described as a "client" as opposed to "patient". Another aspect to be taken into consideration is the fact that, within the public sector, a patient does not choose his/her carer, s/he is assigned one, while a client can be defined as someone who chooses his advisor and pays for his services (Dalrymple 2001:[sp]). At the institution where this study was conducted, the term "patient" is used in teaching and learning, as well as in textbooks.

one of the most important aspects needed in order to arrive at an optimal relationship between physician and patient (Schweller, Costa, Antônio, Amara & Cravalho-Filho 2014:1).

An empathetic engagement stretches beyond the attainment or sharing of information on a cognitive level. It moves deeper into the realms of an emotional connection where the feeling of being understood prevails. Empathy rests upon the basis of feeling “with or for” another.

Blair (2015:[sp]) reminds that scientific literature agrees on three features of empathy. Firstly, that an individual must, to some degree, feel what another individual is feeling. Secondly, that an individual must, to some degree, imagine him/herself in another individuals’ situation. Thirdly, that an individual needs to know that s/he is not the other individual, as this creates awareness of the potential to act differently from the other.

Barbaras (in McLean 2010:190) states that openness to any shared experience creates a willingness to be absorbed with another as well as cultivating attention towards another. By empathising with the patient, the HCP enters the subjective world of another (Geist 2013:265). This allows for the barrier existing between the world of the HCP and the world of the patient to dissolve. This allows the patient to open up towards the HCP and share more personal detail than would have been the case otherwise. The more information the physician receives from the patient, the better the chance of arriving at an optimal diagnosis.

An empathetic connection between HCP and patient also allows the patient to feel in a position to correct and clarify the HCP’s understanding of what is being shared (Geist 2013:267). This assists in reaching an appropriate treatment plan for the patient. The patient may likely be treated as a human being rather than merely treating the disease and symptoms the patient presents with. This leads to improved health outcomes (Marshall 2010:20). The capacity to recognise a patient’s emotional context or status and responding appropriately in the context of the HCP-patient relationship, is termed “clinical empathy” (Dow, Leong, Anderson, Wenzel & VCU Theatre-Medicine Team 2007:1114-1118).

Gillis (2008:7) states that patients do not approach “physicians” [HCPs] merely with their organs, but with all their fears, fantasies, hopes, expectations and other psychological phenomena that constitute them as three-dimensional human beings. “Patients want ... doctors who will listen to their stories ... who will not just offer drugs ... who are sensitive to mind/body interactions. They want doctors who will look at them as more than just physical bodies” (Mehl-Madrone 1998:14). Patients feel the need to be viewed as individuals, as complex psychosocial beings. In order to fulfil the patients’ needs and to arrive at an optimal

treatment plan, an empathetic connection between HCP and his/her patient needs to form an integral part of the consultation process.

Yet, medicine of today has been seeing a decline in the empathy skills that HCPs display (Zulueta 2013:87-90; Ananth 2009:250, Stratta, David, Riding & Baker 2016:286-292). The importance assigned to the clinical aspect in medicine, creates a sense of tension between the patient as object and the patient as subject. In order to arrive at the optimal treatment plan where the patients' backgrounds are taken into consideration, asks that the patient be consulted with empathy. As far back as 1958, Karl Jaspers already observed that – and explained why – HCPs were losing empathy when dealing with patients (Jaspers 1958:1037-1043).

In addition to Jaspers' observation, and despite the documented importance of an empathetic connection between the HCP and patient, the training of students of medicine focuses predominantly on what needs to be memorised, which clinical skills need to be acquired in order to pass the next exam and to recognise signs for diagnosis. There is little chance for reflecting on what they are memorising or practicing. Their whole world becomes what Sinclair describes as “scientised” (Sinclair 1997:151). Although Jaspers³ writing dates back to more than 60 years and Sinclair's book “Making Doctors. An Institutional Apprenticeship” dates back over 20 years, there is little documented evidence that much has changed in the way that students of medicine are being trained.

In many medical curricula, an empathetic approach is regarded as superfluous when compared to the importance of clinical skills in the treatment of patients. Empathy is regarded as a psychosocial aspect that holds very little importance within the scope of the mass of information, facts and skills that students of medicine need to incorporate during their years of training.

However, Vallabh (2011:63) states that “empathy is critical to the development of professionalism in medical students as they progress through their training”. Furthermore, research reports that empathy skills can be taught and/or attained during and after medical training (Vallabh 2011:67). This study aims at measuring the qualitative effect how process drama facilitates the training of empathy skills in healthcare education through elements of

³ In both the medical as well the field of psychology of today, Jaspers is regarded as a seminal source.

process drama, in particular, role-play and the adoption of the Mantle of the Expert (MoE) approach.

I am employed as Simulated/Standardised Patient (SP) Facilitator at Sefako Makgatho Health Sciences University (SMU). My job is to train lay people to portray patients. Students of medicine (and other disciplines) practise clinical as well as communication skills on and with the SPs in order to hone their patient centred skills before they work with actual patients. SPs form a stepping-stone to prevent possible physical or psychological harm to actual patients. My work allows me insight into the inner workings of the training that students of medicine go through before they graduate.

Through my work, I directly observe the “scientisation” that Sinclair refers to. Particularly in situations where SPs portray patients during the medical students’ Objective Structured Clinical Examination (OSCEs). Objective Structured Clinical Examinations form a strong building block of students’ summative assessments. They consist of a series of different stations that students rotate through. Every station is set up to evaluate a different clinical and/or communication skill.

The students find it easy to relate what they had memorised with regards to the skills in order to pass the exam. The moment, they are confronted with a “patient” and are asked to incorporate an empathetic approach towards the “patient”, they revert to the safety of the clinical information they had memorised. They focus on the symptoms the “patient” presents and turn into clinicians instead of HCPs.

In addition, the “scientisation” (Sinclair 1997:151) not only affects the students during their exam sessions, it also affects the way in which students of medicine (and HCPs) deal with patients. The person behind the patient is ignored or in various cases, simply forgotten as the illness (or science) takes precedence (Ananth 2009:250). Students recite what they had memorised while treating the “patient” as the illness s/he is presenting with, instead of taking on a more humanitarian approach. It is as though there is not enough scope within the clinical information that needs to be internalised and memorised to allow scope for focussing on the patient as a human being as well.

The importance of equipping students of medicine with the tools to attend to the psychosocial aspects and/or needs of their patients in order to reach an empathetic connection between HCP and patient is becoming increasingly important. Patients are becoming more demanding about the treatment they are receiving. They want more than to be regarded merely as the illness they present with. Patients would like to consult with the

HCP as a means of receiving treatment that regards them as holistic human beings and takes all aspects of their lives into account.

As stated by Jaspers (1958) and Sinclair (1997) above and from what I have witnessed at SMU and in the students I deal with, the acquisition of medical knowledge is an avalanche of information that needs to be incorporated and remembered. Amidst the hours spent in lecture halls or in front of their books, the students of medicine I am involved with are also expected to deal with patients. In the clinical setting when working with patients, the students witness suffering, pain and even experience death. Due to the workload, they often do not debrief. In an attempt to come to terms and cope with the feelings that are evoked with what they are witnessing without debriefing, students of healthcare become numb, not only to their own feelings, but also to the feelings of others (Siegel & Hartzell 2004:18-19).

As far back as 2003, Rossiter (2012:101) identified the need to address the necessity to develop a curriculum that would address empathy and humanity during the course of students' medical training. Such a curriculum would make use of creative pedagogical means in order to attend to the process of healing and suffering in patients (Rossiter 2012:1).

According to McLean (2014:16), until recently, the topic of empathy training was hindered by the notion that empathy is perceived to interfere with scientific and medical objectivity. Consequently, medical students learn to suppress their emotions. If empathy rests on the notion of "feeling with or for another" then the suppression of feelings automatically leads to the suppression of feeling empathy. The suppression of emotions increases as the students' clinical training advances. This makes it practically impossible to empathise with patients (McLean, 2014:16, Youssef, Nunes, Sa & Williams 2014:18).

Jeffrey states that there is a "problem" in the balance between "scientific-technical and psychosocial elements of patient care" (2016:446). He argues that medicine prioritises technical process and factors such as evidence-based medicine ... and efficiency to such an extent that medicine is regarding patients as objects of "intellectual interest". HCPs distance themselves from patients by focussing on biomedical facts (Jeffrey 2016:446). He agrees that there is an urgent need to address the balance between the scientific and psychosocial care (Jeffrey 2016:446).

Presently, in South Africa and abroad, it seems that students graduate with less empathy than when they enrolled in medical school (Suttie 2015:2; Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski & Gonella 2009; Nunes et al 2011; Kusz, Foreback &

Dohrenwend; 2017). The only way to rectify the situation is to attend to empathy during their years of training. According to Gillis (2008:7), aspects relating to the psychosocial are better taught by literature and other humanities than by the standard medical curriculum.

This study aims at examining the importance of incorporating an aspect of humanities training into the medical curriculum in order to produce HCPs who approach their patients with empathy. The aspect of humanities training that this study falls in lies in the domain of the arts and of Applied Theatre with the focus on elements of process drama.

Applied Theatre is an umbrella term used when referring to the use of drama and theatre-based processes and methodologies in locations such as such as prisons, schools, hospitals or even bomb shelters. The term Applied Drama falls under the Applied Theatre “umbrella term”, as Prentki and Preston state; it is all “inclusive” for practices like drama in education, process drama, community theatre, theatre for development, etc. (2009:9).

Nicholson (in Schonman 2011:241) points out that there is a vagueness associated with the use (and deviations) of the term Applied Theatre (the term surfaced in the early 1990s). She suggests that the term was not coined by any one individual “to describe a very precise set of practices or concept”, but that the term “emerged haphazardly and spread like a rhizome to fill a gap in the lexicon” of drama and theatre (Nicholson in Schonman 2011:241) She continues:

Locating the ways in which this keyword is used, therefore, is not a search for the authentic roots or the essential meaning of applied drama, theatre and performance, but in recognising its pliability and porousness (Nicholson in Schonman 2011:241).

With Nicholson (in Schonman 2011:241), I accept the “pliability” and “porousness” of the term “Applied Theatre” and use it as the umbrella term to describe varied modes and manifestations of the use of drama and theatre for the purposes described on p. 6-7⁴. The forms that Applied Theatre may take are wide-ranging, from a participatory theatre programme to using drama and theatre as a teaching methodology. It is a process, using drama and theatre-based tools and strategies, which is created for the benefit of the participants to activate social or personal change or understanding. These tools and strategies can be mixed and shifted depending on the nature and aims of a project. The

⁴ I acknowledge that there are debates around which term (drama/theatre/performance) is best constitutive of this umbrella. However, such debates fall outside of the scope of this dissertation.

focus lies on the process of learning and/or change that occurs while participating in the process. My research utilises the tools and strategies that process drama, as a mode of Applied Theatre, offer.

As the name suggests, the focus in process drama lies in the change of understanding or perspective that the process evokes within the participants, rather than focusing on an outcome in the form of a performance. In process drama there is no audience present who needs to be taken into consideration. The action need not take the form of an outward display and projection of voice and actions. Instead, the participants can focus on the inward process that takes place instead of needing to focus on aspects that are used to retain the attention of an audience such as the story, plot or other elements of theatre. In short, stage acting is an act of “showing” and presenting something for the sake of an audience. Process drama on the other hand, is more concerned with the experience that takes place within the participants (O’Neill 1984:158-159; Bolton 1984:151-157).

Making use of such a humanities-based aid to investigate empathetic behaviour in students of medicine is one of the most appropriate tools to apply in order to investigate the research question. For the purpose of this study, the dominant process drama strategy that I will employ is that of role-play.

By adopting the strategy of role-play in the study, it places students of medicine in a situation where they will have to connect on an empathetic level with the role they are portraying. In addition, they will also have to connect with the person they are entering the sessions of role-play with, as well as connecting with the role/s that the other person decides to adopt. For the purpose of this study, the sessions of role-play took place after four years of study. By this time, students have adopted coping mechanisms of becoming numb to their own feelings and, in the process, have become numb to the feelings of others (Siegel & Hartzell 2004:18-19). My research thus sets out to explore whether participating in a training session of role-play could aid in enhancing empathy in students of medicine.

Before setting out to describe this study in more detail, I will investigate what has been or is being done within the greater realm of drama and theatre in healthcare. This will enable be to position this specific study within the relevant context both on national as well as international level.

1.2. Research project

1.2.1. Positioning this study through a broad overview of prior research

In this section, I will broadly describe the theoretical concepts that inform this study. Furthermore, I will outline prior research that was done during the past decade that relates to this study, both on national as well as international levels. Delineating prior research in the field of Applied Theatre within the medical setting will serve to position my study in this context.

In order to explore empathy in the domain of medicine, I will use the seminal work of Karl Jaspers with particular focus on his publication “Der Arzt im Technischen Zeitalter” [The doctor in a technological age] (1958) in order to theorise when and why the empathetic connection between HCP and patient first started losing its importance.

I will further investigate what has been or is being done within the greater realm of theatre and drama in healthcare. Although this list will not be exhaustive, it will sketch a broad picture pertaining to previous research with specific focus on empathy and theatre or drama in healthcare. This will position this specific study within the relevant context both on national as well as international level.

I will also look at the curriculum at SMU in order to place the study within the relevant setting of the academic institution at which it will take place.

1.2.2. Applied Theatre (AT) and empathy in healthcare

Rather than aiming to understand the value of theatre in medical education in terms of knowledge and the acquisition of a set of skills, its value consists in the potential to provoke a new way of inter-relating on a human level (Rossiter 2012:1). The use of drama and theatre in the field of healthcare is well known, including in terms of training in, or exploring, empathy. Institutions dealing with healthcare are increasingly employing various forms of theatre in order to achieve outcomes that deal with aspects other than the scientific. There is however still an outcry for a medical curriculum that addresses empathy and humanity (Rossiter 2012:101). This study aims at investigating the qualitative effect of introducing the strategy of process drama, namely role-play, into the training of students of medicine at SMU. In order to investigate what has been done and how my study differs from other studies in this area, prior programmes and research that make use of theatre in healthcare are investigated below.

According to Prendergast and Saxton (2009:87) theatre in health education (THE) emerged as a form of theatre mainly because of the necessity to educate people with regard to the HIV/AIDS epidemic in an attempt at curbing the rapid spread of infection. The traditional ways of informing people of the dangers of unsafe sex through performances and presentations (such as programmes addressing sexual health issues, advocating for abstinence and condom use and addressing social norms at schools, in communal settings and at healthcare centres) were not efficient – often because of being counter-cultural. Theatre in health education proved to be a more efficient way of educating people, partly because it is more engaging on a personal as well as communal level. Since the emergence of THE, theatre has been applied to educate people on a variety of health issues (Prendergast & Saxton 2009:90).

Prior research and projects in the domain of the arts and theatre in healthcare and healthcare education include, amongst others: “Creative Arts in Humane Medicine” (McLean 2014). This written work is entirely dedicated to the importance and the effect of arts in the healthcare setting. Simon Sinclair dedicates his book “Making Doctors: An Institutional Apprenticeship” (1997) to the relation that medicine studies has to the theatre. Mclean’s work focusses on the use of creative arts as a means of expressing illness. Sinclair focusses more on the training of students of medicine in relation to the performance aspect of theatre. Both these works are exploratory works, creating links between healthcare education and theatre. They make no use of research in establishing the qualitative effect of theatre on empathy in healthcare or healthcare education

“Ladder to the moon” enables health and care organizations to develop active, creative, vibrant care services by using approaches that incorporate creativity and the arts. “The Kaiser Permanente Group” and “DramAide” also develop drama-based programs in collaboration with health educators, community advisory committees and HCPs working for the Kaiser Permanente Group to cover important health topics.

Some use the stage and theatre to portray stories of health and the effects of failing health on people, their surroundings and /or family. The plays “Remember me for the birds: an ethno drama about ageing, mental health and autonomy” as well as “Vir Ewig en Altyd” by Tom Holloway and translated by Hennie van Greunen, are examples of plays about health.

There are companies that perform in healthcare settings, such as the “IOU Theatre” that performs in hospitals and encourages patients and staff to join in the theatre making process. The industrial “Health and Wellness Theatre Company” in South Africa educates workforces about specific health issues by making use of theatre. Other institutions that

make use of aspects of performance or theatre in hospitals are the renowned “Dream Doctors” in Israel, which consists of a group of trained clowns that go out into hospitals or disaster and disease-struck areas, such as after the earthquake in Nepal during 2015 to work with the children. The above are all examples of creating a link between healthcare and the arts with the aim of educating about health or easing patients’ distress. They bear little or no relevance to healthcare education; neither do they link directly to empathy on the part of the HCP.

In her book “Theatre in Health and Care” (2010), Emma Brodzinski elaborates on all aspects, making use of the theatrical term of “make-believe” in the healthcare setting. She covers aspects of simulation in the medical field. She also mentions the role of the Simulated/Standardised Patients (SPs) such as the ones SMU makes use of during the training of medical students during their years of study. Brodzinski (2010) proves that the incorporation of aspects of theatre in the form of simulating real life has been used for decades. She refers to simulation as “making students aware of the importance of empathy ... in clinical encounters” (2010:121).

Brodzinski refers to groups that work under the banner of “Women and Theatre” (2010:126-135), “Operating Theatre” (2010:135-140) and “Casualty Union” (2010:142-149). These groups all make use of aspects of theatre through simulation in healthcare training. Students learn through entering a simulated medical scenario. Casualty Union presents real life scenarios on a large scale and the students have the opportunity of acting as though the situation were real.

Nowhere in any of these examples mentioned above do the events focus on learning through an empathetic engagement as this study aims to do. Even the example given where communication training is introduced through role-playing (Brodzinski 2010:137) during students’ second year differs extensively from what this study aims to achieve. Introducing communication training in their second year, as is the case at SMU, where the students are expected to behave as if they were already qualified, causes extra tension on the part of the students (Brodzinski 2010:137). This tension causes students to focus too much on the technicalities of communication rather than focussing on the empathetic engagement between them as future HCPs and their patients.

In the examples above, the learning takes place through staging scenes that students are asked to identify with. This study introduces the Applied Theatre (AT) strategy of role-play, where learning takes place through incorporating what the students bring into the sessions with them (their personal luggage) (Morgan & Saxton 1985:217). As opposed to the

examples mentioned above, AT places the students at the centre of the pedagogical process. The process of how participants in AT are placed at the centre of the pedagogical process will be discussed in more detail below.

The “Central School of Speech and Drama”, based in London, conducted a study in South Africa. The study took place within the communities surrounding Nyanga in the Western Cape. The study explored concepts of safety and feeling unsafe living in a township where “gangsterism” and violence is rife. It was conducted by making use of devised scenes based on information gathered from the community. In a follow up interview, which took place sixteen months after the performance, the members of the community were still making use of the message related through the use of AT to warn acquaintances and relatives of the dangers of going out to taverns in order to drink with friends (Low 2012).

During 2006, a study that was conducted outside of Cape Town aimed at the promotion of voluntary counselling and HIV testing (Middelkoop 2006:[sp]). The participants were trained in HIV/AIDS as well as drama. These participants developed the sketches to be used in their communities. During the course of the three years following initiation of the programme, an increase of 172% made use of voluntary counselling and HIV testing.

Researchers from the “South African Stroke Prevention Initiative” presented an interactive play about cardiovascular disease and strokes. The work was based on anthropological data relating to the disease and was performed for the community. Its aim being twofold: firstly it was used both as educational tool in order to assist audience members to recognise the symptoms of a stroke and in order to teach them to respond accordingly. On second level, its aim was to act as means of collective social action (Stuttaford, Bryanston, Lewando, Hundt, Connor, Thurgood & Tollman 2006:31-45).

The presentation of the play and subsequent theatrical interventions and discussions allowed the audience members to identify the challenges they are faced with when attempting to prevent strokes and/or to care for stroke victims. It also afforded the community the opportunity to strategise about possibilities of improving their local healthcare facilities as well as integrating local healthcare practices with western forms of healthcare (Stuttaford et al 2006:31-45).

Furthermore, a study making use of AT that revolved around communication skills for the medical and dental students was introduced at the University of Pretoria (Krüger, Blitz-Lindeque, Pickworth, Munro & Lotriet 2005). This study, that used the AT strategy of forum theatre, was conducted over the span of two years. Case scenarios were developed and

drama students were employed to re-enact the scenarios, portraying both the role of the HCP as well as the patient. The medical and dental students were encouraged to interrupt the actors where they felt the communication skills could be altered or improved upon. Following these interruptions and suggestions, the actors then re-enacted the case scenarios incorporating the suggestions. During the second phase of research, the joker was introduced in order to facilitate the recognition of the communication skills employed at specific times during the course of the structured interview sessions. The gaining and retaining of knowledge on the part of the medical and dental students was favourable.

The examples above indicate the impression that AT has – even on a cross-cultural multi-national level. Cross-cultural performances enable the performers to enact a sense of cultural connection as well as their differences and in doing so, generate new ways of seeing the world (Chinyowa 2008:85-102). The examples are indicative of the importance of incorporating feedback from the group one addresses. This personifies what is being presented and makes it relevant to the specific communities or groups of people that are involved. However, once again, none of them addresses the importance of empathetic communication between HCPs and their patients.

In their study “Using theatre to teach clinical empathy: A pilot study” (Dow, Leong, Anderson & Wenzel 2007), the authors investigated the effect of four 90 minute lessons about communicating in an empathetic manner when consulting with patients. Professors of the department of theatre delivered these lessons as the researchers regarding the communication skills that take place between actors on stage, liken those of a HCP when consulting with patients. The increase in empathy when dealing with patients was analysed according to an instrument that the lecturers completed while the students consult with patients in the clinical setting. Although the results are favourable, no mention is made of involving any of the participants in active role-play sessions where they are allowed to gain insight into their inner dealings when it comes to empathy.

During 2011, a student from WITS University in Johannesburg, South Africa conducted a study in Ghana. His intention was to implement an AT intervention for HIV and AIDS awareness. He aimed at educating the participants about challenging the existing stigma surrounding the illness at that time. He conducted this study for the fulfilment for his Masters’ in Arts. His findings state that, had he incorporated the participants’ “personal luggage” (Morgan & Saxton 1985:217) into the learning sessions more, and not have expected quick results his study would have made more of an impact.

Various studies have made use of the Jefferson Scale of Physician Empathy (JSPE) (Roff, 2015, Nunes et al 2011, Youssef et al 2014, Mostafa, Hoque, Mostafa, Mashud, Rana & Mostafa 2014) to explore the empathy levels in students of medicine. However, none of these made use of any form of training that aims at facilitating empathy.

The study that comes closest to this one is entitled “Being in role: A teaching innovation to enhance empathic communication skills in medical students” (Lim, Moriarty & Huthwaite 2012). A group of seventy-seven participants, consisting of fifth year medical students, were asked to complete the JSPE and a behaviour change counselling index (BECCI). They were given a lecture on interviewing skills and finally asked to partake in a session of role-play. The session of role-play consisted of background information pertaining to acting skills that can be used in communication. Following the background information, the participants were afforded the opportunity to enter individual sessions of role-play to implement what they had been taught. Apart from comparing pre-and post-role-play intervention scores, the participants’ empathetic engagements during an OSCE were also analysed. The participants were also asked to self-mark their OSCE clinical performance. All results were favourable and showed an increase in empathy.

The main difference between the 2012 study and this one, lies in the sessions of role-play. In the study that was published in 2012, participants were given background information pertaining to empathetic engagement. They were informed about the outward display of empathy as opposed to this study, which made use of the AT strategy of role-play and works with what the participants bring with them into the lessons, instead of enforcing general ideas that they should learn from. If students are shown what an empathetic engagement looks like and are told what an empathetic engagement entails, the danger lies in them adopting outward strategies that look and sound like empathy. In the AT strategy of role-play, the learning takes place internally where the participants are at the centre of the pedagogical process. This allows for an internal learning process and deals with the aspects that the participants would like to investigate regarding empathetic connections and the learning becomes a personal process rather than an outward display.

The University of California also conducted a two-hour theatre workshop for first year medical students. The aim of the workshop was for students “to experience art, theatre and narrative as reflective tools to build empathy” (Reilly, Trial, Piver & Schaf 2012:[sp]). They incorporated improvisational theatre techniques such as observational games, frozen picture and sculpting activities and developing character profiles. The participants were asked to step into the characters’ shoes through means of reflecting in writing. Once again, no use of strategies of AT were employed. The feedback proves that the workshop, although rendering

some positive results in the line of broadening the students' perceptions of observing patients, it achieved little in the line of experiencing an empathetic engagement or addressing the issues that the students struggle with. Just like the study described above, not making use of an AT strategy of role-play, rendered the workshop as an outward attempt to foster growth that should be invoked from inside.

Another study conducted that matches exploring the effect of an intervention through role-play was conducted with nursing students in Spain (Bas-Sarmiento, Fernández-Gutiérrez, Baena-Baños & Romero-Sánchez 2017). "Efficacy of empathy training in nursing students: a quasi-experimental study", made use of three forms of intervention, namely, role-play, behaviour essay and the flipped classroom method. The researcher also included reflective writing. The role-players were actors who were trained to act as patients. They were given a choice of one of three scenarios. The following instruments were used to explore pre- and post-intervention levels of empathy: i) an adapted version of the Jefferson Scale of Empathy (JSE), ii) Reynolds Empathy Scale (RES), iii) The Consultation and iv) Relational Empathy (CARE). Independent observers assessed the explored and observed behaviour. The results proved that "it is possible to implement interventions to improve empathetic competency" (Bas-Sarmiento et al 2017).

In South Africa a study making use of the JSPE (S-Version) was conducted at the Witwatersrand Medical School in 2008 (Vallabh 2008). This study aimed at assessing the empathy levels of final year medical students as well as to examine the psychometrics of the students' version of the JSPE. Measuring the effect of an intervention of the empathy levels formed no part of this study. The study does refer to the importance of empathy in the relationship between HCP and patient. It acknowledges the decline of empathy in students of medicine during their years of study. No mention is made of suggestions of how to rectify the situation, neither does it address humanities in medical training⁵ in any way as this study intends to do.

According to Vallabh (2008), this was the first study conducted in South Africa with regard to empathy in students of medicine. In conclusion, the study does underline the importance of further studies in order to assess the effect of medical education on the empathy levels of

⁵ The humanities in medicine is a field that emphasises the humane aspect of all areas of healthcare. It stands in strong contrast to a medicine of science and advocates for a more holistic and empathetic view and treatment of the patient as a whole. According to Reid (2014:110) international frameworks relating to medical humanities, may "not be helpful in a South African context where issues of social justice and health inequalities dominate the delivery of healthcare".

students of medicine in South Africa (Vallabh 2008:6). According to my knowledge, at the time of submission, no other studies have been conducted in South Africa relating to the above since 2008.

The latest study to be conducted with regards to the effect of role-play on students of medicine was conducted at the Centre for Medical Education, Queen's University in Belfast, United Kingdom. Although more focussed on simulation in healthcare, it did incorporate role-play by making use of drama students that acted as Simulated/Standardised Patients (SPs). The participants were all students in their final year of medicine. The research focussed on the training of the drama students in order to present authentic roles as patients. Although the students all adopted the role in their capacity as HCPs, the authenticity that the SPs brought into the sessions, allowed for "deep levels of immersion" during the simulated scenarios and allowed a certain measure of "exploring empathy" (Walsh & Murphy 2017:1-7). This study's focus lay more on the effect of an authentic portrayal on the part of the SP, rather than investigating the effect of role-play on the qualitative levels on empathy of the participants.

During 2014, the University of Cape Town introduced a course entitled "Medicine and the Arts" in an attempt at introducing an aspect of humanities into the medical curriculum at masters' level. The course does not include any form of AT, neither does it make mention of the importance of an empathetic engagement between HCP and patient. It focusses more on allowing the students to develop a sense of the inter connection between "arts, social sciences and medicine" (Reid, 2004:109). I mention this course to underline the growing awareness of humanities in medicine in South Africa. A medical humanities course in South Africa was first proposed by Benatar (1997) as "a formal component of South African curricula"; however, since then little further development has taken place in this field.

Although Dr Helen Riess does not directly make use of AT in healthcare, her name deserves mention as she deals directly with empathy training in healthcare (Riess, Kelley, Bailey, Dunn & Phillips 2012:[sp]). Riess is known for her ground-breaking work in empathy training for medical HCPs. Riess realised the importance of empathy in medicine after consulting with patients, who spent time in a psychiatric session to express their feelings after their HCPs dismissed aspects that were important to them as patients. Riess' directly addresses the aspects that this study aims at exploring.

This study aims at investigating the importance and lack of empathy within medicine today and aims at exploring the qualitative effect of using process drama to facilitate the training of

empathy skills in healthcare education. These aspects have not been sufficiently addressed in prior research, both on national as well as international level.

1.2.3. Placing this study in context: The medical curriculum at Sefako Makgatho Health Sciences University (SMU)

In order to investigate the above concerning the training of empathy in fifth year medical students at Sefako Makgatho Health Sciences University (SMU), the curriculum will be reviewed shortly. This will be done in order to identify the ways in which the medical curriculum for fifth-years engages with the facilitation of empathy skills at SMU.

At SMU, where this study will take place, medical students enrolled for the MBChB programme, train for six years. Years one to three are regarded as pre-clinical training years where focus is placed on anatomy, physiology and biochemistry. During these years of training students are introduced to consultation skills in a simulated setting, which means, that these sessions are conducted through means of interaction with Simulated/Standardised patients (SPs). Simulated/Standardised patients are lay people trained to portray the roles of patients. The focus in these sessions is for the students to acquire the skills of thoroughly gathering sufficient information by conducting structured and patient centred consultations. During the first three years of training, the sessions with the SPs is the only training the students receive concerning the interaction with “patients”.

It is only in their fourth year, when their pre-clinical training has been embedded, forming the basis of background knowledge that will enable them to diagnose illnesses, that the students are introduced to working with actual patients who need medical care.

During the fourth through to the sixth year of training, focus is placed on the more clinical aspects of medicine. During these years, students are trained to become HCPs within a structure that tends to investigate and treat the physical findings in the patients while ignoring the fact that a patient consists of more than the mere physical problem they present with. The ability of dealing with patients empathetically forms no part of the MBChB curriculum at SMU. The medical curriculum spans various departments, such as psychiatry, Internal Medicine and Practice of medicine (POME) (to name but a few). Therefore, there is no yearbook or curriculum document that encompasses the MBChB course. Every department has their own outline of courses presented to specific years during the MBChB curriculum.

The MBChB curriculum at SMU offers no facilitation of empathy skills during the years of clinical training. This study will thus investigate the qualitative effect of, as well as the importance of integrating such training into the curriculum.

1.2.4. My position as researcher in the study

I work at SMU as a Simulated/Standardised (SP) facilitator. I do not teach clinical skills. My focus lies in the training of consultation skills and making students aware of the importance of a more patient-centred approach. I also present what is called a “selective” to the MBChB III students. During their third year of medical training, students are required to partake in a selective that deals with a creative activity such as singing, swimming, drama and others that lies outside the scope of medical education.

This was instituted to ensure a more balanced level of education where creative aspects can be introduced. Therefore, my capacity as facilitator does not entail contact with the students as the position of lecturer. Although the selective is a credit-bearing module, it does not form part of the curriculum as such. There is no guarantee that the students will choose a selective that bears a connection to the incorporation of an aspect of humanities into their training. This underlines the importance of evaluating which qualitative effect the incorporation of humanities in the training of medical students will have on the empathy levels of students of medicine.

My position as researcher, where this study is concerned, is one of a facilitator of the training session of role-play. The role of the facilitator and researcher in this case, is merely to guide the process in order to create a space where the participants feel safe enough to explore. Being one of the staff at SMU is a fortunate position to be in, as it will enable me to approach the study from within the structure as opposed to an outsider coming in.

In light of the above, I need to recognise that I feel strongly about the importance of an empathetic connection between HCP and patient. I further realise that, through facilitation of the selective, my insight into the emotional struggles students have to deal with during their years of study, such as the fear of failure, feelings of standing alone, etc., may influence my interpretation of the data. Further, my background as a white, middle-class, Afrikaans, English and German speaking South African will necessarily impact on my view of the research material. As such, I do not offer an “absolute” or “complete” result of the findings, but rather discuss a perspective on my explorations in a specific context. In qualitative research, the researcher’s values and objectives and how these affect the research project, are acknowledged as part of the process (Ratner 2002:1). An investigation into subjectivities

pertaining to participants and myself falls outside of the scope of the research. Participants' written and verbal reflections, together with a frame of process drama strategies and the results of the Jefferson Scale mediate my reflections and interpretations to offer critical distance.

1.3. Research question

How does the applied drama strategy of role-play facilitate empathy training in fifth year Medical Students at Sefako Makgatho Health Sciences University (SMU) in Ga-Rankuwa, Gauteng, South Africa?

1.4. Research objectives

Phase one: Review of scholarship

- To review prior scholarship on empathy in healthcare and healthcare training;
- to review prior scholarship on AT in the context of healthcare;
- to identify the ways in which the medical curriculum for fifth years engages with the facilitation of empathy skills at Sefako Makgatho Health Sciences University.

Phase two:

- To investigate, through reflection, what students of medicine observe and experience regarding empathy within the clinical setting between HCPs, their peers and themselves.
- to establish levels of empathy of among eight fifth year medical students by making use of the JPSE (S-version) pre-training.

Phase three:

- To create a process drama training session, with emphasis on the applied drama strategy of role-play, to explore the qualitative effect of role-play on the empathy levels of fifth year medical students.

Phase four:

- To compare pre- and post-training results in order to reach a conclusion.

1.5. Research Approach

1.5.1. Mixed-method methodological approach

In this study, my aim is to explore the qualitative effect of role-play on the empathy levels in eight fifth year medical students enrolled at SMU with the aim of completing their MBChB degree. In order to investigate the research question, I will follow a mixed methods approach. The mixed methods approach combines quantitative and qualitative and research methodologies. The Jefferson Scale of Physician Empathy (JSPE) Student Version (S-version) will be scored according to a quantitative approach. Qualitative extraction of themes following the completion of pre-and post-training reflection sheets, will also be integrated. I will analyse data by following the mixed methods convergent parallel design.

Quantitative data analysis focusses on a relatively small number of concepts and begins with preconceived notions about the interrelation of these concepts. Quantitative approaches in research answers the question of “how much” as opposed to qualitative research where the focus lies on complex human issues such as behaviour and needs. In quantitative research, the instruments to collect data are formal and procedures are structured. Numeric information that had been gathered is analysed through statistical procedures. In quantitative research, the researcher does not participate in the study, but gathers data from a distance. Quantitative research incorporates logistic and deductive reasoning (Brink 2011:11).

Furthermore, quantitative research focusses on measurable aspects (Brink 2011:10) to ascertain tangible values and numerical proof of what the investigation delivered (Brink 2011:10). The quantitative tool, the JSPE (S-version) will indicate the empathy levels of the students before and after role-play training. Because of the fact that qualitative research is a personal, subjective process, the trustworthiness of the process needs to be investigated.

In qualitative research, the focus lies in the importance of people’s interpretations of events and circumstances in an attempt to understand the phenomenon under investigation in its entirety. Qualitative research regards subjectivity as an essential aspect in order to gain an understanding of the human experience. Inductive (based on observations) and dialectic reasoning (the practice of arriving at a conclusion by the exchange of logical arguments, usually in the form of questions and answers), are predominant features of qualitative research (Brink 2011:11). Qualitative research poses questions like “how”, “what” or “why”.

In qualitative research, the theory shapes the aspects that the researcher is interested in. These aspects inform the methods and techniques that I, as researcher, will employ to carry the research through (Isaacs 2014:319). The goal of qualitative research is to enable the

researcher to understand social phenomena by taking the views and experiences of the participants into consideration.

Trustworthiness in qualitative research equals what reliability and validity stand for in quantitative research. It proves the study to be worthy of recognition (Babbie & Mouton 2011:276). Trustworthiness equals the neutrality of findings. It is regarded as a key criterion of good qualitative research (Guba in Babbie & Mouton 2011:276).

According to Leedy and Ormrod, in qualitative research, the words “reliability and validity” should be replaced by words like “trustworthiness and/or credibility” (Leedy & Ormrod 2010:100). For the purpose of this study, I will replace the terms “reliability and validity” with “credibility”.

In order to support credibility in this study, I will make use of triangulation by eliciting different and various constructions of realities through means of collecting data from various points of view. I will achieve triangulation by asking different questions, seeking different sources and by using different methods (Babbie & Mouton 2011:277). De Vos, Strydom, Fouché & Delport (2011:442) state that triangulation is achieved through making use of a triangulation mixed-method design [such as the convergent parallel design]. The application of such a design means that quantitative data as well as qualitative data are gathered at the same time. During the description phase, when the findings are compared, both sets of data carry equal weight in order to reach a conclusion.

According to Leedy and Ormrod (2010:100) negative case analysis is another means of achieving credibility of findings in qualitative data analysis. Following the training session of role role-play and the subsequent analysis of the JSPE (S-version), the results obtained through data transference, showed a decline in empathy where three out of the eight participants are concerned. This adds credibility to the data analysis as proof that the process of data gathering was such that it indeed allowed scope for negative findings to surface.

Dependability is another criterion that could be used to establish credibility of a study. This process requires an audit through another source, such as a supervisor (as in this case). The auditor follows the process and procedures used by the researcher in order to determine that these are acceptable or dependable (Brink 2011:119).

The incorporation of an audit process allows for confirmability to be achieved. This guarantees that the data findings, conclusions and recommendations are supported by the

data. Furthermore, confirmability also means that there is agreement between the actual evidence and the researcher's interpretation (Brink 2011:119).

I will address referential adequacy (that also strongly links to credibility) by storing the video recordings, as well as the answered reflection sheets and the completed JSPE (S-version) questionnaires should further review be required (Babbie & Mouton 2011:277).

In order to contextualise the data analysis in order to reach a conclusion, I will describe the mixed method convergent parallel design and how I will implement it in order to reach a conclusion in the following chapter.

1.5.2. The mixed method convergent parallel design

Combining qualitative and quantitative methodologies, mixed-methods research bridges the gap between philosophy and methodology. It distinguishes itself from other research approaches by rejecting the either-or stance (Cameron 2011:102). According to Creswell and Plano Clark (2007:5) mixed-methods is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data. The central premise of the mixed methods approach is that combining quantitative and qualitative approaches provides a better understanding of research problems than the application of either approach on its own (Creswell & Plano Clark 2007:5).

In the convergent parallel design that I will implement, qualitative and quantitative data collection take place at the same time. I will collect sets of data that consist of the pre- and post-training written reflection sheets as well as the completed pre- and post-training JSPE (S-version) forms.

The diagram below illustrates the convergent parallel design:

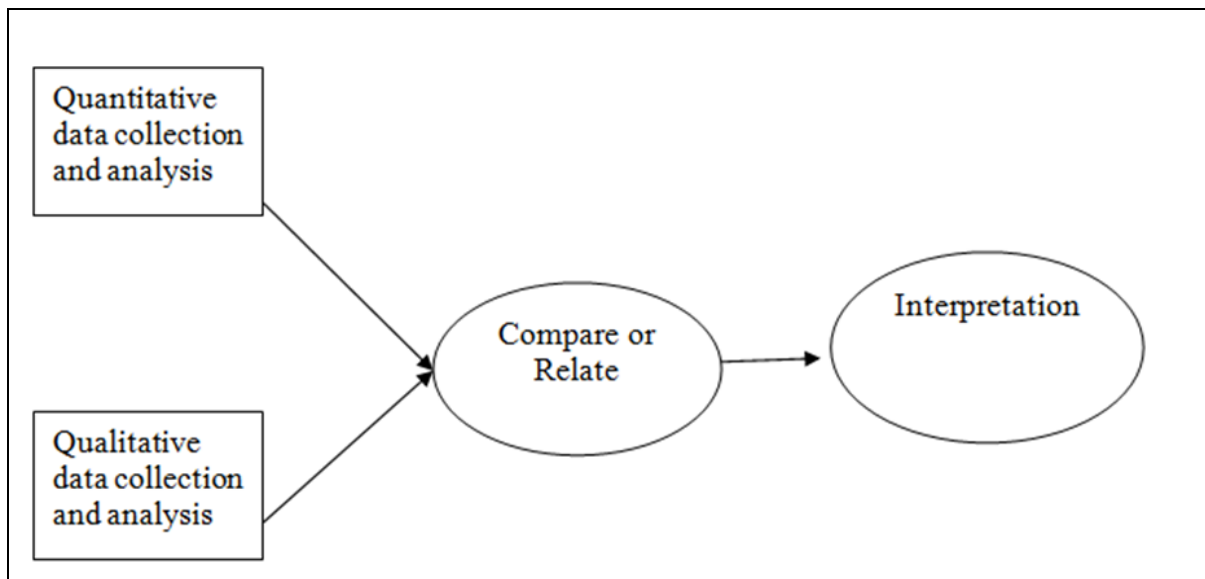


Figure 1. The convergent parallel design (Subedi 2016:[sp])

I will analyse the written reflection sheets through qualitative means by making use of theme extraction and coding. The completed JSPE (S-version) forms will be analysed quantitatively. However, the sample size does not allow for formal quantitative comparisons or statistical testing. Instead, I will analyse the quantitative data through a process of data transference.

The session of role-play will be looked at from the perspective of the employment of strategies used in process drama and how these were employed in order to facilitate the training of empathy skills in healthcare education.

The challenge relating to this study lies in the integration of the quantitative and the qualitative information that had been gathered and incorporating the findings within the scope of the literature review in a discursive methodological approach.

1.5.3. Participant profile

My research aimed at identifying a specific group who are able to offer information and insight into the phenomenon to be studied. This group needed to be in contact or close proximity to the theme to be identified. According to Creswell (2009:178) the “idea behind qualitative research is to purposefully select participants ... that will best help the researcher understand the problem and the research question”. The purpose of sampling with the focus

on a qualitative study is to select information-rich cases to support research (Isaacs 2014:319).

In the case of this study, concerning the qualitative aspect of the research, the sampling will be systematic and non-probable. The sampling strategy of the study will principally be purposive (judgemental), meaning that participants will be invited to participate for the reason that they might have something to contribute to the study (irrespective of whether they support or are sceptical of the study subject) (Babbie & Mouton 2011:166-167; De Vos et al 2011:232). As is usually the case in qualitative research of a case study design, the aim will neither be to avert selection bias nor to achieve findings as necessarily representative of the class or of medical students in general. On the contrary, selection bias is supported, for such bias is also part of the interest of qualitative work and has the potential for a rich and diverse yield.

During their sixth and final year of training the students are mostly focussed on completing their studies, therefore they might have regarded partaking in an additional study as superfluous. The notion that the goal and purpose of their final year is to graduate, may have influenced the study negatively as students' focus would lie in the completion of their studies instead of partaking in a study where in-depth reflection and co-operation was required in order for the study to meet its objectives.

The participants were asked to reflect on what they had observed regarding the interaction between their peers and the patients they were treating. They were also asked how the HCPs deal with patients and what they themselves have noted on a personal level relating to levels of empathy when dealing with patients.

Students' reflections formed an integral part of the study, not only where data gathering is concerned, but also on the part of the training session, making use of role-play. Students needed experience as to what they had observed regarding empathetic behaviour in order to reflect on this topic, they also needed to have been in enough consultation sessions with patients in order to be comfortable with the process for the session of role-play to run smoothly where their consultation skills are concerned. Background into their own consultation sessions with patients also allowed the participants to know which areas they would like to explore more regarding the HCP-patient interaction. Without this prior insight on the part of the students, the study will not be able to meet the proposed objectives.

The reasons stated above are why fifth year medical students were approached to partake in this study. From their fourth year, they would have gained insight into how HCPs interact

with patients of both physical as well as empathetic level and thus would be able to complete the initial reflection sheets required. In addition, during their fifth year of study, students' focus is still on acquiring knowledge instead of merely focussing on the completion of their studies.

As mentioned above, the qualitative approach of the study will deal with theme extraction following reflection. The quantitative approach will be enabled by incorporating the Jefferson Scale of Physician Empathy (JSPE) (S-version). Both the qualitative as well as the quantitative data will be compared through the mixed methodology by making use of a convergent parallel design in order to ascertain the qualitative effect of role-play in the training of empathy skills in healthcare education at SMU.

1.5.4. The Jefferson Scale of Physician Empathy (JSPE)

The Jefferson Scale of Physician Empathy (JSPE) was developed by researchers at the Centre for Research in Medical Education and Health Care at Jefferson Medical College to explore the level of empathy in HCPs and other health professionals (HP/Physician version), medical students (S-version) and health professional students (HP Student version). Permission to make use of the scale for the purpose of this study was granted (see Appendix A).

According to Tavakol, Dennick and Tavakol (2011:54), the JSPE (S-version) enables medical educators to "evaluate the effectiveness of educational interventions aimed at promoting empathy". The JSPE is a brief instrument that consists of a series of 20-items to be answered on a 7-point Likert scale. Apart from the reverse scored items, one equals strongly disagree and seven is marked in cases where the students strongly agree (see Appendix B).

In this research, dealing with using process drama to facilitate the training of empathy skills in healthcare education, I will be using the JSPE (S-version) as pre- and post-training scores in order to investigate the qualitative effect of role-play on the empathy levels of fifth year medical students at SMU. I will be assisted by my co-supervisor, Prof CW van Staden in interpreting the results of the JSPE (S-version).

I will ask the participants to complete the JSPE (S-version) before the training session of role-play takes place. Four weeks after the role-play session had taken place, the participants will complete the JSPE (S-version) form again. The question arises as to whether the post-training results will be influenced by the fact that the participants are

familiar with the questions posed in JSPE (S-version) after having completed the questionnaire during the pre-training section of the study. Does the fact that they are familiar with the questionnaire enable them to tweak the answers according to what they believe their response should be or what they would like the answers to be instead of answering without bias?

The time delay of four weeks between the pre- and post-training testing is likely to mitigate this challenge. Four weeks of interacting with patients in the clinical setting is likely to be long enough to infuse the participants with new experiences and enough new insights for them not to remember what they had answered in the initial session while they were completing the form. During this time, the participants will be able to integrate what they had experienced and the insights gained during the session of role-play when interacting with patients. This might serve to change their initial perspectives regarding the empathetic connection between HCP and patient.

If the question is about bias invoked by an expectation of change rather than real change in the participants, the qualitative aspect of the study may shed light on such bias (i.e. in support or refutation thereof). The fact that a change in beliefs and feelings between pre- and post-training testing is the very subject matter of the study should be taken into consideration and need not be regarded as bias.

1.5.5. Reflection questions

In order to ascertain what the participants observe in other HCPs, their peers and themselves, open-ended questions will be used in order to facilitate the reflection process. Open-ended questions allow for deep levels of personal reflection and emotional exploration. This affords the students the possibility of honestly reflecting without feeling pressured to think within the boundaries of questions directed towards a specific outcome. Open-ended questions ask of the participants to reflect on a personal level. This allows for the incorporation of emotions. Open-ended questions do not steer the participants towards specific areas, which they themselves might not feel strongly about or might not have been attracted to from the outset.

Broad open-ended questions also allow for a wider spectrum of feedback, which opens up the possibility for themes to emerge that I, as researcher, might not have considered. This allows a more profound impact as more themes, emotions and thoughts can be touched on. Theme extraction will follow.

Theme extraction deals with a systematic investigation of the data. It allows for the generation of patterns in order to “shed light on the phenomenon” that is being investigated. It is a feature often used in qualitative data analysis (Gale, Heath, Cameron, Rashid & Redwood 2013:3).

The extracted themes allow for the researcher to reflect on “emerging issues” that were captured during the data gathering process (Gale et al 2013:1) and so enables the researcher to reach conclusions. The process of theme extraction can either take on a deductive, an inductive approach or a combination of these.

In the deductive approach, themes are “pre-selected based on previous literature” pertaining to the research question. In an inductive approach, the themes are extracted with no prior inclination to the themes that might emerge. It is a more “open” approach. In the combined approach, as I adopted during theme extraction in this study, themes are extracted according to specific issues that a particular study wishes to explore. The combined approach, however, also allows for enough space to discover “other unexpected aspects of the participants’ experience or the way they assign meaning to phenomena” (Gale et al 2013:3). I discuss the process that I followed during theme extraction further down in chapter four.

In the paragraphs above, I outlined the methodology that I will implement in order to address and investigate the research question. The next step will be to outline the training session of role-play that I will implement with the aim of answering my research question.

1.5.6. Outline of the training session

The study proposes to explore the qualitative effect of the process drama strategy of role-play on the empathy levels of fifth year medical students enrolled at SMU to complete the MBChB degree. I introduced the study to the 40 fifth year students enrolled at SMU for the year 2017. After eight fifth year medical students volunteered to partake in the study, session 1 dealt with signing of the letters of informed consent. The participants completed the JSPE (S-version) and reflected on what they had observed concerning empathy in other HCPs, their peers and themselves. Session two consisted of the training session of role-play. The final session, session three, took place four weeks after the session of role-play. In the final session, participants completed the JSPE (S-version) as post-training and reflected on how they experience empathetic engagement between themselves and patients following the session of role-play. They also reflected on how the session of role-play had impacted them, in their role as HCP.

I introduced the study by giving the sum group of fifth year medical students a broad outline of what the study entails. The Hawthorne effect explains that people adopt a certain measure of acting behaviour the moment they are aware that they are being observed. Consequently, the perceptions gained by those observing become tainted by a degree of a newly adopted artificiality (O'Neill 1995:69; Coombs & Smith 2003:98). In order to prevent the above, no mention of empathy was made during the introduction phase. Instead, I introduced the study as a study that will allow the participants to get to know themselves better in an "interhuman connection situation". The insight that the study deals with empathetic behaviour and the awareness of being observed critically may lead to the students attempting to display the best means of interaction with patients instead of interacting in their usual manner.

I assured the students that the proposed training session would be arranged according to their schedules at times that suit them best. I also assured them that they could withdraw from the study at any time without any negative consequences. Eight fifth year students volunteered to partake in the study. I took their contact details in order to ensure that we could arrange for the following sessions.

The first mention of empathy was made during the first session when I asked the participants to sign the informed letters of consent (see Appendix C). They were also asked to complete of the JSPE (S-version), as well as a reflection sheet that consisted of five questions relating to what the participants had observed regarding empathetic behaviour in themselves, their peers and HCP in the clinical setting (see Appendix D).

After careful reading and signing of the letters of informed consent and before completing the JSPE (S-version) and the reflection sheets, I asked the participants to identify themselves by choosing an individual marker. This enabled me to compare the reflection sheets with their original counterparts in order to ascertain the qualitative effect of role-play on the empathy levels of individual participants. Individual markers will also ensure for the collected data to remain anonymous.

I asked the participants to complete the JSPE (S-version) in order to explore their initial empathy skills before I asked them to reflect for two reasons:

- i) to afford them with a deeper understanding as to what empathy entails before they will be asked to reflect on the subject;
- ii) to allow them to complete the JSPE (S-version) before their own reflections/feelings influence what might have been an untainted, initial response.

After completion of the JSPE (S-version) form, I guided the participants as to what the process of reflection entails and informed them about the different levels of reflection. The reflection questions consisted of broad open-ended questions.

The number of participants partaking in this study does not allow for formal quantitative analysis, I analysed the JSPE (S-version) through means of data transference instead. I analysed the reflection sheets thematically. Following data transference and thematic theme extraction, I introduced the training session of the process drama strategy of role-play.

The second session consisted of a three-hour session dealing the role-play (Appendix E). After enrolling, each of the participants was afforded the opportunity to portray the role of physician as well as that of the patient. Following the session of role-play, the participants were asked to reflect about what they had experienced during the session of role-play (Appendix F).

A time span of four weeks was allowed before a post-training survey was conducted. The four week break enabled the exploration of retainment following what the participants had experienced during the training of role-play. During the final one-hour session, I asked the participants to complete the JSPE (S-version) as post-study. The second set of broad open-ended reflection questions asked to the participants to reflect, once again, about the experience of role-play with relation to their levels of empathy (Appendix G). Once again I analysed the data through transference and theme extraction. The pre- and post-training scores and themes will be compared in order to ascertain the qualitative effect that role-play has on the participants' level of empathy.

In order to validate the study, the participants need to have had previous dealings with patients and observing other HCPs in the clinical setting. At SMU, students are only asked to engage with patients from their fourth year on. The option thus, was to engage fifth or sixth year students in this study to ensure prior exposure. In their sixth and final year of training, the students are pre-occupied with completing their degree. Asking them to partake in a study such as this one might have been regarded negatively, thus I approached students who are in their fifth year of training. In order to ensure that no students are influenced negatively or disadvantaged by agreeing to partake in this study, ethical considerations need to be set in place.

1.6. Ethical considerations

As a student enrolled at the Drama Department of the University of Pretoria (UP), conducting a study that involves medical students enrolled at SMU, required ethical clearance. I applied for, and was granted, ethical clearance from both academic institutions (Appendices H and I).

In this study, I followed the guidelines for ethical clearance as required by UP and SMU. During the introduction of the study, I informed the participants about the nature of the study and their role in the study and obtained their informed consent for participating in the study. The study made use of the students who volunteered to partake and are willing to do so without any additional gains being offered (financial or otherwise). Students were offered the option of withdrawal from the study at any time without negative consequences. Should any participant have withdrawn, the data pertaining to his/her involvement would not have been used. The details pertaining to the above are stipulated in the letter of informed consent that all participants were asked to complete and sign before commencement of the study (Appendix C).

The participants were not subjected to any potential harm, be it physical, psychological, legal, social or emotional. In case of unforeseen emotional occurrences where specialised assistance may be advisable, the educational psychologist at SMU (from the centre for student counselling and development) agreed to counsel any of the participants, should the need arise (Appendix J).

The fact that the educational training of the possible qualitative effect of role-play on the empathy levels of medical students forms no part of the curriculum at SMU, as well as the fact that participation will be voluntary, means that no student was disadvantaged by deciding not to partake in this study at this time. Eight participants of the group of 40 fifth year medical students volunteered to partake in the study. In order to mitigate any possible advantages that participation in this study might bring forth, I afforded a same opportunity of partaking in a role-play session dealing with empathy to the remaining 32 of the same group of medical students during October 2017. No participants volunteered.

Participants identified themselves with an individual marker (for example a heart or spiral) to ensure and retain confidentiality and anonymity. In order to ensure safety from risk of exposure and to keep the participants safe, no one will have access to the raw data collected except myself as researcher, Professor M-H Coetzee (Drama Department, UP) and Professor CW van Staden (Weskoppies, UP), who acted in the capacity of supervisor and co-supervisor respectively.

In accordance with UP regulations, data will be stored in the archive of the Drama Building, Room 2-16 at the University of Pretoria for a period of 15 years. Permission of the participants will be requested again should any person require access to the data in storage for further research.

1.7. Breakdown of chapters

Chapter one contextualises the study. A broad outline is sketched concerning the importance of empathy in healthcare and healthcare training that introduces the significance of the study. It investigates prior scholarship on AT in the context of healthcare. In this chapter, I sketch a short outline of the medical curriculum at SMU in order to place the study in context within the academic institution where it will be conducted. I also place my position as researcher in the study. Chapter one addresses the research question to be investigated the objectives to be met. Furthermore, this chapter gives insight into the research approach that the study will follow. It briefly describes the tools that were employed in order investigate the research question. Finally, after sketching a brief outline of how the training session of role-play was conducted, it addresses aspects concerning ethical considerations.

Chapter two deals with all aspects of empathy in healthcare. It clarifies the concept, explains why Jaspers' theories are incorporated as seminal source. Furthermore, this chapter touches on neuropsychology and empathy by introducing the concept of mirror neurons.

Chapter three explores the theoretical underpinnings of AT, with particular focus on process drama, in order to create a framework within which the training session of role-play took place. It describes how and why role-play evokes growth in the participants through metaxis. Chapter three briefly touches on Erving Goffman's theories set out in *The presentation of self in everyday life* to underpin the approach I adopted during the session of role-play. The chapter describes the process I followed during the session of role-play. It addresses the status of the facilitator in process drama and mentions some of the strategies I employed during the training session of role-play. This chapter also looks at the importance of enrolling and describes the process chosen.

Chapter four elaborates on the creation and implementation of the lesson plan. It deals with the training session of role-play. The session of role-play, the strategies employed and the qualitative effect thereof are also described. In this chapter, the extracted themes are discussed and compared to the results from the JSPE (s-version) through the convergent parallel design in order to reach a conclusion.

Chapter five concludes the study. The introduction sums the study up shortly, research aims are re-iterated, limitations and recommendations for future research are discussed before the study is concluded in its entirety.

1.8. The significance of the study

The chapters above prove the importance of empathy in healthcare. This study aims at filling the gap of the lack of a more humanitarian approach in medical training. This was achieved by proving that training where empathy is concerned yields positive results. The study also serves as an indication of how a more humanitarian approach to medical training could be incorporated into the curriculum.

At the time of submission, no study in print in English or Afrikaans, on national or international level, has been undertaken that explores the qualitative effect of role-play on the empathy levels of fifth year medical students.

Like any other craft that is to be mastered in consultation skills, the crafting of empathetic skills should also be facilitated (McLean 2010:190). Students of medicine cannot be expected to practice empathy skills if they have not been in a situation where they have been introduced to these skills. In the training programme at SMU, the skills of dealing with patients empathetically may become part of the medical curriculum where the humanities are included into medical education. It is in this regard that process drama can offer an experiential engagement with those skills in a safe space.

I would like to regard the outcomes of this study as a means of establishing a basis of exploring the importance of humanities in medical education and by elaborating the qualitative effect of introducing role-play into the medical curriculum. This might indeed open up the scope of introducing a more humanitarian approach to medical training, not only at SMU, but at other medical academic institutions.

1.9. Chapter conclusion

In this chapter, I defined and discussed the positioning of this study within the context of an overview of prior research relating to the field of Applied Theatre/drama in healthcare. I explored the medical curriculum at SMU. This was done in order to ascertain the level of importance that empathetic engagement with patients holds within the training of students of medicine at academic institutions worldwide. This chapter addresses the research question to be answered and defined the objectives to be reached. All aspects relating to the research

process were described and explained. I also addressed the significance of the study within the field of healthcare education.

The next chapter addresses the importance of empathy in healthcare and healthcare training and touches on the neuroscientific aspect of mirror neurons and the role they play in the empathetic engagement between a HCP and his/her patient.

Chapter 2: Empathy and healthcare

2.1. Chapter introduction

In chapter one I introduced the theoretical frameworks that the study will draw on with the aim to contextualise the study; it also deals with an explanation of the research approach. Chapter two theorises the notion of empathy. It places specific focus on the importance of empathy in the setting that HCPs operate in. In this chapter, I position Jaspers as central theorist and draw on his theories to frame the seeming decline and lack of empathy in HCPs. In chapter two I also briefly look at the domain of neuroscience and explore the role of mirror neurons in empathetic engagements between individuals.

If HCPs of today, as teachers and role models of students of medicine, seems to lack empathy when dealing with patients, they may convey these same traits to the students they have under their care. These same HCPs are also the people who are in charge of setting up the medical curriculum. If they do not deem empathy as important when dealing with patients, then there is little chance that they make space available for the training of empathetic behaviour within the curriculum.

They may teach the students what they know and students may adopt the mannerisms and means of coping that the HCPs demonstrate. In his publication, "Der Arzt im Technischen Zeitalter" [The doctor in a technological age] (1958), Jaspers explains that in medicine, the results obtained from labs have become the central point around which HCPs treat their patients. The students learn to deal with patients as illnesses instead of dealing with people. They are not taught to form an empathetic connection with their patients to find out what the matter is. Instead, they learn to wait for the results from the labs to know which treatment to prescribe.

Apart from placing focus on the empathetic engagement and/or the lack thereof between HCP and patient, chapter two also briefly refers to the role of mirror neurons. I incorporate the role of mirror neurons in order to draw a parallel between the empathetic engagement between individuals and the empathetic engagement between a person and the role they are adopting, as will be the case during the training session of role-play.

2.2. Empathy: a clarification of the concept

According to Rossiter (2012:89), empathy refers to the way that one relates to someone or something and McClean (2014:xvi) states that: "To be humane is to show empathy or

understanding, to care about the condition and suffering of others, to treat others as we ourselves wish to be treated". Empathy occurs when the division between the feelings of one individual and the feelings of another individual dissolve. Empathy allows for one individual to imaginatively and sensitively feel and think him/herself into the life of another (Geist 2013:267). An empathetic relationship has to do with a sense of a shared experience – empathy lies in a common sharing of feeling or an understanding of what is being felt by another. In such an interaction, "a range of neural, cognitive, affective, and kinaesthetic responses" are activated (Bateman & Coetzee 2017:[sp]) that allows an individual to understand and vicariously experience the thoughts and emotions of another.

According to AT practitioner Augusto Boal (1990:38), an analysis of the word "empathy" looks as follows: "en" stands for inside; while "pathos" refers to emotion ..." The word empathy thus takes on the meaning of "inside emotion". "Inside emotion" is the emotion not on display to the outside world. It describes the inside, or subjective, world of the patient. When two people share a space, there are two subjective worlds present: one within every person. During an empathetic engagement the two subjective worlds connect. The moment when the two subjective worlds connect, the subjective process becomes an inter-subjective process. During an inter-subjective process, thus, two conscious minds connect with each other (Geist 2013:265). In other words, inter-subjectivity can allow for the conscious thoughts of the HCP and the conscious thoughts of the patient to interlink on the subjective level of the patient. Empathy, thus, affects the inter-subjective healing process (Geist 2013:265).

As far back as 1958 the German philosopher and historian Karl Jaspers⁶ witnessed and discussed the lack of empathy on the part of the HCP when treating patients. Jaspers⁷ refers to empathy as an act of understanding (*Verstehen*). Empathy, for Jaspers forms the basis of an inter-subjective connection between HCP and patient. Although the article I will refer to dates back to 1958, it will be incorporated as a primary and seminal source.

⁶ Karl Jaspers is renowned for his work in the field of philosophy in healthcare. His theories and insight carry weight. Although Jaspers' publication dates back to 1958, the lack of an empathetic engagement between HCP and patient is still being heavily scrutinised today. This gives reason to believe that there has been little development in the field of creating a more humanitarian approach to healthcare in over fifty years. This fact underlines the urgency of invoking change for the healthcare system to return to a more patient-centred approach where healing takes place as a holistic practice.

⁷ In contemporary times, Jaspers' work is still incorporated in areas of clinical practice as well as referred to in research (Kapusta, 2014; Stanghellini, G., Bolton, D., Fulford, W.K.M. 2013).

In his article, Jaspers investigates why an empathetic connection between HCP and patient has given way to (what he describes as) a technical process. He also investigates the importance of an empathetic connection between HCP and patient. He defines such a connection as grasping psychological events “from within” (Aragona, Kotzalidis & Puzella 2013:8). Grasping psychological events “from within” only becomes possible when there is empathy present to allow an inter-subjective process (as described above) to occur. Jaspers believed that, if there were an understanding on the side of the physician, it would enable the physician to place him/herself in the position of the patient. This would activate the corresponding process occurring in the other and may allow the physician to experience a similar emotion (Aragona et al 2013:8). The basis for a HCP to understand what a patient is experiencing in order to create an inter-subjective process between a HCP and his/her patient is the consultation process.

According to Gelhaus (2012:[sp]) “Even a very basic and seemingly banal history-taking between HCP and patient is not feasible without a considerable amount of empathy”. An empathetic connection between HCP and patient allows the patient to feel understood and safe enough to share his/her subjective world. This enables the HCP to enter the world that has belonged only to the patient up to now. In other words, both HCP and patient share in the subjective world of the patient. The moment he HCP shares in the subjective world of the patient, the two subjective worlds combine and the process becomes an inter-subjective one. An inter-subjective process leads to insight and eventual understanding of the patient on the part of the HCP.

Gelhaus (2012: [sp]) continues by saying that, without empathy it is impossible to optimally interpret and understand what the patient is communicating. If the interpretation is incorrect, it hinders the physician in asking the relevant questions. Asking irrelevant questions does not guide the HCP in the right direction of further diagnosis in order to find out about indications and contraindications. Taking both indications and contraindications into consideration, are the essence that lead to a holistic treatment plan. Without taking both indications and contraindications into consideration, the diagnosis cannot be complete as the HCP has only gathered half or less than half of the information the patient has to share.

In cases where empathy is lacking during consultation sessions, patients are not afforded the opportunity to express their emotional difficulties or offer a more holistic picture of their illness or symptoms with HCPs, instead the focus of these interactions tend to lie in the exchange of medical information (Yagila, Biron, Pat, Mizrahi-Reuveni & Zollerc 2015:1631).

When empathetically engaged, there is possibly more insight into, and understanding of, the world of patient. This may lead to less of a discrepancy between what the HCP thinks or feels in relation to what the patient thinks and feels. Such an engagement would allow for the worlds of the HCP and patient to merge in certain areas for the duration of the consultation session. In turn, this affords the HCP insight that moves beyond symptomatic treatment. Yet, the awareness that the HCP is not the patient remains crucial to diagnosis and the ability of the HCP to move between modes of inter-subjectivity, subjectivity (personal viewpoint/experience) and objectivity (that which is tangible, for example, a rash on the skin). Empathetic engagement, thus, does not mean that worlds of the patient and the HCP become “intertwined” or “one”: it merely allows the HCP deeper insight into the world of the patient – temporarily ‘stepping into the shoes’ of a patient - enabling a more thorough diagnosis and more optimal line of treatment.

Should the physician display empathetic behaviour towards his/her patient it may have a positive influence, not only on the emotional health of the patient, but also on symptom resolution. In other words, an empathetic connection tends to the functional status of emotional healing as well as pain control (Stewart 1995:1429). Empathy in healthcare is a pivotal point, which every consultation should revolve around, yet it is one of the aspects that is strongly lacking (Ananth 2009:250).

Given the importance of an empathetic/intersubjective connection between HCP and patient in order to reach a holistic diagnosis, as described above, the question that arises is why medicine came to disregard such connections as integral to consultation sessions? In order to answer this question, I would like to refer to Karl Jaspers’ investigation into the healthcare industry as he analysed it in “Der Arzt im Technischen Zeitalter” [The doctor in a technological age] (1958).

2.2.1. Jaspers and the lack of empathy

In *Der Arzt im Technischen Zeitalter* [The doctor in a technological age] (Jaspers 1958:1037-1043), Jaspers explains the lack of empathy on the part of the physician. He accomplishes this by tracing the development of the healthcare system back to Aristotle and ancient Greece. Jaspers explains how Western⁸ healthcare evolved from a mainly humane practice to a more technical one.

⁸ Medical and healthcare practices, approaches and HCPs outside of the Western medical paradigms do not necessarily demonstrate these limitations and may be more holistic. However, a study of such practices falls

According to Jaspers, before Western medicine turned into the technical science that it is today, the physician had to build his/her practices not only around the natural sciences, but s/he also had to rely heavily on his/her skills as “Förscher” [explorer/examiner] and being “Menschenfreundlich” [philanthropic] (Jaspers, 1958:1037-1043)⁹. However, crises accompanied scientific progress within the medical fraternity. The mention of reforms, of overcoming the restrictions of scholarly medicine and “Neugründungen”¹⁰ [re-establishing] “Krankheitsauffassung”¹¹ [the meaning of medicine in its entirety] as well as redefining the meaning of being a physician, are aspects that needed to be addressed with the progress taking place within the field of medicine (Jaspers 1958:1037-1043). As far back as 1958, HCPs were selected solely according to the ability of achieving high enough marks instead of their ability to treat patients with a humanitarian approach. Accepting students into medical school with their academic achievements as main criteria, according to which they were assessed, means that the humanity in medicine was being left behind.

The examination and diagnosis of illness in a patient is becoming a process of making use of apparatus and tests that are carried out in a laboratory. The patient finds himself/herself in a world of apparatus through which s/he is being placed in an object-position where s/he is analysed and medicalised. The patient is seen and treated as an illness instead of a person who has come in need of help. The (then) modern physician has become a technician. This, arguably, did not change much over the years.

According to Jaspers (1958), before the practice of healthcare became one of conducting tests in a laboratory, the physician’s role was one of a “Förscher” [explorer/examiner]. In order to reach a diagnosis, HCPs had to explore or examine the inner workings (both physical and emotional) of the patient. Such in depth exploration could only be achieved if the HCP approached the patient with empathy, establishing a measure of trust, which would

outside of the scope of this dissertation. The current medial curriculum at SMU conforms to Western medical and healthcare practices and approaches.

⁹ According to Jaspers, healthcare has become a technical science where treatment is predicted by results obtained from laboratories, rather treating the patient as a holistic human being by addressing psycho-social aspects as well.

¹⁰ The German word “Neugründungen” as used by Jaspers (1958) means to re-establish the basis that medicine had been built on. In doing so, it would mean that the meaning of medicine as it was known during 1958, when Jaspers wrote *Der Arzt im Technischen Zeitalter*, would be redefined in order to align with Jaspers’ findings.

¹¹ *Krankheitsauffassung* deals all aspects of illness: what illness consists of, what it means and how illness is accepted and dealt with in society.

allow the patient to open up in order to reveal what is taking place inside on emotional levels not visible to the eye.

Approaching the patient as an explorer and/or examiner would allow for an empathetic connection, leading to an intersubjective experience between HCP and patient where the HCP will be in a position to explore the patients' feelings. Such in-depth exploration would enable the HCP to reach areas within the patient that cannot be ascertained through even the most stringent laboratory tests and/or their results.

The technical aspect of laboratory tests and results has arguably nullified the importance of exploring or examining the patient through an empathetic approach. This reinforces the idea that many HCPs regard the patient through the eye of a scientist or a technician. The division between physician and "Forscher" [explorer/examiner] is of value only if the tests conducted in laboratories are important as far as the diagnosis aids in the process of healing. But in the case where the physician should fulfil the role of explorer/examiner, the goal is not a scientific analysis of what might be wrong. The goal rather, is to help the patient, through means of a more holistic approach. It is important for the HCP to remain patient-centred, lest the connection to the human being be lost.

Through maintaining a patient-centred approach where the HCP regards every patient as a unique human being, the HCP uses the health sciences not merely to place this specific case within the context of where it generally fits. S/he rather makes use of science to connect the "Erscheinungen" [presenting complaints], circumstances, factors and possibilities in order to distinguish what needs s/he needs to take into account and what can be ignored when s/he decides about the most appropriate treatment plan.

Jaspers states that a HCP needs to: i) possesses clinical insight (*Blick*), ii) be capable of open acceptance of the individual patient based on gained experience, iii) accept the new that the individual offers, iv) observe the body, its movement, the patient's "Benehmen" [composer and specific behaviour] and v) have a sense of awareness for the patient's "Umwelt" [environment]. It is only when a HCP takes all five of the above actions are taken into consideration that s/he possesses the ability to distinguish between what needs to be considered and what can to be discarded to reach an appropriate diagnosis. Scientific tests in a laboratory narrow the above down to mere science without taking the world of the patient into account.

The HCP needs to be aware where s/he deals according to his/her knowledge of the sciences in opposition to dealing with a patient when s/he enters the realm of mutual

understanding, and the exchanging of a “gemeinten Sinn” [shared meaning or what is meant]. According to Jaspers, the recognition of illness does not lie in “Verstehbarkeiten” [that which can easily be understood] but rather lies in that which is more difficult to understand.

Through the ages, HCPs have been “Menschenfreundlich” [philanthropic] with the inherent desire to bring about positive change. The conversation between HCP and patient remained the pivotal point of the consultation until the science of medicine as described above, became the centre point of the path to being healed (Jaspers 1958:1037-1043).

Thinking does not end where “wissenschaftliches Erkennen” [scientific recognition] is unable to predict a way forward. This is where “Vernunft” [reasoning] should take over (Jaspers, 1958:1037-1043). Moreover, reasoning can only be achieved when enough information has been gathered through means of an empathetic connection between physician and patient. As Viall ([sa]:24) states: “The crucial ingredient in any integral medical practice is not the ... medical bag itself – with all the conventional pills, the orthodox surgery, subtle energy medicine and acupuncture needles – but the holder of that bag”. In other words, the equipment and scientific knowledge are not the most important aspects of a HCP, but the intrinsic, human qualities of a HCP that enables him/her to reach an optimal treatment plan. The human quality of empathy creates a common understanding and leads to intersubjectivity between HCP and patient. If these are not present during the consultation, the HCP runs the risk of treating the patient as the illness s/he presents rather than a holistic human being.

As I explained in chapter one, contemporary HCPs have seemingly lost the skills of empathetically engaging with their patients. The patient leaves the consultation merely with a set of instructions and a prescription for the newest or most appropriate drugs to treat his/her symptoms. Medicine should not remain a two-dimensional assimilation of symptoms allowing merely for a prescription of the best suitable medicine, but should be a three-dimensional, people-centred, investigation that allows HCPs to look into what lies beneath the surface. In medicine today, HCPs regard and treat patients as an illness (an object) instead of treating the person behind the illness (a subject). Is it possible that time spent on empathy or caring, has become regarded as time wasted?

As mentioned earlier in the chapter, apart from their training, there are various psychosocial reasons for HCP to display a lack of empathetic engagement when dealing with patients that fall outside of the scope of this dissertation¹².

The question that remains is why it is so difficult to create an empathetic connection between HCP and his/her patient when too much focus is placed on the scientific aspects of medicine.

A brief look at elements of neuroscience, with specific focus on the role of mirror neurons, might reveal a possible answer.

2.2.2. Neuron-mirroring and empathy

Neuroscience deals with all aspects related to the human nervous system, such as the brain, the spinal cord and nerves. Of all these, the brain is the main organ. It controls our basic functions, such as moving, breathing and thinking. Our brains also control our thoughts and behaviour (LeDoux 2003:[sp]). Neuroscience mainly occupies itself with questions why we do what we do and how the brain carries out these tasks. Although a detailed description of neuroscience falls outside the scope of this study, mirror neurons deserve some attention as they play a pivotal role in an empathetic engagement between people and are an integral part of why participants of role-play connect empathetically with the roles they portray.

According to Lohmar (2006:6) mirror neurons are located in the brain's premotor cortex. The premotor cortex area of the brain is responsible for controlling the movements of our bodies (Lohmar 2006:7). Research has shown that there are neurons in this area of the brain that also respond to visual observation of movement in someone other than the self (Lohmar 2006:7). Mirror neuron activation occurs when individuals see something happening to others that they could imagine happening to themselves – whether real or imagined (Blair 2015:[sp]). The individual responds to an expression (bodily or facial) and reacts as if it were

¹² Also lying outside the scope of this study, the work of Deborah Padfield (2011) is worth mentioning in order to exemplify the need for alternative methods of communication between physician and patient than those presently employed. Art in medicine is a powerful tool that could be used. Padfield, a chronic pain sufferer herself, was encouraged to express the pain she is suffering through means of drawing and writing. According to Dr. Charles Pither, a pain consultant, images may not assist in the diagnosis of an illness, however the diagnosis is only of "marginal relevance in many pain syndromes" (Wildgoose, 2002:1786). The notion of the importance of communication between physician and patient is confirmed and an empathetic consultation forms the cornerstone of open communication between patient and physician.

her/him performing the specific action as though s/he were viewing her/himself in a mirror performing the action (Iacoboni 2009:659). The mirror neurons thus fire, or activate the brain, in similar manner when we observe an action, as they would fire if we were to execute the same action.

Mirror neurons not only react where physical action is concerned, but may aid in the understanding of others' emotions. Iacoboni (2009:654-670) states that there is a strong interconnection between the imitation of actions and/or facial expressions or even thoughts of others and the ability to empathise with those we are communicating with – be on verbal or non-verbal level. The entire body reacts to stimuli on verbal and non-verbal level. According to Lamm (in Blair 2015: [sp]) human beings can either respond *with* another person or *to* another person. Both responses entail a measure of imitation. These can either take a 'bottom-up' level of processing that describes an automatic tendency to mimic the expressions of others or there is the 'top-down' way of processing, which is more of a cognitive process, where the conscious mind is involved. In both instances, there is the possibility that the imitation of others relies on neural mechanisms that become involved when emotion is experienced (Blair 2015:[sp]).

Our personalities and struggles are evident in the way we walk, talk and carry ourselves. Imitating what is being observed, activates the neurons responsible for evoking the emotion within the limbic region of the brain (Pessoa 2008:150) that can also enhance empathetic engagement. The argument that arises is how, neuroscientifically speaking, mirror neurons in the brain activate empathy. Although the answer to that question lies outside the scope of this study and will thus not be investigated, reference should be made to Pessoa (2008:150) who states that there are areas in the human brain where both cognitive as well as emotional responses are formed (Pessoa 2008:148-158).

Medical students are trained with the focus on clinical knowledge. Thus, possibly, the material they incorporate, stimulates only the cognitive areas of the brain and there is little opportunity for them to activate the emotional areas when it comes to practicing healthcare. In addition, medical students imitate other HCPs in their actions and manner of working as these are their role-models. If students of medicine activate the mirror neurons that imitate movements and expressions of HCP who do not display empathetic connections with their patients, they could empathise with these HCPs instead of the patients they are treating. This means that the medical students will feel closer to the HCPs and their way of working instead of feeling concern for their patients. This gives reason to question whether they, as future HCPs, might also treat their patients as HCP who lack empathetic engagements and prevent inter-subjectivity.

Apart from the role of mirror neurons when dealing with patients, the aspects of imitation that leads to feeling and empathy when mirror neurons are activated, are all present when adopting a role. When adopting a role, the participants know the thoughts and feelings of the role being portrayed; they adopt the posture and they feel what “the other“ is feeling. This gives reason to conclude that the adoption of a role may foster an empathetic connection to the role being portrayed. I will elaborate on the role of mirror neurons during role-play under the heading of metaxis further down.

2.3. Chapter conclusion

This chapter aimed at clarifying the concept of empathy in relation to the HCP-patient relationship. It draws strongly on the theories of Karl Jaspers, incorporating his theories and explanations as to why HCPs of today focus more on the clinical signs and symptoms of their patients, instead of investigating through an empathetic connection where the problem lies.

Furthermore, this chapter briefly looked at a domain of neuroscience with particular focus on the role that mirror neurons play in stimulating empathetic engagement between HCP and their patients. The chapter also makes brief reference to the role of mirror neurons play in an empathetic engagement when portraying a role. The following chapter moves into the field of AT with the aim of creating the backdrop against which the training session of role-play will be portrayed, as well as explain the relationship between role-play and empathetic engagement.

Chapter 3: Stepping into the shoes of another

3.1. Chapter introduction

This chapter provides a theoretical framework for process drama. This chapter also explains key strategies of process drama, in particular, role-play. The chapter further explains how partaking in role-play enables the participants to enter the state of metaxis by referring to Boal (2006) and Linds (in Cohen-Cruz et al 2006:114). The chapter furthermore looks at the connection between role-play and empathy by incorporating aspects of inter-subjectivity and mirror neurons. All of the above assist in contextualising the session of role-play within the framework of a clinical setting that I will discuss in Chapter four. The chapter moves on to a possible contextual structure for incorporating role-play into the session of role-play and elaborates on the role of the facilitator. Finally, the chapter addresses the importance of enrolling and derolling on the part of participants.

3.2. Applied Theatre (AT): a frame¹³

I make brief reference to Applied Theatre (AT) in order to frame the broad domain in which the mode of AT that I use for the purposes of this research is located. According to Nicholson (2014:5), distinctions between AT and applied drama are “moot” and the terms are often used “quite flexibly” and “interchangeably”. As mentioned in Chapter one, I acknowledge that there are debates around which term (drama / theatre / performance) best describes the ‘umbrella’ I referred to in chapter one (most notably, ‘drama’ or ‘theatre’). However, such debates fall outside of the scope of this dissertation.

I follow Nicholson’s position on the pliability and porousness of the term “Applied Theatre”. I use it as the “umbrella” that describes related practices and processes of drama / theatre that generally takes place outside of conventional theatre buildings – theatre for the purpose of education, research, training and that is situated within the “applied” domain.

Although applied drama and AT share conceptual, theoretical, methodological and practical principles, it may be more useful to focus on the aims of social and personal development that they also share, rather than to focus on what exact forms they take and what the

¹³ The work of Bolton and Heathcote (1995) is central to conceptualisations of the use of drama/theatre as a mode(s) of learning. They are incorporated as seminal sources in this study. O’Neill coined the phrase “process drama” to indicate the way in which she engaged with conceptualisations of drama as a methodology. Her work is indebted to Bolton and Heathcote. As such, she is also a seminal theorist.

divisionary lines are between them. Nicholson (2014:71) also states that contemporary practitioners combine elements of a multitude of forms, expressions and manifestations of AT to serve the aims of a specific project. In this chapter, the focus is on elements of process drama as a mode of the umbrella of AT.

Applied Theatre often refers to a cyclical process in which practice generates new insights and where, reciprocally, theoretical ideas are interrogated, created and embodied in practice (Nicholson 2005:44). AT inspires thought, critical reflection and empathetic engagement, which afford the opportunity of personal and/or social transformation (Rossiter 2009:36) through insight and growth. Applied Theatre is an ideal tool to use when conducting research, especially in the field of healthcare where medical knowledge revolves around complex questions of the human condition (Rossiter 2009:ii).

The role of the facilitator in AT is one of a revolutionary agent whose work it is to facilitate learning and a change of understanding, as well as set up a way through which participants can discover and personalise knowledge and learning content. Incorporating participants' experiences with regard to the proposed learning objective/s, allow them to engage meaningfully with the process that will be/or is taking place. This means that, in AT, participants are at the centre of the pedagogical process (Nicholson 2005:125). Applied Theatre uses a variety of modes, strategies and conventions to facilitate learning, including process drama.

3.2.1. Process drama

Process drama revolves around knowledge making through co-creation between facilitators and participants by means of engaging with drama and theatre-based strategies.

Rather than teaching didactically by adding to the participants' knowledge, process drama invites the participants to become actively involved in the learning process. In doing so, process drama diminishes the space between theory and practice. This means that the knowledge does not occur through the attainment and integration of facts, but occurs within the participants themselves. Process drama enables the participants to create the new knowledge by making use of what they already know and bring with them into the sessions (their personal luggage) (Morgan & Saxton 1985:217).

Through the incorporation of previous knowledge, process drama aims at exploring issues or problems and negotiate meaning around these. In doing so, the reciprocity between

participants in process drama generates new forms of social and cultural capital (O'Neill 1995:xiii).

Process drama focusses on the process evoked in the participants through engaging with drama and theatre-based strategies and the effects thereof, rather than on a staged product (Nicholson 2014:5). In process drama, there is no need to take a script or audience into consideration, or to display acting or theatre skills. In doing so, the participants become both players and audience – they self-spectate. The experience in process drama is of an inward self-reflective nature. This affords the participants the possibility of a state of inner connectedness, allowing for a more conscious awareness of meaning making that is occurring at the very moment the experience is taking place.

This state of inner connectedness where the participants reflect inward and connect with themselves may be likened to the inter-subjective process that takes place when HCP and patient share an empathetic engagement and the world of the HCP and the world of the patient become one for the duration of the consultation (Geist 2013:265). During a session of role-play the participants are asked to step into the shoes of another and represent the self in an unfamiliar situation. They are asked to enter into a fictional world and connect to the self in the realm of this fictional world and the role they are adopting. Much like it is expected of a HCP to step into the world of the patient and form an inter-subjective connection in order to be able to understand what the patient needs in line of optimal treatment (Stewart 1995:1429). Thus the consultation sessions between HCP and patients as well as the sessions of role-play lead to inter-subjective connections. The first consists of an inter-subjective connection between HCP and his/her patient, the other consists of the participant during sessions of role-play that form an inter-subjective connection with the roles they adopt.

In process drama, participants are placed in imaginary contexts where they are encouraged to engage with the learning content by identifying and empathising with 'real life' issues via roles and dramatic situations and so investigate relationships or issues related to the learning content 'as if' they were real (O'Neill & Lambert 1990:11). I will address the notion of taking on a role more fully later in this chapter. The imaginary context is strongly centered on human interaction, dilemmas, situations, behaviour, and relationships in relation to the learning material (the human condition). In the light of a human dilemma surfaced by the imaginary context, participants negotiate between their own beliefs and those of the role. Whilst obtaining concrete and factual knowledge is necessary in an educational context, dramatic exploration of the human context in which the knowledge is located allows

participants to evaluate their own positions in relation to the perspectives, values, decisions, behaviours, actions and biases of the role they play.

Although process drama is instituted with a specific learning objective in mind, the actions and the justification for actions are determined by the participants themselves (Weltsek-Medina 2008:[sp]). The unscripted and possibly unpredicted decisions leading to dramatic action are based on prior knowledge that the participants possess and bring with them into the session. Participants are encouraged to make sense of themselves within their own cultural and social contexts, investigating, transforming and questioning their own personal experiences and meaning-making processes by stepping into the shoes of another in an imaginary context. This means that any discoveries made in the fictional world of process drama, are discoveries that stem from personal convictions and/or experiences. Participants formulate their actions and reactions according to their own lived experiences and their own realities (Weltsek-Medina 2006:1). Process drama offers participants the opportunity to discover the knowledge they already possess and allows them to access how they feel about what they know in a new, different situation.

Participants experience the process while they are evaluating at the same time and are able to make connections to other experiences (O'Neill 1995:1). This is possible because participants think "*in and through* the materials of the medium they are working in", manipulating and transforming these materials according to the parameters of the learning experience (O'Neill 1995:1). The inner connectedness to the self, enables inner exploration and learning can take place.

Furthermore, process drama offers the participants a safe platform to experience and investigate their feelings and thoughts in relation to the roles they adopt. The roles the participants adopt within the given scenarios are far enough removed from their personal lives for them to allow the action to take its course without them feeling threatened because these may be too close to them on a personal level (Nicholson 2014:55). The safe platform that process drama offers, allows for improvised action to take place which, in turn, allows for the exploration of "deep personal connections to themes and issues" (Weltsek-Medina 2008:[sp]) if facilitation is optimal.

Regarding the pedagogy of process drama, learning takes place through the interaction with others. Process drama affords the participants the opportunity to portray the self in circumstances not necessarily encountered in their normal, everyday lives. This opportunity enables them to gain insight into situations and experience emotions they would not necessarily have experienced under other circumstances (O'Neill 1995:79; Nicholson

2005:74; Bowell & Heap 2013:113). All the aspects contribute to meaning making and a personalised process of knowledge-creation. If the strategies employed are used optimally and the session of process drama is facilitated well enough, the experience gained, takes place on a personal level, unique to every participant yet relational to those of other participants.

Applied Theatre offers the possibility of constructing the session of process drama around any given set of circumstances, depending on the learning outcomes that have been set out to be achieved. This study is taking place in a healthcare setting, involving students who have chosen to become HCPs. This, together with the fact that this study's main focus lies on the empathetic engagement between HCPs and patients, for the purpose of this study, thus, the participants will be expected to enter both the world of a patient as well as that of HCP. The most appropriate process drama strategy to be introduced in order to meet the objectives of the study, was that of role-play. During a session of role-play, participants enter the world and gain insight into the attitudes, values, thoughts and feelings of the role they adopt.

3.2.2. Role-play

Role-play refers to a process where one adopts the actions, attitudes and demeanour of a role to gain insight into how another (or oneself in a different role) thinks and feels. It forms an integral part of any process drama.

Role-play consists of the two words "role" and "play". In this case, "role" refers to the action of taking on a role and "play" defines the fact that the action of "taking on a role" should contain a measure of "play" (Ladousse & Malay 2004:5). Playing means that the act of role-playing takes place in an environment where participants feel safe to create their own reality within the structure of the role-play (Ladousse et al 2004:5). By doing so, they are also experimenting with their knowledge of the real world (Ladousse et al 2004:5).

Bolton (1984:176) states that taking on a role enables the participants to detach themselves from their adopted worldviews. Role-play "invites modification, adjustment, reshaping, and realignment of concepts already held". Detaching from an experience allows the participants of sessions of role-play to look at their experiences from a new perspective (Bolton 1984:156). It is this new perspective of prior knowledge that leads to new insight and where learning takes place.

Through the process of role-play, individuals can gain new insights or awareness by taking on a role and responding to a situation in an unplanned and unpremeditated way (O'Neill 1995:80) *as if* it were real. This leads to a dynamic process of "self-creativity" which offers the possibility of reflecting about the relationship between the "self and other" (Nicholson 2005:72).

Role-play has the capacity of breaking through the frames of ordinary existence and creating an own reality (Chinyowa 2006 [sp]). Through this process, established norms can be recognised and historicised (regarded as history). The process of historicising enables distancing and an objective viewing and analysing becomes possible, this can lead to dissection and questioning – the answers offer the opportunity for possible growth (Nicholson 2005:74).

Linking strongly to the above is the fact that the participants involved in role-playing are aware that the situation is not real. By entering a world of make-believe, the players willingly suspend their disbelief as they enter a symbolic world and operate in it "as if" it was real. The knowledge that this world is a world of drama, enhances the notion of a safe space for them to explore thoughts, feelings and reactions not always possible in the world of day-to-day living (Weltsek-Medina 2006:1). Without the creation of a safe space that enables the participants to suspend their disbelief for the duration of the sessions of role-play, role-play cannot fulfil its role as the powerful learning tool that it could be.

According to (Bolton 1998:179) complete engagement on the physical, emotional as well as the cognitive levels is of the utmost importance in the experiential learning process that a session of role-play consists of. If the engagement lacks any of the above aspects, the learning process will be a superficial one at its best as process drama deals with the learning on personal and feeling level as opposed to didactic teaching where the process is of a pure cognitive nature. If the participants have not been sufficiently prepared to step into role, it will negatively influence their ability to create an empathetic connection to the role they have been asked to portray. Without complete engagement of the participants on "physical, emotional as well as cognitive levels" (Bolton 1998:179), the training session of role-play will not bring about the insight that has been hoped for. The greater the immersion or engagement, the greater the potential for reflection following the session and the greater the learning experience.

If the participants are fully engaged, as stated above, partaking in an activity of role-play fosters the development of empathy because, as the participants take on a role, they experience another's distress as their own and they experience empathy and understanding

from a different perspective (Poorman 2002:34). The different perspective that Poorman (2002:34) refers to, bears reference to the fact that, by taking on a role, the participants of role-play experience their own feelings from inside the situation the role of another.

Yet, Decety and Lamm (2006:1146–1163) state that the sharing of feelings is not sufficient to elicit empathy as it is a “complex form of psychological inference in which observation, memory, knowledge, and reasoning are combined to yield insights into the thoughts and feelings of others”. As mentioned in Chapter two although the neuroscientific aspect of empathy falls outside the scope of this study, mirror neuron activity during role-play deserves to be mentioned as it stands central to why role-play encourages empathy. As presented in Chapter two, Iacoboni (2009:653-670) argues that the imitation of the actions and/or expressions of another, activates the involvement of mirror neuron activity in the brain. Human beings feel what they imitate. Because imitation is an important aspect of the process of role-play, it underpins the concept of empathetic engagement in the process of role-play. The neural-affective-kinaesthetic-cognitive responses that imitation evoke are not limited to what is “real”.

As Blair (2015:[sp.]) states, emotions and/or responses can be “evoked in us by another, who can be real or ... imagined” (Blair 2015). Apart from mirror neuron activity in the brain, role-play is a means of activating the imagination. Through imagining, the participants place themselves in the situation of another and act as another in that situation. By doing so, they experience sensations that might be similar as those of the other (Decety et al 2006:1151). This answers to Blair’s suggestion that conditions for empathy include that an individual must, to some degree, feel what another individual is feeling and imagine him/herself in the situation of another. Engaging in role-play thus has the capacity to evoke an empathetic response as one considers and feels for the situation that another finds him/herself in.

By partaking in role-play and taking on the role of another, the empathetic engagement is internalised (Nicholson 2014:78). At the same time, Blair’s (2015) reminder that a prerequisite for empathetic engagement, is that participants should be aware that they are not another. This needs to be taken into consideration if the potentialities of role-play are to come into effect. In role-play participants are confronted by themselves-as-another in another reality.

Plato referred to the condition of existing between being human and experiencing the divine as *metaxis* (Falconer 2011). The origin of the word *metaxis* stems from the Greek word “*metaxu*” which means in the middle, between or in the interval. It is seen neither as good nor bad. It is regarded as a space that sees the mediators between the two worlds as

entities that fill the space in between. By filling the “space in between” it connects two universes (fictional and real) and creates a whole (Cohen-Cruz & Schutzman 2006:114). Boal applied the Platonic idea to his explorations with the “Theatre of the Oppressed”. In the Boalian sense, metaxis is the state of living in two worlds simultaneously—the actual and the imagined (Cohen-Cruz et al 2006:6).

During the state of metaxis, the participants of role-play experience the self while they are portraying a role. During sessions of role-play, the participants exist in the space that is being created between the fictional and real worlds. They are participants of role-play as well as spectators to what is taking place within themselves during the process at the same time. The fictional world of the drama versus the “real” world outside are two worlds that overlap during the process of role-play. Thus, role-play becomes a process of oscillation between the fictional world of the drama and the “real” world outside (Van den Berg et al 2014:3). It is in this space in between the real and the fictional where learning takes place.

Although participants of role-play feel and express real emotion, Bolton (1984:155) states that, due to the level of abstraction when participants find themselves in the state of metaxis, raw emotion is made lighter by the space between the world of the role and the real world when the participants find themselves in both the role as participants and observer. The distance to raw emotion that metaxis creates, allows the process to remain emotionally safe enough for the participants to feel brave enough to explore their inner selves in order to learn (Bolton 1984:156).

In addition to metaxis and living in two worlds at the same time, the function of mirror neurons deserve mention. Whilst adopting a role, the participants take on the posture and expressions of the role they are portraying. According to Lohmar (2006:10) we feel and experience the movements of those we observe as though we are in an “as if” (Lohmar 2006:10) mode. He continues by saying that that the experiencing of another’s actions cannot be limited to the kinaesthetic [movement of the body] as “an action always has a goal and is accompanied by sensations” (Lohmar 2006:10). In other words, the actions we observe in others, evoke feelings in us. The mirror neurons that are triggered in response to actions observed also bring with them emotions (Lohmar 2006:10). He states that “we experience an unavoidable proximity and cognitively immediate bodily equality which is the basis of access to others” (Lohmar, 2006:15). Linking strongly to the above, is Iacoboni’s statement that: “we come to understand others via imitation, and imitation shares functional mechanisms with...empathy” (Iacoboni 2005:2). Mirror neural activity provides access to, and understanding of, the minds of others by modelling emotions, actions and intentions in/through an individual’s own body (Iacoboni 2009:653).

The participants of role-play adopt the posture of the role being portrayed. If we feel and experience the movements of those we observe, then observing the self in a role that is being adopted, and the activation of the relevant mirror neurons will establish an empathetic connection to the role being portrayed.

As a brief summary of the above, in the state of metaxis where participants live between the real and the imaginary, the activation of mirror neurons activates an empathetic connection to the role being portrayed. It is in this state where the observer (the self) and the observed (the role) become one through empathetic engagement and form an inter-subjective connection to the role they have adopted. Insight and understanding follow and learning takes place.

For the purpose of this study, where an empathetic connection between HCPs and his/her patients formed the central part of the training session of role-play, the participants were afforded the opportunity to portray both the role as HCP as well as that of patient. Through the portrayal of roles and breaking through the frames of their ordinary existence (Chinyowa 2006:[sp]), the participants enter into a space that they create as a reality for the duration of the session of role-play. This is a space where the world of the play and the real world overlap. It is a safe space (Ladousse et al 2004:5) as the adoption of a role removes the participants from their everyday lives and they can explore their own feelings, thoughts and beliefs.

While the participants find themselves in this space, they are also at the centre of the pedagogical process (Nicholson 2005:125), which means the learning revolves around them and does not contain learning that comes in from outside – as is the case with didactic teaching.

According to Linds (in Cohen-Cruz et al 2006:114) metaxis not only occurs at the border between the real and the fictional; it also exists as an encounter between participants and their role in the play. The encounter between participants and the roles they adopt enable the participants to form an inter-subjective connection with the role as the worlds of their “everyday selves” overlaps with the world of the role they are adopting. There is simultaneous exploring and observation taking place.

By filling in the space between the worlds of being and the representation of an assigned role, the participants find themselves in the middle of two modes of existence: the person s/he is in real life and the role s/he is portraying. By identifying with this role, the participants create a sense of an awareness of the self that leads to both identification (in-role) as well as

a stronger awareness of identity (outside of the drama) (Nicholson 2005:72). This is the moment of insight followed by cognitive investigation and concluded by understanding. It is this state of 'being' while 'experiencing [metaxis]' during role-play that generates new insight.

By adopting both the role of the HCP as well as that of patient during the session of role-play, the participants were able to explore themselves in their roles as HCP as well as patient. They were able to question and explore and in doing so, reach their own conclusions as to what they would like to experience of how they would like to adopt the role as HCP toward their patients once they re-enter the clinical setting.

3.2.3 Mantle of the Expert (MoE)

Making use of the Mantle of the Expert (MoE) approach requires of the participants to "question, negotiate, compromise, take responsibility, cooperate and collaborate, all in the service of something beyond themselves" (O'Neill in Heathcote & Bolton 1995:viii). Adopting the MoE approach enables the participants to take risks, while the facilitator's role is one of a co-creator of knowledge (Sayers 2013:80).

Dorothy Heathcote adopted the idea of a frame, or position from which participants would respond, throughout her practice. It was to become the "expert perspective" of MoE (Edmiston 2003). Heathcote based her notion of the "frame" on the work of the Canadian sociologist, Erving Goffman (in Howell & Heap 2013:54). Goffman used the term "frame" to refer to "viewpoint that individuals have about their circumstances". The frame enables them to make sense of an event or a specific situation concerning the impact this will have on them as individuals (Howell et al 2013:54).

According to Heathcote "... the 'Mantle of the Expert' [MoE] system of teaching involves a reversal of the conventional teacher student role relationship in which the students draw on the knowledge and expertise of the teacher. When the MoE is used in drama, the teacher assumes a fictional role, which places the [participant] in the position of being 'the one who knows' or the expert in a particular branch of human knowledge" (Heathcote and Herbert 1985:173).

The MoE approach regards the participants as the co-constructors of the learning process (Fraser 2013:35). In the didactic teaching method where the transmission of knowledge is based on what the facilitator would like for the students to learn, where learning is for "some time in the future or for a test" (Fraser 2013:38), learning becomes merely a cognitive acquisition of knowledge. Instead of regarding the viewing learning as an interactive process

of processing information, it views the participants as a “passive receiver of knowledge” ((Heathcote et al 1985:173). In the case of didactic teaching, participants are regarded as consumers of knowledge in a context where they have little status and few rights” (Edwards & Furlong in Heathcote 1985:173). They are regarded as subordinate participants in a learning process where their main role is to listen (Edwards et al in Heathcote 1985:173).

In the MoE approach, the facilitator relinquishes the role as a giver of information and adopts the role of the enabler of knowledge. It allows the participants to take an active part in the process of the creation of knowledge by placing him/her “inside the structure” (Heathcote 1985:173). The MoE approach can be regarded as “a communication system that allows learning to take place simultaneously at conceptual, personal, and social levels” (Heathcote et al 1985:173). Adopting the MoE approach enables the participants to “change the context from the inside” because they control the direction that the session of role-play will develop. The facilitator of a session of MoE, does not give information as the expert, but rather guides the process for the participants to discover what they know (Sayers 2013:82). The MoE approach, places the participants at the centre of the pedagogical process (Nicholson 2005:125).

During the MoE approach, characterisation is central to the process as meaning comes to light through the context in which the role-play is set (Sayers 2103:79). In MoE there is less focus on “being” as the learning takes place through “watching” (Sayers 2013:90). Through the introduction of a symbolic imaginative reality, a “problem” is introduced through the affective [feeling] mode, which the participants explore and work through on cognitive [thinking] level (Heathcote 1985:174). In other words, the combination of the affective and the cognitive, allows for the participants to combine prior knowledge, what Morgan and Saxton refer to as personal luggage (Morgan & Saxton 1985:217), and feelings. This allows for a creative (affective) exploration of solving problems on cognitive level.

By following a step-by step approach during a session that adopts the MoE approach and through the application of the dramatic imagination with regards to the social reality that is to be adopted symbolically, the facilitator enables the participants to gain expertise (Heathcote, 1985:174) through participation.

A more detailed description of some of the elements of the MoE approach into the training session of role-play will follow below under the heading of “Strategies used to facilitate the MoE approach during a session of the AT strategy of role-play”. I will describe how I incorporated the elements into the session of role-play in more detail in chapter four where I elaborate on the lesson plan and the session of role-play.

Mantle of the Expert deals with the notion that in applied drama that the students, not the teacher, are the ones who hold the knowledge. The participants enter the sessions of role-play with predetermined ideas, experience and knowledge. Students who take on the MoE are in an active state of attention, they generate their own knowing which is embedded in a fertile context (Heathcote & Bolton 1995). In order to render the learning process valuable, the facilitator works with what the participants bring into the sessions by drawing and building on their predetermined knowledge towards the envisaged outcome. In this way, the participants are regarded as the experts in their field of knowledge concerning the roles they adopt. The MoE approach asks of the participants to find “solutions to problems” (Wagner 1999:180). This approach empowers the participants to draw on their knowledge to make decisions (Wagner 1999: 212) to drive the action. So, although they may not be real “experts” in the realm of the roles they adopt, the participants are regarded as experts concerning the decisions they make based on the knowledge they bring with them into a session of role-play.

The MoE approach allows the participants to remain actively involved as the sessions revolve around their inputs, ideas and knowledge. The teaching method builds on what the participants already know. This approach enables the participants to create new knowledge with them instead of being a purely didactic session where the knowledge they are expected to acquire has no connection to who they are as human beings.

3.3 Strategies used to facilitate MoE approach in the applied drama strategy of role-play

Throughout Heathcote’s teaching, she made extensive use of symbols or a “dramatic metaphor” (Heathcote 1985:174). She often started a session of role-play with an object that carried specific symbolical meaning (Wagner 1999:93). Introducing an object served to create a central point of focus around which the drama will unfold (Wagner 1999:91). The introduction of an object also created a “frame” within which the drama will take place.

In terms of the MoE approach, through the AT strategy of role-play, the “frame” enables the participants of role-play to view the unfolding of the session through “a window that has been shaped by ... previous life experience” (Bowell et al 2013:54). In process drama, the frame creates a collective concern and binds the participants to steer the focus of the sessions in the direction that “the learning is located” (Bowell et al 2013:55). Although the participants will work from the same point of view, everyone will regard the situation from their individual windows and the learning occurs on individual level within the framework of the training session of role-play.

The frame within which sessions of role-play are set, aid in building belief. Building belief is a means of drawing the participants into the world of the drama to such an extent that they immerse themselves and believe in “the big lie”. The big lie refers to the fictional world of the drama (Wagner 1999:67). It is in this world of the drama that the participant needs to create a role with an own personal inner world (van Vuuren 2004:217). This role lives in the world of the drama while the person who survives in the ordinary world observes the role’s action from the perspective of an inner audience. In other words, the participant fluctuates between the states of reality and fiction. This fluctuation allows for an oscillation between empathetic involvement and a more objective detachment, creating the state of metaxis (Van den Berg et al 2014:3). As mentioned above, it is in this space where learning and growth takes place. Without belief in the world of the drama, complete engagement on the part of the participant cannot take place.

Heathcote assigned particular roles or tasks to the participants involved in the sessions of role-play (Wagner 1999:135). Heathcote chose the roles she assigned with care and introduced specific roles that align with her learning objective (Wagner 1999:135).

According to Heathcote (1985:176), teacher modelling refers to indirect teaching “through the dramatic metaphor”. Incorporating this strategy, the facilitator of sessions of role-play adopts a specific role, which is in line with the “frame” and the learning outcomes. This adopted role enables the facilitator to create a link between the sessions of role-play and the learning objectives that need to be met (Heathcote 1985:176).

Withholding expertise links strongly to the MoE approach. The improvisation that takes place during the sessions of role-play, allows the action to flow according to what the participants bring with them into the sessions, what they give and how they respond. Should the facilitator intervene in such a manner as to influence the action to move away from the route it would have taken without the facilitators influence, because s/he regards his/her own insight as more valuable than what the participants are delivering, the sessions will take on a direction that the participants would not have not proposed and the learning will be influenced negatively.

The second strategy that I introduced and that was incorporated throughout is thought tracking. Thought tracking is a process that makes use of “stopping the action” at any given time during the session of role-play. Thought tracking relates to questions that are asked about the thoughts and feelings of the person being portrayed at any given moment in time. This enables the participant to enter the role on a deeper level and allows him/her insight

into what they are experiencing at that time. It enables insight and understanding of the person being portrayed (Fernandez 2002:140).

I also integrated the reverse as a strategy. It links the fact that every situation has two sides (Morgan & Saxton 1989). This notion was utilised in the manner that every student had the opportunity to portray both the role of the HCP as well as that of the patient. By enabling the students the experience of adopting the role of the patient, afforded them the insight into how the patient feels. In turn, this served to deepen the students' understanding of how "the patient" feels when in consultation with a HCP. This insight should lead to more empathy towards the patient sitting opposite the healthcare practitioner (O'Neill & Lambert 1990).

Questions are also an integral part of any process drama session. Questions are a tool that I used to enquire and incorporate what the participants are thinking and/or feeling. Heathcote used questions with a specific purpose in mind that steered the lesson towards the desired learning outcome. Making use of the correct goal driven questions, and incorporating the answers into the session, allowed for Heathcote to incorporate the MoE approach. The participants feel that their thoughts and inputs are important and valued. This leads to confidence in their own thoughts and keeps the interest alive (Wagner 1999:185).

According to Wagner (1999:56) Heathcote used seven varieties of questions in order to, "seek information or assess student's interest" and to supply information. Heathcote made use of "branching questions" that asked of the group to decide which course of action they would like to take. There were questions she used to control the class; some were posed to establish moods or feelings, to establish belief in the action or to deepen insight.

Another important strategy that the facilitator of a session of process drama can incorporate is teacher in role. This refers to the moments when the facilitator steps into the drama and becomes a part of it (Morgan & Saxton 1987). The aim is to assist the students' learning process by introducing aspects that the students' might not arrive at spontaneously. This strategy needs to be applied with deep regard and respect as to what the aim of the drama is at the given moment when the facilitator decides to step into role (O'Neill & Lambert 1990).

There are numerous advantages of the teacher in role. Stepping into role allows the facilitator to view with the class what is happening from the inside. It also allows the facilitator into the drama and s/he can therefore control the pace and rhythm from a space within. As a teacher in role, s/he can support and encourage by keeping communication

open as well as share the discovering with her/his students and move them to new understanding (Morgan & Saxton 1987).

The status of the facilitator in process drama is to observe the action closely in order to allow for the drama to stay in one place for students to pull out new information which leads to depth (Wagner, 1999:26-35) or to introduce elements of theatre craft (like focus, tension, contrast, symbolisation) in order to create dramatic tension (Morgan & Saxton 1987:1-5).

Apart from the above, the facilitator dealing with process drama has numerous strategies that s/he can employ in presenting a learning session. There are further strategies that came into play to allow the sessions to progress. I will mention and discuss them further down in my discussion of the role-play session where and as applicable.

In order for the session of role-play to follow a certain structure to head results, I relied heavily on Morgan and Saxton's example of the outline for a lesson plan (Morgan & Saxton 1985:217). These need to be referred to before the outline of the lesson plan can be discussed in the following chapter.

3.4. Role-play within a contextual structure

Morgan and Saxton (1985:217) outline a contextual structure according to which a lesson plan for process drama may be developed (See Figure 2). They describe three main sections consisting of substructure, structure and superstructure. In the paragraphs below, I will shortly describe what substructure, structure and superstructure entail. I will also outline how I incorporated Morgan and Saxton's contextual structure into the planning of the training session of role-play.

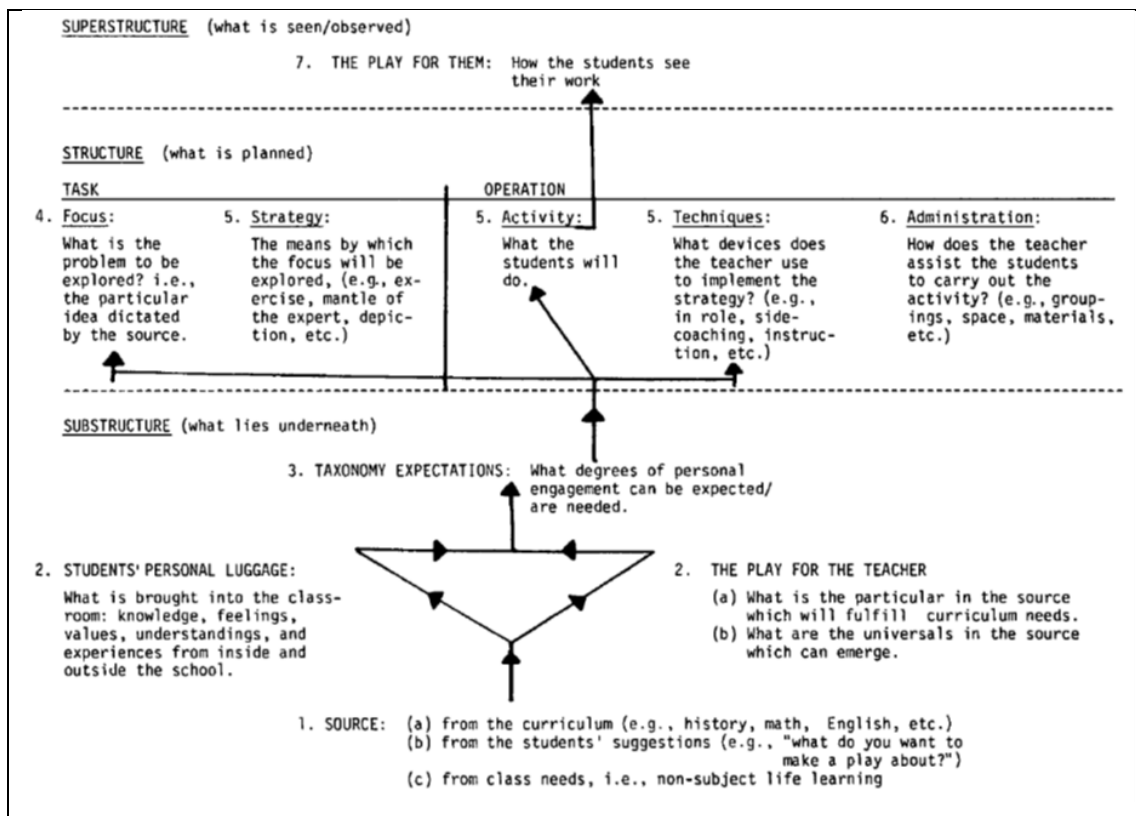


Figure 2. A contextual structure for drama planning (Morgan & Saxton 1985:217)

The substructure deals with the preparation phase of the training session of role-play. It places focus on the source of the session, the play for the teacher (in this case it is the question this study aims at answering) and takes the students personal luggage (or what they bring to the session) into account. The substructure also addresses taxonomy expectations (or what degree of personal engagement is required from the participants in order for the study to reach its objectives) (Morgan & Saxton 1985:217).

In the case of this study, the source of the action will be a consultation session between HCP and patient as the empathetic connection between HCP and patient forms the basis of the study. I addressed the play for the teacher by structuring the session of role-play around the research question I want to investigate during the training session of role-play. The participants' personal luggage was taken into account by adopting the MoE approach during enrolment. I will discuss the taxonomy expectations in more detail under the heading of enrolment.

According to Morgan and Saxton (1985:217) the structure, as depicted in Figure 2, serves to outline the lesson plan in preparation for the training session of role-play. During preparation of the training session of role-play, I made use and relied heavily on the contextual structure

as depicted above. The description of the lesson plan pertaining to this study will be discussed in more detail chapter four under the heading “Structure”.

Superstructure deals with “the play for the students” (Morgan & Saxton 1985:217) and deals with what takes place during the activity phase of the training session of role-play. I will discuss superstructure through a description of what took place during the session of role-play in chapter four further down.

Because of the fact that much process drama is a “cyclical process” where the focus lies on an internal process, it necessitates an outside driving force in order to move the process drama forward. A session of role-play within the broader scope of process drama, cannot take place without a skilled facilitator present.

3.4.1. The status of the facilitator in process drama

The status of the facilitator in process drama is to facilitate a process where the participants investigate and share the prior and/or embodied knowledge they possess. The facilitator incorporates what participants share. Through guiding the process and ensuring that it moves towards the learning objective, s/he enables the participants to create new meaning given to what they already know. The facilitator needs to be open and accepting to work with what the participants contribute. This method of learning stands in strong contrast to didactic and teacher-driven learning where students are asked to incorporate the ideas of the teacher and giving this back as it has been received (banking education).

The moment the participants take over the responsibility for the direction the work is going in process drama, can be a point of anxiety for the facilitator. The facilitator handles this feeling of loss of control in one of two ways: s/he either freezes because the “pattern of expectation has been shattered” (Morgan & Saxton 1985:211) and the facilitator is unsure of what to expect next. Another way in which the facilitator might react is by spending time in an attempt at manipulating the participants’ answers and responses back into the expected format (Morgan & Saxton 1985:211).

In order to prevent the facilitator from feeling that s/he is losing control, facilitators need to equip themselves with sound tools to guide the process in order to reach the learning objective through incorporating what the participants have shared. It is important for the facilitator to have a sound foundation of “know how” because every group is different and the strategies of teaching need to be adapted accordingly for the group to be directed in the most appropriate manner for learning to take place (Morgan & Saxton 1989, Balfour 2016).

Incorporating what the participants share into sessions of role-play, is what keeps them at the centre of the pedagogical process. In order for the sessions of role-play to incorporate what the participants bring to the sessions, while still working towards the learning objectives to be met, it is of the utmost importance that the facilitator is in possession of a “tool kit” in the form of strategies that can be employed (Appendix I). The structure and strategies that were employed during the course of this study will be described and explained in detail in the following chapter.

3.5. En/derolment

As mentioned, the focus in process drama lies on the participants’ individual discoveries. (Weltsek 2005: 76). In process drama where the participants work in a space where the setting does not necessarily resemble the setting that the drama is unfolding in [such lighting to create atmosphere and as set to reflect the world on stage], means that the participants must rely heavily on their imagination (Anderson, Carrol & Cameron 2009: 24). In order to create a dramatic world that the participants can believe in, it requires what O’Neill refers to as pre-text (1995:19). O’Neill (1995:19) uses the term “pre-text” when referring to the enrolment process. She states that the “dramatic world may be activated by a word, a gesture, a location ... an object”. According to O’Neill, pre-text refers to the stimulus that the facilitator uses to introduce the drama. It either can be deeply “significant with the ongoing action” or can function merely as starting point (1995:XV).

As I describe in chapter four, I realised that, as researcher and facilitator of the training session of role-play, I have a duty towards the participants to protect them from the aspects raised during reflection while they are partaking in the session of role-play.

Sayer (2012:87) states that partaking in role-play should be accomplished by a “carefully structured projection into emotion”. Participants of role-play should be able to engage without feeling threatened (Sayer 2013:87). According Heathcote and Bolton assuming that a topic should be entered through characterisation, one takes the risk that the participants, “in their attempts to express the pain felt by those fictional characters, will retreat into glibness or expose themselves to distress” (1995: 84).

I relied heavily on the above during the enrolment process. I wanted to assure that the participants did not feel threatened by the roles they adopt as it might force them to withdraw into “the glibness” mentioned above (Sayer 2013:87). The enrolment process I followed is described in more detail in chapter four, after which the deroling process will be discussed.

3.6. Chapter conclusion

After offering a broad description of AT, the chapter narrowed its scope down onto process drama. Then it focussed on the strategy of role-play, the relationship between empathy and role-play and the workings of metaxis. I incorporated a possible contextual structure for incorporating role-play into a lesson plan. The contextual structure is included as an outline that I based the session of role-play on. I also discussed the importance of the status of the facilitator in process drama before I touched on some strategies that I incorporated into the role-play session in order to incorporate the MoE approach.

The following chapter will serve discuss the process of how the session of role-play was structured and what transpired during and following the session of role-play. The extraction of themes will be described and I will look at, and discuss, these themes and the pre-and post-training results of the JSPE (S-version).

Chapter 4: The empathetic physician

4.1. Chapter introduction

In chapter three, I sketched a brief outline of process drama in order to contextualise the session of role-play pertaining to the study that I conducted. I elaborated on the strategies I, as facilitator, employed during a process drama session of role-play and described the role of the facilitator.

Chapter four contains my preparation and planning for the role-play session with eight fifth year medical students. I document the planning and implementation of the session and elaborate on some of the key process drama strategies that I employed. This chapter also serves to discuss theme extraction following reflections as well as the results obtained from the JSPE (S-version). The focus lies on what surfaced from students' engagement with role-play and what the comparison between the pre- and post-training survey brought to light. After the final set of data gathering and theme extraction, the data were analysed by making use of the mixed method convergent parallel design in order to reach a conclusion.

The purpose of my study is not to analyse myself as facilitator, but rather to use my facilitation towards exploring my research aims. In order to reflect on and discuss what arose from the role-play training session, I refer to some of my own reflections on my teaching process where necessary.

At this point, it necessitates a brief outline of the developmental phases of the study that I had discussed in chapter one. The outline serves as a reminder pertaining to how the session was conducted and will serve the aim of contextualising the session of role-play in this study.

4.2. Data gathering and analysis

4.2.1. Introductory session

I introduced the study to a group of 40 fifth year students enrolled at SMU for the year 2017. The introductory session of ten minutes was introduced during the Practice of Medicine (POME) 502 integrated presentation block.

I informed the students that I could not tell them what the session of role-play would be about that they would be given the opportunity of looking at themselves to explore where

they experience difficulties in terms of “interhuman connection situation” during a training session making use of role-play in order to possibly surface alternatives.

No mention was made that the session of role-play would deal with an empathetic connection between HCP and his/her patients due to the Hawthorne effect, where people’s reactions change the moment they are aware of being observed (O’Neill 1995:69; Coombs & Smith 2003:98). If the participants would be forewarned that the study involves an empathetic display of emotions, the possibility could arise that they would adopt an artificial measure of displaying empathy as explained by mention of the Hawthorne effect.

I explained the structure of the study in terms how the sessions would be laid out by stating that session one would deal with the completion of reflection questions. Session two will deal with the session of role-play. Finally, the third and last session, will be conducted four weeks after the training session of role-play. Session four will consist of the completion of another set off reflection questions pertaining to what they had experienced during and the effect that the session of role-play had on them. Following the introductory first session, eight participants volunteered. I assured the students that the study would work according to their schedule in order to accommodate them, that they can withdraw at any time and that they will remain anonymous. I obtained the details of the participants in order follow up and arrange a time that would suit them.

4.2.2. Session one

Session one took place on the 31st of May 2017. During this session, I asked the participants to sign the letters of informed consent (see Appendix A). They also completed a self-reporting measurement tool of empathy, namely the Jefferson Scale of Physician Empathy (JSPE) Student Version (S-Version) (see Appendix B). I also asked the participants to reflect, in writing, by answering five questions pertaining to what they had observed regarding empathetic behaviour in themselves, their peers and HCP in the clinical setting (see Appendix C).

After I thanked the participants for arriving on time and being willing to partake in the study as well as a briefly recapping an outline of what the study will entail, I revealed to the participants that the study deals with empathy. This disclosure was necessary due to the nature of the reflective questions and the JSPE (S-version) that they had to complete. Before I asked them to sign the letters of informed consent. I reminded them, once again, that they can withdraw from the study, should they so wish.

After signing the letters of informed consent, I handed the participants the JSPE (S-version) forms. I asked the participants to choose an individual marker that will remain the same for all forms to be completed for the duration of this study. Using Individual markers, instead of names, ensures for the collected data to remain anonymous. Retainment of the same individual markers would enable me to compare the JSPE (S-version) forms as well as the reflection sheets with their original counterparts in order to ascertain the qualitative effect of role-play on the empathy levels of individual participants.

I handed the JSPE (S-version) to the participants before I asked them to reflect, in writing, on what they had observed in relation to empathetic behaviour in themselves, their peers and other HCPs. I asked them to complete the JSPE (S-version) first, in order to afford them a deeper understanding as to what empathy entails before I asked them to reflect on the subject.

The JSPE (S-Version) deals extensively with questions pertaining to empathy (Appendix B). Completing the score by answering the questions, I felt that the participants would have gained insight into the scope of what the term empathy between HCPs and their patients entails. I did not see the need to explain the term to them in more detail. I did not want to take a chance to influence the participants in any way so as to taint their own thoughts and ideas during reflection. I also wanted to allow them to complete the JSPE (S-version) before their own feelings could be influenced through answering of the reflection questions. I was aware that, once they had reflected on what they had observed regarding empathy in the clinical setting, they might feel compelled to score the JSPE (S-version) according to the insights gained during reflection. The possibility exists that, what might otherwise have been an untainted, initial response, relating to the completion of the JSPE (S-version), may become tainted through their newly acquired insight.

I wanted them to reflect purely from their point of view. This would allow the incorporation the MoE approach (Wagner 1999:185) where the students “personal luggage” (Morgan & Saxton 1985:217) forms part of the session of AT, enabling the participants to become co-constructors of the knowledge they would create (Fraser 2013:35) during the session of role-play.

After completion of the JSPE (S-version), I briefly explained the difference of superficial versus in depth reflection. I asked of the participants, instead of merely repeating occurrences in their reflections, to reflect on the effect of the occurrence on themselves and others. Following the brief explanation, I asked the participants to reflect, in writing, on what

they had observed in their peers, HCPs and themselves with regards to empathy when treating patients.

The formulation of appropriate open-ended questions that guided the reflection process ensured that the participants could touch, or elaborate, on aspects regarding empathy they wished to express or explore. The reflection sheets were analysed through theme extraction, while the first set of the JSPE (S-version) was analysed through means of data transference. Both sets of data (extraction of themes and JSPE (S-Version) results obtained through data transference) were compared by making use of the mixed method convergent parallel design in order to reach a conclusion.

4.3. Substructure

4.3.1. Theme extraction: pre-training

In order to create an outline or structure within which I designed the 16 sessions of role-play, I drew on Morgan and Saxton's contextual structure (1985:217) as outlined in Figure 2. As mentioned in Chapter three, substructure in process drama deals with the source for the training session of role-play, the question that this study addresses, what the participants bring with them into the session and the taxonomy of engagement (Morgan & Saxton, 1985:217). The substructure forms the outline within which the individual sessions of role-play were placed.

The pre-training set of reflection questions dealt with what the participants had observed regarding empathetic behaviour in other HCPs, their peers and themselves prior to the training session through role-play. Further questions that were asked related to the effect of empathy on patients, which difficulties the participants observed within themselves regarding being empathetic and the effect this has (from their perception) on the patients they deal with. Lastly, they were asked what they would like to see changed.

Following the written reflections by the participants, theme extraction took place. Initially the study proposed to do the theme extraction electronically by making use of a computer programme such as NVivo. However later during the study, my co-supervisor, Professor CW van Staden, advised me to do the theme extraction manually.

I extracted the themes by combining the deductive as well as the inductive approach (Gale et al 2013:3). A combination of both the approaches takes the specific aspects that the study wants to investigate into account, whilst leaving space to take all other aspects that the

participants express, into account (Gale et al 2013:3). By adopting the combined approach of theme extraction, allowed me to incorporate the MoE strategy where what the participants express, is taken into account as an integral part of the research process.

The process of theme extraction that I followed was guided by Prof. CW van Staden. After typing out and printing the participants' responses, I divided the sentences that hold similar meaning together and physically cut them into phrases. I grouped the phrases and awarded each group a code word that describes the main thoughts encapsulated within the groups of phrases that were grouped together. I repeated this process and once again grouped code words that held similar meaning, together. These code words with similar meaning became categories that I assigned themes to.

Theme extraction presents as follows:

Table 1. Themes - pre-training

Themes	Subthemes
Pressures of academic life	<ul style="list-style-type: none"> • The importance of obtaining the grade influences empathetic engagement with patients • Academia keeps students' minds occupied they forget to be sensitive
<ul style="list-style-type: none"> • <i>"The locus and pressures of academic life results in the primary focus in patient interactions being the grade one can obtain from the experience ..."</i> • <i>"... all we want to do clerk [obtain our degrees] and learn and try not to fail ..."</i> • <i>"...the end of the day, we forget to be sensitive towards patients ..."</i> 	
An empathetic engagement allows for patients to feel that they can exploit medical students by asking personal favours	<ul style="list-style-type: none"> • Patients use students' empathy against them • Patients lie about their feelings in order to exploit kindness
<ul style="list-style-type: none"> • <i>"... when you show empathy to patients ... [they] want to use this to exploit whatever they can from you ..."</i> • <i>"They will end up lying about their feelings or even go to an extent of faking some feelings ..."</i> • <i>"Patients sometimes see an opportunity to use your empathy against you ..."</i> 	
Time constraints influence the display of empathy	<ul style="list-style-type: none"> • Empathy can be very time wasting in medicine when a queue is waiting.

	<ul style="list-style-type: none"> • Showing empathy is not easy due to the setting, the number of patients and the long hours
	<ul style="list-style-type: none"> • <i>“I feel empathy comes with a lot of emotions, which can be very time wasting in medicine when a queue is waiting ...”</i> • <i>“Those who have heard a thing or two about empathy really try to show it, this is not easy to do due to the setting, the number of patients and the long hours ...”</i>
Loss of empathy in healthcare	<ul style="list-style-type: none"> • Detaching from feeling makes it better to deal with these emotions • HCP become cold and heartless • Students cope by developing “lesser empathy” during their years of study
	<ul style="list-style-type: none"> • <i>“... very often I prefer to cut myself off from the patient entirely ...”</i> • <i>“Detaching from these feeling makes it better for practitioners to deal with these emotions but [...] become cold and heartless beings in the processes ...”</i> • <i>“I’ve learned that by being too empathetic in the hospital leads to over-attachment to patients which is something that shouldn’t happen and something I struggle with, hence the lesser empathy I need to develop during the 5 years in the medical school ...”</i>
Patients’ experience when treated non-empathetically	<ul style="list-style-type: none"> • Patients feel like lab rats • Patients do not open up and share enough information • Leads to non-compliance to the prescribed treatment plan • and/or misdiagnosis
	<ul style="list-style-type: none"> • <i>“... when you go to a patient that has been subjected to such behaviour and be nice to them, they will explain how much this belittled them and made them feel as ‘lab rats’ ...”</i> • <i>“... Patients are then unable to overcome the illness because they do not receive the necessary help and support needed in dealing with their condition or illness ...”</i> • <i>“This makes patients less willing to speak to us. When people feel used and unappreciated, they become reluctant to talk to us ...”</i>
Lack of empathy of part of HCP	<ul style="list-style-type: none"> • The patient is just another case and is regarded as their disease • HCPs are unprofessional and rude

	<ul style="list-style-type: none"> • Fear of liable suit [patients sue HCPs for mistakes] leads to lack of empathy
<ul style="list-style-type: none"> • <i>“Empathy is practised very seldom in the hospital by practitioners ...”</i> • <i>“I think that sometimes (if not most) Drs tend to see the person as their disease not as a whole person - therefore treat the person not the disease...”</i> • <i>“... the Dr was not empathetic at all, which made him to be unprofessional. He could have simply eased the patient by ensuring that she is going to be okay, not be rude ...”</i> • <i>“What we observed is minimal use of empathy by professionals but that which doesn’t emanate from a cold unfeeling place or lack of caring, but rather from a place of fear and apprehension. Most doctors care and feel empathy for their patients but the brick wall of professional code of conduct, fear of liable [sic] suit often prevents them from displaying empathy ...”</i> 	
Authoritative attitude on part of HCP	<ul style="list-style-type: none"> • No regard for patient’s feelings • They are mean and judgemental
<ul style="list-style-type: none"> • <i>“They always think they’re the experts and don’t need to hear the patient’s opinion ...”</i> • <i>“They are very mean and judgemental and [...] no consideration of patient’s emotions ...”</i> 	
Difficulty on part of students where feelings are concerned	<ul style="list-style-type: none"> • Difficulty in striking a balance between empathetic engagement and self-protection • Inability to connect with own emotions • Frustration and helplessness because of lack of solutions • Questioning own lack of insight • Guilt due to lack of time • Fear of getting too emotionally involved • Fear of making a fool out of self in front of doctors by [through being shunned after displaying a lack of knowledge]
<ul style="list-style-type: none"> • <i>“As a student it becomes confusing to identify with patients and be empathetic. You confuse empathy with sympathy and it becomes difficult as a student, because now you want to provide solutions of which you can’t most of the time ...”</i> • <i>“... my inability to connect more with my own emotions ...”</i> • <i>“People will say ‘I’m just going through things’. I’ve never really known what people go through ...”</i> 	

<ul style="list-style-type: none"> • <i>“Students become frustrated at the end ...”</i> • <i>“Maybe my lack of self-insight fails me or my fear of ‘looking under the rock’, keeps me from getting to that point, maybe I don’t have stuff to go through ...”</i> • <i>“I feel so guilty when I try to rush through taking history from a patient ...”</i> • <i>“I want to still be empathetic, but also still be able to remove myself from the situation without being too emotionally involved ...”</i> • <i>“I get caught up in my own head and being a student who is trying not to make a fool out of themselves in front of the doctor ...”</i> 	
Barriers between HCP and patients	<ul style="list-style-type: none"> • HCPs need to draw a line between them and the patients and differentiate between sympathy and empathy.
<ul style="list-style-type: none"> • <i>“They must also draw a line between having empathy and getting overly attached to their patients ...”</i> • <i>“Some practitioners find it difficult to differentiate between ‘empathy’ and ‘sympathy’...”</i> 	
Need for education	<ul style="list-style-type: none"> • Students, HCPs and patients need to be educated about the use and importance of empathy in the clinical setting. • Students should learn from HCPs who practice empathy • Interpersonal skills of empathy should be taught and encouraged in medical school.
<ul style="list-style-type: none"> • <i>“... and health care students must also have short courses on this subject [empathy] ...”</i> • <i>“I would actually like to get all health practitioners be trained or made aware about empathy ...”</i> • <i>“Patients need to be educated about how they need to interact with the health care professionals ...”</i> • <i>“I also hope that we can learn from practitioners who practise empathy and compassion every day in the clinical setting ...”</i> • <i>“In the ideal situation I’d like to see firstly interpersonal skills of empathy being taught and encouraged in med school ...”</i> 	
Personality traits and upbringing influences empathetic behaviour	<ul style="list-style-type: none"> • Empathy can be taught
<ul style="list-style-type: none"> • <i>“I never had any problems with empathy, it comes naturally so to me right from the beginning, also ‘cause of my cultural background we are taught to love and care about</i> 	

<p><i>everyone and even so to always put ourselves in everyone's situation before anything ..."</i></p> <ul style="list-style-type: none"> • <i>"I have observed that in qualified healthcare practitioners it is clear to see someone who has been taught or exposed to the importance of empathy whether during their up-bringing at home or during their studies ..."</i> 	
<p>Effects of empathy on patients</p>	<ul style="list-style-type: none"> • Patients feel at ease and understood • They share information more readily • Better diagnosis, better treatment and adherence [to prescribed treatment]
<ul style="list-style-type: none"> • <i>"I've observed that empathy eases the patient during consultation and makes the patient feel understood ..."</i> • <i>"They will not be afraid to be judged and it can also open their minds to suggestions and ways to find solutions when dealing with their problems or illnesses ... The patient feels at ease and gets comfortable. This leads to proper history taking that is easier as the patient will feel obliged to give more info ..."</i> • <i>"This will make an easier examining session due to co-operative and proper diagnosis ... Patients are prone to take their medication accordingly when given by a doctor who shows that they care about them ..."</i> 	

4.3.2. Results JSPE

Due to the sample size that does not allow for formal quantitative comparisons or statistical testing, the JSPE (S-version) was analysed through a process of data transference instead.

In order to implement the mixed method parallel convergent design as described in chapter one, it requires both qualitative as well as quantitative sets of data. By making use of both qualitative data and quantitative data, mixed methodology bridges the gap between the philosophy of qualitative data and the methodology of quantitative data and (Cameron 2011:102). For the purpose of this study, therefore, I compared and analysed the qualitative themes extracted from the reflection sheets and the qualitative data obtained through the JSPE (S-version) simultaneously by implementing the mixed method parallel convergent design in order to reach a conclusion.

The JSPE (S-version) scale consists of twenty questions measured on a seven-point Likert scale ranging from one = strongly disagree to seven = strongly agree, with four = not sure. Questions one, three, six, seven, eight, 11, 12, 14, 18, and 19 are reverse scored items. Following the instructions that Jefferson University supplied with the scale, I added the

answers to all the questions. I calculated the reverse scored items accordingly. The closer the score is to 140, the higher the level of empathy in the individual (Youssef et al 2014:186). After obtaining the participants' scores, I calculated the percentage of empathy the scale delivered, by regarding 140 equal to 100%.

Table 2. The pre-training outcomes

		Questions																				Total score
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Participants	1	7	7	4	7	1	4	7	7	7	4	5	7	5	6	1	6	4	1	1	5	96
	2	6	6	5	7	5	3	6	6	6	6	6	6	6	7	6	7	6	3	7	7	117
	3	6	6	5	7	2	6	7	6	7	7	5	7	5	6	6	7	6	2	6	7	116
	4	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	4	7	7	137
	5	3	7	6	7	7	3	1	1	7	7	7	7	7	7	7	7	4	1	7	7	110
	6	7	6	2	7	7	4	7	7	7	6	7	7	2	6	6	6	5	3	7	6	115
	7	7	7	3	7	5	5	7	6	7	7	7	7	7	7	7	7	7	1	7	7	125
	8	6	6	3	7	6	3	7	6	7	6	7	6	6	7	6	7	5	2	6	7	116
																						out of 140

		Pre %
Participants	1	68,571
	2	83,571
	3	82,857
	4	97,857
	5	78,571
	6	82,142
	7	89,285
	8	82,857

Following theme extraction and results from the JSPE (S-version), I could move onto the next phase of the study, which consisted of the training session of role-play. Before commencing with the role-play session, however, the preparation had to be set in place.

4.3.3. The training session of role-play: preparation

According to Beckerman, in O'Neill (1984:158), a play presented in theatre is brought together to present the audience with an "imagined act". The stage actor works toward giving the audience an experience (Tsiaras [sa]:[sp]). Process drama does not follow a script nor does it work towards a performance to present to an audience, but works on the notion of "making personal meaning and sense of universal, abstract, social, moral, and ethical concepts through the concrete experience of the drama" (Norman in Bolton 1984:155).

Process drama is an internal process, which incorporates the participants' personal luggage (Morgan & Saxton 1985:217), where the learning takes place through the process of metaxis (Bolton 1984:155). There is no external structure in the form of a script to follow or a performance to work towards, which means that a different structure needs to be set in place. The structure, which outlines the session of process drama, needs to allow enough flexibility to enable the participants the space to explore, yet it needs to be defined such that the learning objectives and research aim could be met. In order to integrate and work with what the participants give without knowing what I will be given to work with, means that I needed to equip myself with a wide enough range of tools to be able to still meet the research aim while integrating what the participants give and/or share.

4.4 Structure

4.4.1. Outline of the training session

The next phase of the study moves onto what Morgan and Saxton refer to as the structure in their contextual structure for drama planning as depicted in Figure 2. It focusses on "what is planned" (1985:217) and deals with the lesson plan for the training session of role-play.

Before the participants could partake in the session of role-play, it required some background preparation. Apart from the administrative duties, such as setting a date and time that would suit all the participants and booking of the recording venue in the Skills Centre, the outline of the role-play session had to be established in order to meet the objectives as set out for phase three.

The objectives that were set out were to create a process drama training session, with emphasis on the applied drama strategy of role-play to explore the qualitative effect of role-play on the empathy levels of fifth year medical students.

In order to reach the objective as set out above, the participants would be expected to enter both the world of a patient and that of HCP. As the session of role-play formed the centre of the AT strategy and we worked within a limited timeframe, I started by calculating how much time the individual sessions of role-play would entail. I worked on the notion that every participant would portray the role of a patient as well as that of HCP. The participants are familiar with a consultation session between HCP and patient. Not only do they experience it during their history-taking classes in their second year, but they also deal with patients in the clinical setting.

I decided to structure the individual sessions of role-play around a consultation session between an HCP and his/her patient. This decision was taken for three reasons. The first being that by the time students reach their fifth year of study, they are expected to consult with patients in the clinical setting. Much of the difficulty that the participants expressed concerning displaying empathy towards patients stems from these same consultation sessions. I decided that by incorporating the MoE approach and enabling the participants to experience metaxis through role-play, to let them experience and work through the difficulties they had expressed in order to find their own answers.

The second reason for deciding to structure the individual sessions of role-play around the setting of a consultation session, was because a large part of this study deals with the importance of an empathetic connection between HCPs and their patients during consultation (Jaspers, 1958; Aragona, Kotzalidis & Puzella 2013:8) and the importance of an inter-subjective experience (Geist 2013:265; Stewart 1995:1429).

Thirdly, this decision was taken to create what Sayers (2003:26) refers to as a frame or viewpoint. Heathcote drew on Erving Goffman's theory of frame analysis and applied it to process drama (Edmiston, 2003:[sp]). A frame or similar viewpoint allows the participants to inhabit "a common concern" (Sayers 2003:26) and enables all the participants to share in the vision that the drama is creating.

Although session of role-play where all the participants are involved at once would keep everyone active for the duration of the session, I decided against the possibility of creating a drama that is centred on empathy between an HCP and his/her patient, following the themes that surfaced following the participants' first set of reflection questions. I did not want to expose the participants to a situation that they are already struggling with. I will deal with this aspect in more detail under the heading of enrolling. Instead, I introduced the strategy of thought tracking and hot seating in order to keep the observing participants involved in the individual sessions of role-play. These strategies are described in more detail below.

Eight participants partook in the study. If each one of them portray the roles of both HCP and patient, there would be 16 individual sessions of role-play in total. Due to the limited time (three hours) that were set out for this phase of the study, I allowed seven and a half minutes per consultation session with five minutes in between for debriefing from the role as HCP and enrolling into the role as patient. This left me with 15 minutes for the introduction and the scenario development. The equation looks as follows (see table below):

Table 3. Time allowance equation

Introduction and scenario development	Role-play	Debriefing/Enrolling	Total
15 min	16 x 7,5 min = 120 min	8 x 5 min = 45 min	120 min

Once I had decided on the structure for the training session of role-plays, I started working on the outline of the session of role-play as set out by Morgan and Saxton (1985:217).

The following table serves merely as a broad contextual structure regarding the outline of the session of role-play. I elaborate and explain it in more detail further down.

Morgan and Saxton's suggestion (1985:217) as depicted in Figure 2 has been adapted slightly in order to best suit the envisaged outcomes, whilst still allowing for enough flexibility for the participants to be able to share. The outline of the session is described in hindsight of what took place during the session of role-play. It looks as follows:

Table 4. Outline of the role-play session

Duration	Structure	Strategy	Activity
	Preparation Theme extraction from the first set of reflection questions formed a large part of the preparation for this session of role-play. Setting the space		
14:00-14:05 (5 min)	Introduction	<ul style="list-style-type: none"> • Introduce session of role-play by shortly explaining the structure that we will follow • Link the session of role-play to the reflection sheets in order to place it into context • Explain the MoE approach to make the participants aware of the importance of their contributions • Explain process drama as internal process in order for the participants to know that, although they should embody thoughts and feelings and express what they think and feel, they need not feel as though they have to “perform”. Due to time constraints, I explained this instead of allowing the participants to discover what it is through an exercise 	<ul style="list-style-type: none"> • I greeted the participants and thanked them for their honest and detailed reflection • I explained how their reflections gave rise to the fact that the session of role-play will focus on giving them coping tools • I explained the MoE approach and that I would be working with what the participants choose to share during the individual sessions of role-play • I stressed the importance of improvisation <ul style="list-style-type: none"> • Improvisation allows for inner thoughts and feelings to surface without the filter of thinking “what might expected” or “what would others think”. Improvising thus, is a means of tapping into those corners of ourselves that often remain hidden when one needs to conform to the

		<ul style="list-style-type: none"> • Introduce thought tracking and hot seating in order to open the floor and invite the observing participants to partake in the action. Once again, time constraint only allowed me to introduce these strategies through verbally explaining what they entail 	<p>environment one operates in on a daily basis. Improvisation allows for a door into the self and enables exploration and discovering of the participants' own knowledge (Berk, 2009:30).</p> <ul style="list-style-type: none"> • I reminded the participants that there is no right and no wrong in order for them to have the freedom to act on their initial responses • The more you share through improvisation, the better the process • I explained the reason for the teacher chair and when seated, I am out of role When "out of role", the facilitator's role is one of an observer. The moment s/he steps into role, s/he enters the action as a participant and facilitates from inside the scenarios • I introduced the timer. In order to ensure that the individual sessions of role-play adhere to the limited time, due to time constraint, but also to ensure fairness regarding the duration of the individual sessions of role-play, I used a timer • I explained that thought tracking deals with questions that link to thoughts and feelings of the characters.
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			<ul style="list-style-type: none"> I opened the floor to the observing participants to partake in the role-play by making use of any of the strategies mentioned above
14:05-14:15 (10 min)	Scenario Development	<ul style="list-style-type: none"> I purposely gave very little guidelines, as I wanted to allow the participants the freedom to construct scenarios around aspects of empathy they would like to explore 	<ul style="list-style-type: none"> Students develop their own patient scenarios Focus was placed on: <ul style="list-style-type: none"> i) Name of patient ii) Age iii) Symptoms of illness and their effect on patient's life.
14:15-14:35 (20 min)	Enrolment to distinguish the world that the participants find themselves in daily from the world of the play that they are about to enter	<ul style="list-style-type: none"> Enrolment I regarded the students' active participation in the discussion about assigning characteristics of an HCP to the white lab coat as part of the process of enrolment. The moment they don the white coat, they step into the role as HCP and when taking the white coat off, they step out of that fictional world. MoE Students took on the MoE by answering the simple open-ended question as to what this coat means to them. I regarded all answers appropriate and incorporated them when I asked follow-up questions <p>The MoE approach was also used when the Stethoscope was introduced as symbolic prop and the</p>	<ul style="list-style-type: none"> Assign the characteristics of an HCP to the white lab coat as symbolic prop Establish the stethoscope as a symbolic prop to create a connection between HCP and patient

		<p>participants were asked the simple initial question as to what the stethoscope means</p> <p>1) I accessed “the source” or “germ” for the action by asking the students what they had observed or regarded as important qualities in HCPs</p> <p>2) I accessed the participants’ “personal luggage” by allowing them to bring into the room any prior experience or any thoughts they held about empathy in healthcare</p>	
14:35-16:35 (2 hours)	Session of Role-play	<p>The strategies I would employ could not be specified before the session of role-play as I did not know which strategies would be most appropriate to introduce during specific session of the role-play. Therefore, the strategies to be employed do not form part of outline of the lesson plan</p> <p>I prepared for this by having a list of strategies and reason for introduction at hand (Appendix K)</p> <p>I describe the strategies I employed and the effect thereof in this chapter further down under the section of role-play</p>	<ul style="list-style-type: none"> • Participants perform both the role of HCP as well as that of a patient • Switching of roles – from HCP to patient through scenario development

<p>16:35-17:00 (25 min)</p>	<p>Derolling</p>	<p>Five minutes before and after each session of role-play was allocated to debriefing from the role as HCP and enrolling into the role as patient</p>	<ul style="list-style-type: none"> • As a means of derolling, the participants who had taken on the role as doctor, reflected about what they had experienced while taking off the white coat and removing the stethoscope • The participants took on the role as patients, derolled physically by stepping out of the room. I advised them to re-orientate themselves into the present situation mentally
		<ul style="list-style-type: none"> • Reflection 	<ul style="list-style-type: none"> • I asked the participants to reflect about the session in writing

4.4.2. Setting the space

Phase three of the study that dealt with the session of role-play took place on the fourth of August at 2017 at the recording venue in the Skills Centre on SMU campus. This was roughly three months after I had first introduced the study to the fifth year students on the 31st of May 2017.

In order to create a broad frame to guide the participants in the space where the individual sessions of role-play will take place, I set up the venue where the recording would take place, to resemble a consultation setting. I placed a board containing medical equipment in the form of an ear-nose-throat (ENT), ophthalmology as well a blood pressure set on one side of the recording venue. Apart from containing the visual features of a clinical medical setting, it also aided as performing the task of creating a division between the recording venue and the other room behind a one-way mirror. I placed a medical scale in one corner of the room to enhance the setting as a medical one.

I made sure that there were sufficient chairs for all participants and checked the recording equipment. Due to the fact that the camera is a fixture that cannot be moved, the observing participants could not be incorporated in the visual recording. Focus was placed on the area where the action in the form of interaction between “HCP” and “patient” took place. The observing participants’ contributions were recorded audibly on the same DVD disc that was used for the visual recording.

I set an extra chair aside for myself in order to distinguish my role as facilitator “out of role” (seated) versus “in role” (standing). I explained the feature of the chair to the participants. I might get up to enter the role-play as teacher in role, and the moment I sit down, means that I will be observing as facilitator again.

4.4.3. Introduction

I thanked the participants for their detailed reflection during the first set of reflection questions. I explained that process drama works in such a manner that all information comes from the participants.

During their second year of training, the students are introduced to the concept of consultation skills with particular focus on history taking. No focus is placed on an empathetic engagement between HCP and his/her patients. The aim of the history taking

sessions is for the students to learn about the correct techniques of obtaining information from their patients.

Due to the fact that the students have been introduced to role-play during the history taking block in their second year, I did not elaborate on how role-play works in AT. I did not want them to link the training session of role-play that they are about to enter into with what they had experienced in their second year. I was aware of the fact that they might recall the nervousness they had experienced and that this might block any improvisational responses which would affect the learning negatively. In addition, I did not want them to feel that they need to try to remember what is expected of them during history taking and that they attempt at doing anything “the right way” as this would also affect them in their role as HCPs negatively. I felt strongly that I wanted them to enter into the individual sessions of role-play as closely as possible to the way they interact with patients in the clinical setting in order to afford them the opportunity to investigate, question and find their own solutions where they are struggling.

Often the recording of the consultation sessions during their second year of study goes hand in hand with much nervous tension. In order to alleviate the stress that the students experience in a very similar situation during the history taking session, I assured the participants that the focus of this session of role-play, is for them to feel and to express who they are in their role as HCP, instead of thinking that they need to conduct the “perfect consultation”. I encouraged the participants to forget everything they had been taught about patients’ history taking. For this session, they should rather focus on their personal feelings and allow themselves the freedom to express what they are experiencing. I also encouraged them to connect to the person they are outside of the healthcare session and outside of what they have learned thus far, in order to gain more from this session on personal level.

I briefly explained the importance of improvisation. I told the participants that there are no right or wrong actions in process drama, that improvisation is of the utmost importance and that the more they allow themselves the freedom to express their initial ideas, feelings or thoughts, the more impact the session will have on them as individuals. In hindsight, I realise that introducing the participants to some form of improvisation exercises before the study might have enabled them to express themselves more freely. I will discuss this limitation in more detail at the end of the chapter under the heading of limitations.

I made the participants aware of the fact that the role of the facilitator is merely to facilitate the process. In order to achieve this, I explained the function of the chair for the facilitator as well as my functions “in role” and “out of role” so as not to confuse the participants when I

take on a role inside the action. I asked the participants not to take conscious note of where I find myself. I merely explained so that the participants will not feel confused when I do step into role as part of the action. I did not elaborate on this aspect through asking them questions or invoking any responses. Warning them in too much detail about the fact that the teacher could “step into role” during any time of the role-play session, could also hamper the flow of improvised action. The participants could find themselves waiting for the “teacher in role” to step into the action. This would have added a dimension to the interaction taking place between the two participants that could possibly hamper the natural flow of events as it would place focus on an area that lies outside of what is taking place within the session of role-play.

I introduced and explained the strategy of hot seating and thought tracking. Introducing these strategies amongst many others that could have been chosen, was done for various reasons. I wanted to keep the observing participants involved on a level that goes beyond that of mere spectators to keep them actively involved in the action that is taking place in front of them. The second reason for inviting the observing participants to step into the action was to incorporate the MoE approach where they will be the experts as to what is taking place. In this way both the performers as well as the observing participants were regarded as experts during the session of role-play. This would enable the participants to ask questions that fall out of the scope of my knowledge pertaining to the areas they wish to explore. By introducing the processes of thought tracking and hot seating, means that the observing participants are invited to stop the action at any point where they felt they would like to explore more. This would allow for more exploration on deeply personal level as the observing participants could ask specific questions that they would like to have answered. This allowed the observing participants to drive the action in the direction they would like it to go and involved them in the pedagogical process on very personal level.

After I had explained the background pertaining to some of the strategies the individual sessions of role-play would incorporate, the next step I had to introduce was that of developing written scenarios.

4.4.4. Scenario development

Initially I wanted to develop the scenarios by incorporating the themes that were extracted following the first set of reflections relating to what the participants had observed in the clinical setting in HCPs, peers and themselves concerning empathetic behaviour. Following theme extraction, however, I realised that the participants’ experiences stretch far beyond

my knowledge or insight and that they knew best which aspects they would like to explore in more depth.

Although the study was initially compiled so that the scenarios would be constructed around the themes that were extracted following the participants' first set of reflections, I decided to ask the participants to develop their own, individual scenarios. I was very aware of the fact that the students face many insecurities and difficulties when dealing with patients and other HCPs in the clinical setting.

Bolton feels strongly about the fact that participants of role-play should be introduced to a scene or a setting [frame] that would enable them to own the learning situation without experiencing any feelings of vulnerability (Sayer 2018:87). According to Bolton (in Sayer 2018:87) when adopting a role, there lies a paradox in the art form. He says that "distance can bring closer, for the distancing gives us permission to move closer when we are ready, whereas facing the painful issue directly may cause us to back away". The participants should be engaged, not threatened (Sayer 2018:87).

I was very concerned that, if I develop the scenarios according to the themes that were extracted, it would place the participants in a position that they feel threatened in and instead of taking on the roles as HCP and/or patient, they would "back away" (Sayer 2018:87). Backing away would hinder the participants from engaging with the roles and the session(s) of role-play would be nothing more than an outward show of what they feel they can handle. This would prevent them from entering the state of metaxis and there would be no or very little learning.

During reflection, the participants gained insight into the areas they are struggling with pertaining to empathetic connections between HCP and patient. As individuals, they would know better than anyone else would which areas they feel they need to investigate.

Asking the participants to construct their own scenarios, would enable the participants to portray roles that they feel safe enough in to prevent feelings of vulnerability or fear. This would prevent the participants from "backing away" (Bolton in Sayer 2018:87) and would allow them to explore the areas of empathy they would like to. These aspects could be faced from a distance until they feel safe enough to "move closer" (Bolton in Sayer 2018:87) in order to investigate their feelings and find answers. I will elaborate on this matter below under the heading of enrolling.

Therefore, by asking the participants to construct their own scenarios, I incorporated the MoE approach. Although I did not directly draw on the extracted themes, I regard them as incorporated into the scenarios through the participants by drawing on their own reflections.

Regarding the study, the extracted themes following the first set of reflection questions, were thus incorporated in the research methodology as part of the convergent parallel design when comparing pre-and post-theme extraction.

Scenario development forms an important aspect of my work as SP facilitator. In the past seven years, I have learnt which aspects are pivotal when the scenarios need to be developed in a short space of time, but yet need to render enough background to enable the person portraying the role of the patient to deliver an authentic portrayal.

Due to limited time of only 10 minutes allocated to scenario development, I placed the focus on only three aspects instead of expecting detailed descriptions of the patients the participants will portray. I asked the participants to construct scenarios around the following three aspects:

- i) Name of Patient
- ii) Age
- iii) Symptoms of illness and the effect on patients' life.

Constructing the scenarios around the above-mentioned aspects will allow the participants to identify with the roles they are about to adopt. Identification with a role leads to insight (Wagner 1999:16) and learning.

The name given to a patient acts as a safety mechanism as it immediately creates an aspect of distance between the participant and the role that is being adopted. This strategy may be regarded as part of the process of enrolling. Every time someone refers to the participant by the adopted name, it reminds the participant that s/he is actually "in role" and that the situation is a fictitious one. This may allow for the oscillation between distancing and immersion that I referred to in Chapter three. I asked the participants to construct the scenarios from the patient's point of view.

In my view, constructing a scenario from the HCP's point of view could be a barrier to empathetically engaging with the roles the participants will portray. Asking of the participants to construct the patient scenarios from the HCP's point of view could easily enable them to slip into the modes of interaction they adopt as HCPs within the clinical setting when dealing

with patients. This would have defied the aim of the role-play session as it would hinder an empathetic connection to the patient they are portraying from the outset.

The participants constructed scenarios individually and did not disclose their scenarios to the observing participants. I incorporated this aspect into the individual sessions of role-play as means of enrolling, which will be discussed in more detail further down.

I incorporated the aspect of age in the development of the scenario, as this would place the representation of patient in a more realistic situation. A person still attending school will have a different frame of reference to draw from than a mother looking after children whilst trying to make ends meet. Introducing age into the development of the scenario aided in immediately placing the patients the participants will portray within a certain realistic setting and supported the participants in the creation of the background information to draw upon whilst partaking in the individual sessions of role-play.

The age of the patient also places the patient within a more realistic situation from a clinical point of view. Generally, various kinds of illnesses present themselves within a certain age group. For instance, one could hardly expect a youngster of five or six years to be suffering from osteoarthritis as this is a condition mostly found in bodies where the cartilage and bones have undergone some years of use/abuse. Age also introduces access the MoE approach concerning the participants' clinical knowledge relating to the above and in relation to scenarios witnessed that they would like to investigate, experience, or work through in more depth.

I incorporated the illness and the effect of the symptoms on the patients' lives as a means to establish sufficient background to facilitate the process of an empathetic connection between the "performer" and the role s/he is engaging with empathetically. The moment that the effect of an illness on a patient's life is addressed, it necessitates the answer to questions regarding all aspects of the lives of the patients such as the careers they follow, their situations at home, for instance whether they need to take care of children. It also addresses the areas of concern such as if they have a support structure in place. Incorporating the effect of the illness on the patients' lives enable the participants taking on the role as patient to come into the scenario with enough background to portray the person behind the patient. Connecting to the person behind the patient is pivotal in establishing an empathetic connection. Without such background, the patient is merely regarded as a set of symptoms to be treated as the life of the patient and his/her feelings and why they feel the way they do or have reason to worry as much as they do, does not form part of the consultation. Looking at the effect of the illness on the lives of a (fictional) person places the engagement between

HCP and patient, as well as the illness, in 'the human context' (please see Chapter 3). It also foregrounds the idea of 'man-in-a-mess'. In addition to the above concerning the creation of a scenario, incorporating sufficient background information served to alleviate the fear of questions being posed to which there might not be an answer already present.

Injecting tension into any session of role-play is a pivotal strategy to introduce as it enables the participants to immerse and remain in role. Tension is "the bonding agent that sustains involvement in the dramatic task" (Morgan et al 1987:3). Morgan et al define seven types of tension that Heathcote used. This tension stands apart from the pressure a facilitator injects when stepping into role and injecting tension by setting a limit to the "real time" that is available for solving an issue. This tension deals with the tension within the role-play between the participants.

In theatre tension is created by placing focus on one "particular moment in time that captures the essence of a general human experience" (Wagner 1999:148). Howell and Heap (in Sayers 2013:22) "explain the importance of tension by referring to dramatic tension, within the theatre, as an ingredient of all well-crafted plays. 'It is the fuel which fires the imperative for action in a play. It is created by the friction which exists at the interface between the differing, and sometimes rival, values, beliefs and aspirations of characters'". In theatre the playwright dictates the actions, the setting and infuses the tensions (Wagner 1999:148). Kenneth Tynan (in Wagner 1999:148) states: "Good drama form is made up of the thoughts, the words, and the gestures that are wrung from human beings on their way to, or in, or emerging from a state".

In role-play, this tension is created by the participants themselves as they are fighting to find answers through what is taking place between them and the other role-players. Placing the participants into the role of HCP and asking them to conduct a consultation with a patient without knowing what the patient will present with, means that I asked the participants to adopt a role that they have difficulty with in their everyday lives. The unspoken expectation of finding answers in itself lends itself to the creation of tension before the action had even started.

According to Wagner, Heathcote believed that "... everything that the human race knows now and has ever known and believed to be true exists side-by-side in an unsettling tension and ambiguity" (Wagner 1999:168). By asking the participants to step into role as both HCPs and patients and thus introducing a relationship between two people that the participants find complicated, also introduced tension (Wagner 1999:149). The tension mentioned above

was introduced as a means of keeping the participants engaged in the action for the duration of the individual sessions of role-play.

With regard to the development of the scenarios I did not guide the participants in terms of role-play within AT. This was partly due to a lack of time, but mainly it was not to influence them. Being students of medicine, which is still regarded as a science – not an art – any guidelines or pointers might have been regarded as a logical answer. I did not want to supply the participants with logical ways of creating scenarios. It was more important for me that they tap into their experience and construct scenarios of patients they would want to explore. Having reflected on the empathetic engagement between HCPs and patients, I trusted them as the experts concerning the areas they would individually like to explore in order to find answers to their queries. Constructing their own patient scenarios, would enable them to learn through adopting the role of patient. They would experience what it feels like to be the patient and this would afford them insight into how to deal with the situations that they find difficult.

In situations where it became apparent that a participant seemed to become unsure of what to write in the scenario development by looking around as if trying to find some measure of assistance by assessing how the other participants are dealing with the situation, I encouraged them by reminding them that there is no right or wrong.

When all the participants had constructed their patient scenarios, I asked participants to put the clipboards and scenarios aside. I made this request as a means for the participants to lay the patient they would portray down on metaphorical level so that they could focus solely on the next step of development, which dealt with enrolling.

4.4.5. Enrolling

Before theme extraction, I wanted to make use of the themes in the creation of scenarios for the role-play session to ensure that the aspects addressed during the individual role-play sessions are those the participants deal with directly when in the clinical setting. I wanted to invoke possible shifts in knowledge in the areas that the participants have reflected upon. I regarded this as more significant than working on an intellectually fabricated notion of an ideal situation, which might bear no relevance to what the participants are experiencing.

During theme analysis of the first set of reflection questions, however, I was deeply touched when I realised that the participants witnessed a serious lack of empathetic behaviour towards patients in the clinical setting. Through their reflections, they conveyed a sense of

insecurity and a lack of coping tools to deal with what is expected of them. It became obvious that the participants experienced situations that were difficult for them to handle on a personal/empathetic level.

As a researcher, this placed me in a difficult position. I did not see my way open to address the issues that the participants are already struggling with for the fear of causing unnecessary and deeper uncertainty. I did not want to evoke empathy through the session of role-play, touching on the aspects that they are already struggling with, knowing that they will return to the clinical setting where they are already struggling with issues relating to empathy. I was worried that this might just leave them with more feelings to deal with instead of answers.

Apart from the above, Heathcote and Bolton (both seminal sources in AT) were aware of the importance of protecting the participants from sensitive material, whilst at the same time drawing them into an engagement with it (Sayer 2012:34). Bolton (1985:156) believed that participants could look at their experiences from a different perspective if they detach from what they are experiencing.

According to Sayers (2013:78) MoE is a model of learning where the emphasis lies on tasks that need to be accomplished in order to satisfy or resolve problems for a fictional client. The participants of a MoE approach “should be motivated by problem and challenges that arise ... [and] ... there is an emphasis on making participants aware that they are learners”. In this case, the structure of the individual sessions of role-play did not allow for the creation of a community where every individual takes on the role of a specific member of a community. Instead the “collaborative” solving of a task (Sayers 2013:78) lay in the fact that all participants took on the role as HCP, which enabled them to investigate and find solutions pertaining to the specific aspects they felt they were struggling with.

During a session of MoE it is more important for the participants to engage both on cognitive [thinking] as well as affective [feeling] level in order for them to “experience and reflect” at the same time (Sayers 2013:20). Whilst partaking in a session of MoE it is less important for the participants to “be in the action” and more important that they are able to comment on the action taking place (Sayers 2013:84). Therefore, in MoE the participants are not required to be “in role” at all, it is of more importance that they are enabled to “look at something from a particular scientific perspective” (Sayers 2013:85).

Taking the above into account, I wanted to find a way to frame the participants in their roles as HCPs and patients that would enable them to feel in control and take ownership of the

learning that is about to take place without becoming too emotionally involved for them to feel vulnerable (Sayers 2103:87). Vulnerability on the part of the participants could lead to a feeling of being threatened, which could result in them to “back away” (Sayers 2018:87) from the action rather than to remain involved. According to Bolton (in Sayers 2013:87), dealing with a topic indirectly is a way of offering protection to the participants when dealing with sensitive topics. Handling a topic in an indirect way and creating some distance between the participants, introduces a “cool strip” that prevents an emotional, vulnerable or threatening engagement with the action (Sayers 2013:89).

The introduction of a symbolic prop would serve the purpose of engaging the participants into the session of role-play while there is still enough distance on cognitive level for them to search for answers. Dorothy Heathcote made use of symbolic props to start sessions of role-play with (1985:174). The introduction of a symbolic prop has a dual purpose. It introduces the action about to take place in an affective mode, which draws the participants into the role (Heathcote 1985:174) yet, at the same time, it allows them to explore and work through on cognitive level (Heathcote 1985:174).

According to Erikson (2011:115), if symbolic value is added to a prop or costume, it ascribes a greater, deeper meaning to the object than its mere function. Adding symbolic meaning to a prop can accredit the object with the emotions or values that society attach to it.

In order to introduce a symbolic prop, I decided to draw on Erving Goffman’s theory as set out in “The presentation of self in everyday life” (1959). Goffman argues that social role adopted by people is an enactment of “rights and duties attached to a given status” (Goffman 1959:16). Goffman refers specifically to the “white lab coats” worn by students of medicine as coats providing the patients with an understanding that “the delicate tasks performed by these persons will be performed in what has become a standardised, clinical confidential manner” (1959:26). He further states that, just as the setting enables the participants partaking in the social role-play to “begin their act” at the time when they enter the “setting”, it also allows them to “terminate the performance” once they leave it (1959:22). As mentioned earlier, Heathcote also drew on Goffman’s theories and introduced the “frame or viewpoint as a window through which the participants engage in the action” (Sayers 2003:26).

Both Goffman’s theories pertaining to the social roles we adopt in life as well as his work on frame analysis (Sayers 2003:26) give rise to the fact that the “white lab coats” as worn by students of medicine within the clinical setting can take on various meanings. In the case of the training session of role-play, the “white lab coat” not only places the participants within a

particular frame, it also assigns them with certain qualities that the HCP is perceived to possess from the patients' point of view (Goffman 1959: 26). The argument arising from this notion is that medical students are assigned qualities of an HCP not because of the fact that they are inherently part of the students' personalities, but because they step into the role of a HCP by donning the white coat.

Taking the above into account, I regarded the "white coat" as a perfect symbolic prop to introduce and frame the session of role-play. Through the introduction of the "white coat" and assigning certain qualities that the participants feel a HCP should possess would enable the participants to create some distance between themselves and the role they adopt. When donning the "white coat" the participants can take on qualities of a HCP. This would enable them to hide their vulnerability behind the qualities the "white coat" offers as protection.

I supplied and hung a "white coat" from a drip stand – another medical feature that formed part of "setting the space". I raised the simple question as to what this coat resembles. I had to keep a close check on myself not to steer the questions and answer session in any direction, but rather to pose simple open-ended questions merely to activate the participants' knowledge. I asked the simple questions: "What does this coat mean?", once again incorporating the MoE approach.

Through a short questions and answer session, pertaining to the qualities the participants would assign to the "white coat", I obtained knowledge what they would regard as the qualities that a good HCP should possess. I did not elaborate on this aspect in any way, as I wanted the participants to share what they had observed or regarded as important qualities in HCPs. Through not leading the conversation in any way, the participants' personal luggage was accessed by enabling them to bring into the room their "knowledge, feelings, values, understandings and experience from inside and outside" (Morgan & Saxton 1985:217) of their learning environment. The answers that the participants gave became "the source" or "germ" for the action, since these were the qualities they adopted with the donning of the white coat during the individual enrolment phases.

During this part of the session, questioning is of the utmost importance. Heathcote's teaching is about exploring significant human experiences by asking freeing questions instead of threatening ones. Freeing questions allow the students to voice their opinions without feeling that there might be one correct answer. The answers are then used to ask the following questions, all taking the students points of view into consideration and merely facilitating the direction in order for learning to take place. The students potentially participate willingly as they regard this as their own work (Wagner 1999:55).

I asked the participants to think about the white coat they put on when they go into the hospital setting or when dealing with patients. In order to lift any inhibitions that might prevent them from answering openly and honestly for fear of saying something “wrong”, I encouraged the participants to speak openly and reminded that the more honest they are at this point during the session, the more helpful the eventual outcomes, pertaining to personal areas they might be struggling with.

The question I posed was merely: “What does this white coat mean?”

The answers that followed:

Participant one felt that the coat resembles respect on both the part of patient and “doctor”. Participant two said it deals with the recognition and identification of a “doctor”.

The following contribution was participant three who feels that it resembles the sense of knowing that “things are going to get better when you see that white coat”.

Trust that the patient has for a solution in “the coat” that they will help “him” is the manner in which participant four regarded the coat. Participant five felt that the coat resembles the fear of having to be touched by a stranger and putting your whole life in “that person’s hands”.

Although the aspect of “the coat” could have been dealt with in more detail, due to time constraint, following the five points above, and as a means of reflecting, I asked the following question: “What do these five ‘things’ have in common?”

The participants reflected in silence. It took some discipline on the part of the facilitator to “withhold expertise” (Wagner, 1999:100) and to allow the participants to remain in the position where they could retain the MoE.

Participant three contributed the first answer: “They all involve the patient’s feeling or view”. This response opened the way for one of Heathcote’s questions that would deepen insight. I asked: “what does that lead to?” and “how do you think it makes the HCP feel?” The first response was: “superior, maybe” (participant two) after which participant one responded with the following words: “I think it needs better healthcare provision – if you put yourself in ... if you understand the emotion that these patients go through at times and if you can put yourself into those shoes, then it allows for you to be more empathetic/sympathetic and understand the view they have ... things or see things from at times” (quoted verbatim).

At this point, I realised that my initial broad open-ended question of what the white coat resembles needed to be narrowed down and that I needed to rephrase the question. I

reminded the participants that by putting on the “white coat”, one adopts the characteristics mentioned above. Then I asked: “What does this mean to the HCP?”

“There’s a lot of responsibility” (participant six), was the first response. I acknowledged the positive weight of the response and asked if there is a way to change it around.

When it became apparent after another long silence that some probing was required, I asked the following question: “What characteristics would you like to assign to the “coat” that could help you instead of placing the responsibility on your shoulders?”

Participant one responded by saying: “I think I would like the coat to be more protective in such a way that, at times, the coat makes you stick out and subject you to more mental strain ... at times, because you wear the coat you need to know ‘this that’ ... ‘you need to know this that’ ... you need to know ... but at times if it could protect you from the expectancy which then comes about with wearing it, it doesn’t bring about that sense of protection, if I could call it that” (quoted verbatim).

I asked how one would do that? Participant seven responded by saying that the reason there is so much responsibility is because HCPs are dealing with lives, not numbers, and that there will always be some sense of responsibility. So inevitably, there will always be some degree of responsibility.

I agreed that one cannot get away from the sense of responsibility and then posed the question: “What makes the patient’s life more important than the doctor’s life?” Although this is a very leading question that underpins assumptions from my, not the participants’, side I asked this question on purpose, since I regarded it as the crux as to why the participants struggle with the aspects mentioned during reflection. I wanted the participants to realise that they need not be so afraid of the patients’ feelings or of doing something wrong when they are working with patients. I believed this would relieve much of the anxiety and/or confusion they experienced in the clinical setting.

The participants all agreed with participant seven’s view that the doctor can only help the patient if s/he is okay. So, technically, the doctor needs to be primarily responsible first before s/he can attend to the patient. The conclusion participant seven came to: “Back to the white coat to remove or share the responsibility”. I wanted to know from the participants how they think they could achieve this. Participant six resolved that there is nothing that makes the doctor’s life more important than the patient’s. Moreover, the patients need to share the responsibility. As much as the doctor is responsible for his/her own health, so the patient is responsible for his/her own. If both doctor and patient can agree on this, the doctor and

patient can work as a team – one would not be superior to the other. Through the participants' responses, I felt that I had achieved the objective the questions set out to achieve. The participants realised that, as HCP, they are not solely responsible for their patients' lives. I was hoping that this would alleviate some of the pressure expressed in the first set of reflection questions.

When there was no response to the question if anyone can think of anything more to add, I asked the participants how they feel in comparison to when they entered the room. Relief was evident through sighs of relief and much laughter. This proved to me that much of the emotional burden that the participants had expressed in the reflection sheets had been lifted.

Apart from the "white coat", the stethoscope is as much part of a HCP's image. The next phase of enrolment was moving on to the stethoscope an integral part of medical equipment. The stethoscopes that they carry with them often allows patients and lay people to recognise an HCP. Here the question arises what it would mean if, added to the qualities one affords to the "white lab coats", one were to assign a certain symbolic meaning to the stethoscope (Heathcote 1985:174).

I asked the simple question regarding what the stethoscope means. The answers were given as simple phrases: To participant one, the stethoscope resembled intelligence. On the other hand, participant six links it to skills and "know how". Participant five's contributions were as follows: "To some patients it means that, by placing the stethoscope you can immediately feel what they are feeling". Participant three felt that the stethoscope resembles anxiety on part of patient, because you never know what "the person" could be finding. In addition, the final contribution relating to the meaning of the stethoscope was: "Hope and appreciation" on the part of the patient.

As a means of finding common ground between the meaning of the white coat and the stethoscope and in order to re-establish their meaning with regard to the role the HCP adopts, I asked what the similarities are between them. Participant seven answered: "the patient". I decided to turn the questions around and asked: "What does the stethoscope mean to the doctor?"

Participant seven regarded the stethoscope as a sign of authority and identification of a doctor. Participants said: "Pride". Participant three saw the stethoscope as a sign of perseverance and participant one's response was: "Pressure".

I realised that participants needed further probing. I posed the question if one could possibly use the stethoscope to turn this around the way they had changed the meaning of the white

coats around. The response was a negative one because of the fact that the stethoscope is not specific to doctors only and then specific only to certain discipline within medicine (participant one).

I felt that the participants were still not delving deep enough in order to find an answer and needed some more probing. I asked the participants, when considering their discipline, whether they could think of assigning the stethoscope qualities that could assist rather than place pressure. I referred to the feeling participant one had by exhaling after assigning a role to the white lab coat. I asked whether the participants think they could find *that* in the stethoscope. I rephrased question: "How are we going to find it in the stethoscope?"

The participants stated that it would require a change of mind set within the medical community. Often the stethoscope is associated with a doctor and how doctors treat each other. How the participants view the stethoscope is how they view the field as a whole. If doctors could be kinder to each other, when they see one another, the stethoscope would then represent a doctor who is kind to his fellow HCPs (participant three).

This was followed by the contribution by participant six that all of these things are inanimate objects it is just the students' attitudes towards them, which is bringing all of this out. Participant six stated: "Because of the fact that you put it to your ear, you can hear, but it is not actually doing anything. It is your attitude towards it that is bringing all of this out. The core of this is an attitude".

I still felt that there were areas that were unexplored: I asked the participants to think of themselves as a doctor with their stethoscopes busy examining a patient. I wanted to know if there is something for themselves that they could assign to the stethoscope that will assist them in not taking the patient's burden, feeling their anxiety, their hopes and appreciations unto themselves. I wanted to know if there is something that they could assign to the stethoscope that would give them the chance to breathe out?

There was another long silence before participant eight responded by saying: "I like the way the paediatricians approach this, this 'things' the stethoscopes and the coats, they attach little cartoons, they buy bright colours ... I mean a black and a pink stethoscope doesn't mean the same thing. Maybe even its appearance or maybe me not always hanging it around my neck, maybe taking it out of my pocket just like I take out my phone. I think that will mean something different to patients, it'll mean something different to me to me if you count me as a doctor you have your white coat with a bunny or something here and then the stethoscope you take it of your pocket instead of always having it around your neck. I think it

means something different to me, it means it is just an object, but it helps you other than it brings something that defines you as a doctor". I thanked the participant for her contribution. This was followed by laughter. A sign of relief. The laughter concluded the phase of enrolling and it was time to move onto the next stage of phase three of the study, which dealt with the individual sessions of role-play.

4.5. Training session: role-play

In the following paragraphs, I describe the individual sessions of role-play, placing focus on the strategies of applied drama and MoE that were employed (Appendix I). Every participant was afforded the opportunity to portray a HCP as well as a patient. In total, there were 16 individual sessions of role-play. I will not describe all the sessions in detail, but rather highlight the areas that were important in the context of this study.

Fortunately, there was no difficulty in finding volunteers who were ready to start the role-play. There was a bit of insecurity on the part of the participant three taking on the role as HCP during the first session of role-play. She was unsure of "understanding how this is going to work" and said that she would just "go with it". I assured her of the importance of just going with it and of the importance of not understanding how this session is supposed to work. Introducing an exploratory activity to introduce role-play and to let everyone see and experience how it works would have assisted in alleviating some of the insecurities on the part of the participants. However, I felt that, given the fact that the students were introduced to role-play sessions during their second year of training, they should have a good idea of what is expected. I was also apprehensive about creating an example that the participants might find easier to follow on superficial level, rather than to allow the natural internal process to take its course. Adopting a superficial role of what they think might be expected, rather than to feel and think about what the role demands, would have influenced the empathetic connection to the role being adopted. In turn, this would have influenced the learning objective negatively.

In relation to and expanding on the above, I mentioned the fact that the "moment we understand how things work we immediately want to act according to how we think things work". I assured the participant that I myself do not know how the session of role-play is going to work because I do not know what the participants will give me to work with. I mentioned the importance of improvising again to assure them that they can allow themselves to freely act on their feelings and thoughts. This is important as experiencing yourself in the shoes of another, is where the learning in role-play takes place.

Being closely involved in this aspect of their training, I am very aware of how nervous the students are about asking the right questions during their history taking block when they are introduced to role-play sessions during their second year of studies. Any nervous tension that might have remained from this part of their training could hamper the creative and uninhibited process of role-play I was aiming to facilitate. In order to alleviate any possible tension, I informed the participants that they should not try to follow the rules they think a consultation session should consist of. They should forget what they have been taught to think is right. For this session of role-play, they should focus more on how they feel the patient would like them to respond. I was hoping that this would allow the participants to find and explore their own unique voices as HCP. Using their own unique manner of communicating with their patient would aid in establishing an empathetic connection with the patient as the participants would be able to allow themselves the liberty of feeling for their patients.

For the first session of role-play and to allow the participants partaking in the action to feel a sense of familiarity within the situation, I asked the first two participants to bring their own chairs into the consultation setting. The participant, taking on the role as HCP was asked to set the consultation area up, as she would like it to be in order to allow her to feel a little more at ease within the situation. Every participant had the opportunity of placing the chair (or setting the space) as they felt comfortable before the commencement of every session of role-play. The other participants became part of the setting the space of the consultation area through observation. There was a tangible sense of excitement and comradery in the venue as though something big was about to happen.

The next set of instructions were that, before every session, the “doctor” should take the white coat and stethoscope and step out of the room. As s/he put them on, s/he was asked to think back of what has been discussed, to think of what s/he is putting on and what s/he is doing as part of the enrolling process. The active participants were specifically not involved in an enrolling activity to deepen their engagement and belief for the reasons described above.

The “doctor” stepping out of the room was also a strategy put in place to get the patients’ histories without the doctor hearing what discussions are taking place regarding the patients’ illnesses. If the participant taking on the role of doctor were to have the patient’s background, it would predispose them to information that they should evoke when dealing with patients on an empathetic level. Having background information before entering into the session of role-play would also influence the listening on the part of the doctor, as s/he would see no need in carefully listening to what the patient is saying as s/he already knows

what the problem is. This would influence the empathetic connection negatively as for a patient “to be heard” is core to an empathetic connection between HCP and his/her patient.

Asking the doctor to step out of the room whilst the patient shared his/her scenario with the rest of the group, was also to create a sense of anticipation – creating tension by withholding information” (Wagner 1999:34).

Building belief in the “big lie” was also part of asking the doctor to step out of the room. In a real life clinical setting, a doctor would not be present as the patient discusses his or her situation. In order for the MoE approach to be operative, it needs to be believable to the participants. It is central to building belief in what is about to take place and is crucial to the success of the session or role-play that participants enter into (Wagner 1999:67). The “big lie” forms the “suitable material” which forms a session of role-play. Without it, the participants feel self-conscious and they respond by adopting defences like silliness (Wagner 1999:68). Aspects like silliness or laughter are aspects that the participants would bring with them from the “outside world”. In order for process drama to be effective the “outside world” should have no place in what is taking place during a session or role-play. It would directly influence the process of metaxis and would nullify the learning process that the facilitator is aiming to achieve.

The participants stepped into the role while they were outside. I asked them to take the white coat out with them. By donning of the “white lab coat” while they were outside the room, and thus adopting the role of the HCP as well as the qualities that they had assigned to the coat during the enrolment phase, assisted the participants taking on the role as HCP, to make the transition from the real to the fictional. When the patient was ready and had stepped into role by sharing his/her scenario with the rest of the group, I called the doctor in by saying: “Your patient is ready”. Using the phrase “patient” when asking the doctor to re-enter the room, furthermore established the fact that they were entering the scene about to unfold, not as themselves, but as HCP. The doctor entered the room where the patient was waiting, which added to the reality of the situation.

Had the doctor acquired any information that the patient revealed before the session of role-play commenced, it could have influenced the process of improvisation negatively. The doctor might have pre-empted questions s/he wanted to ask or thought s/he thought have to be asked. The “doctor” might even have created a sense of anticipation as to how the role-play session should evolve in order to reach a specific, desired outcome.

By expecting of the “doctor in role” to delve into the patient’s background through questions and answers, incorporates the strategy of evoking information through reflective questioning instead of directing the actions according to how the doctor believes, the action should go. Not only does this retain the interest of the participants, it also retains their commitment to the drama and allows them to direct the flow of the session as their actions and reactions are taken into account and are incorporated into the session of role-play.

Before the doctor stepped out, I informed the group that this is a first consultation session. There is no prior background to the patient – not even as much as a file. I also informed them that they do not have to get to the point of reaching diagnosis. Experience with partaking in role-play sessions as part of my work as SP facilitator, has taught me that many students view the role-play “session “ as a successful one, once they have a diagnosis. In this case, the process of experiencing the interaction was of more important focus than “fixing” the patients’ problems. The focus of this exercise should lie in listening, experiencing and responding. Not with the cognitive process of integrating medical knowledge. I instructed them that they should regard the ten minutes they have for the role-play as “just to have a conversation”.

I suggested that the “patients” do not keep the notes at hand that they wrote at the beginning of the session pertaining to their background. I asked them to leave the clipboards and the notes where they had left them before entering the area where the session of role-play takes place. I did this in order to create a sense them of inherently possessing the knowledge instead of looking for possible answers in the scenarios that they had written down. Looking for answers outside the scope of role-play could deviate the attention away from what is taking place between participants and could influence the process of improvisation negatively as the participants’ focus would be outside of what is taking place in the individual sessions of role-play.

As a part of the process of enrolling, I asked the participants to tell us about the patients they are about to portray. What became apparent right from the first scenario is that the background to the patients formed a large part of the scenarios the participants had developed. As facilitator to these individual sessions of role-play and bearing in mind the fact that an empathetic connection between HCP and patient forms a large part of the role-play, I regarded this as immensely positive. A sound background to the patients would allow the participants to explore the personal luggage on the part of a patient in depth. I regarded this conducive to the possibility of creating an empathetic connection between the doctor and patient.

Before commencement of the role-play session, I reminded the observing participants that the floor was open and that they could partake through thought tracking and hot seating as explained earlier on. I will give a short introduction pertaining to the patient scenario at the beginning of the individual role-play sessions that I will discuss to place the developments and process drama strategies that were employed, into context.

I regard these sessions as the means to an end to establish the qualitative effect of role-play on the empathy of the participants when dealing with HCP and patients in a clinical setting. Therefore, the individual sessions themselves will not be analysed through transcription, but will be described, focussing on the aspects that bear relevance to the study when regarded as the training session, or the central point, in the study. I will therefore focus on what transpired during the sessions and on choices made during the individual sessions of role-play relating to the introduction of various process drama strategies.

A constraint throughout was the lack of time. The fact that the participants verbally reflected on the actions they had observed or partaken in, aggravated this aspect. These reflections took the form of discussions throughout the session following every individual the session of role-play. This affected the limited time negatively, as I had not taken time for discussion into consideration during the planning phase in the outline of the training session. In order to remain fair throughout as to how much time each participant has in the role of HCP or patient, I placed strict emphasis on the time limit of the individual sessions of role-play by using a timer and warning them if there were one or two minutes of role-play left, in order for the participants to round off role-play.

I regarded these discussions as meaningful to the development of the participants' levels of empathy as the participants shared. I allowed some discussion to take place. Bearing the aim of the study in mind, I monitored these discussions closely. The moment the discussions became matters pertaining to information relating to the general state of healthcare in South Africa, for instance, I re-directed the action back to the session of role-play through using some of the strategies of process drama as described below.

4.6. Superstructure

Superstructure, or what is seen and observed, deals with what the students see and/or observe during the session of role-play. In other words, it deals with the pedagogical process that takes place during the session of role-play. Superstructure also deals with "how the students see their work" and looks into what the students take with them following the

session of role-play (Morgan & Saxton, 1985:217). I will discuss superstructure in the pages below.

4.6.1. Role-play session one

Doctor: participant three

Patient: participant eight

The first session dealt with 15 year old Lola who presents with burning urine and severe lower abdominal pain. This pain prevents her from doing her house chores and she cannot “play with” her friends. She cannot be the “cool kid at school” anymore. She lives with her grandfather and cannot discuss her illness with him as she feels that sharing female issues with him would be uncomfortable for both of them. She also cannot “have sex” with her boyfriend because of the pain. This puts strain on their relationship. Her illness is affecting her relationship with the two people closest to her: her grandfather as well as her boyfriend. The fact that her relationships are strained, is affecting her to such an extent that she cannot focus at school and started bunking.

I reminded the participants that the floor is open for them to ask questions, should they want to. I clarified that Lola is the only child, that she has no siblings and that her grandfather and her boyfriend are the two people closest to her. I did this to supply information in order for me to know if there would be a possibility to step into role as someone close to the patient, should the need for creating tension arise.

When the patient was ready, I called the doctor into the room with the words that “Your patient is waiting”.

After introduction, one of the first questions the doctor asked the patient was where she stays. As the facilitator to the session and bearing the fact that an empathetic connection and the building of rapport is important, I asked why the question about where the patient stays, was important. The doctor explained in role that the demographic of the patient’s background before the actual consultation begins, would give her insight into the context of patient’s problem. I was not quite convinced about the validity of such an answer and after allowing the patient to explain why she came to see the doctor and observing closely how this was described, the I asked how the patient would have felt if the first question had not been about where the patient stays. The patient felt that it was a way of the doctor showing interest in who she is that it is was “all right”.

Following these two questions right at the beginning of the first role-play session I realised that I might need to take a step back. I should allow the action to flow by withholding how I thought the action should go and by allowing the participants to wear the “mantle of the expert”.

The first question from one of the observing participants through the process of thought tracking was asked early after commencement of the first session of role-play. The nature of the question pertaining to why the patient waited for two months before consulting showed that interest, commitment and belief in the big lie had been achieved. It also touched on the strategies of dropping to the universal of the patient’s situation by finding an empathetic connection and connecting to others in a similar situation. I would like to point out that “universal” is used contextually based and not in the Heathcote way. Heathcote used the strategy of dropping to the universal as a means of reminding the participants that, throughout time, there are people who have found themselves in the position that the role-players find themselves in across time and contexts (Wagner, 1999:76). In this instance, the strategy of dropping to the universal deals more with the connection in context of the relationship between doctor and patient as seen during the session of role-play and the ways in which other participants could recognise the problem of patients not consulting HCPs timeously.

This question also incorporated the time before, after and within as it revealed the fact that there is more to the patient than the symptoms she came to present with. At the same time, this question allowed for the action to be slowed down as expecting of the patient to answer the question required for the participant to look a little deeper into the person she chose to present.

This is a point in the study where I might have started feeling insecure and aware of the fact that the locus of control is indeed shifting away from my intentions. Instead, I decided to embrace the fact that the responsibility of creating knowledge is clearly becoming a shared one. At this point, I made the conscious decision that I would only intervene when necessary in order to introduce any of the strategies described above in case of the role-play sessions becoming stagnant. For the main part, however, I decided to allow for the participants to direct the flow of what they felt they needed to learn through participating in the action.

The patient could answer the question with no hesitation on her part. Promptly answering the she thought the symptoms “would go away”, strongly linked to her background context that she had created during the development of the scenario.

When the session became one of the doctor focussing merely on and taking notes pertaining to the clinical symptoms on the part of the patient, I felt it important to bring the focus back to the empathetic connection that the study focuses on. Through the process of thought tracking, I stopped the actions ('freezing time') and asked the patient how she feels at this point in time. In response to her answer that she feels like crying, the question "why" was asked, creating a more holistic view of the patient by asking a question relating to the patient's feeling.

The answer that patient gave, was one that holds an intense connection to the empathetic connection between HCP and patient as she responded by saying that the doctor is "the first person I am confiding in and I don't even know her I don't know how she is going to take all of this". The fact that the participant answered the question in the first person was a good indication that she is involved on a level of personal engagement.

About half way through the session of role-play, it became apparent that the patient, Lola has no one to confide in, I became involved on a slightly more personal level than anticipated. I felt the inherent need to want to protect this "patient" from the pain and discomfort she is experiencing. By stepping back out of myself and viewing the situation from a facilitator's point of view, I realised that the participant had indeed taken on the body language of a fifteen year old who is insecure and lonely. Her legs were swinging to and fro – as that of an immature person in an awkward, uncomfortable situation. The participant was also fumbling with her fingers – a sure sign of feeling a sense of unease and insecurity. At this point I realised that the participant has entered the state of metaxis in the role portrayal as patient where she finds herself in the world as person portraying the role as well as the in the role of the patient at the same time. The patients' thoughts and expressions were those of the role being portrayed not those that participant eight had displayed when out of role.

At one point during the session, participant seven asked the doctor about how she is feeling. The Doctor expressed serious concern for the patient. She expressed the desire to "scoop" the patient "up" to protect her. This was an important aspect that surfaced as it forms the basis of an empathetic engagement between a HCP and his/her patient. During the first set of reflection questions the participants disclosed insecurity and fear of displaying empathy when dealing with their patients. I regarded the fact that the "doctor" in this instance displayed empathy as an ideal opportunity to assist them in alleviating some of the fears and concerns they had expressed during reflection. Through the incorporation of the MoE approach as well as reflection, I asked the participant: "How, as doctor, are you going to handle those feelings?" Participant three acknowledge that this is a very good question. She responded by stating that she would "assume the role of being the informant ... assuming

the role of bridging the gap between the patient and doctor by having an open door policy” in terms of being someone the patient could come and see regarding any matters she feels she would like to discuss that are not possible elsewhere.

All the questions that were asked during this first session of role-play – and throughout – were answered with serious intent on the part of the role players, It was obvious that everyone participating in the session – be it as observer or as participant in the drama – had bought into the big lie and were regarding the session with earnest interest and intent.

Before closure, participant seven asked the patient how she feels, once again incorporating the strategy of thought tracking. Participant eight said “I am becoming a bit scared because she [the doctor] is talking about contraceptives which is a reason I think I am in this point because I can’t get contraceptives now she’s going back to that issue again and the only contraceptives I know about are condoms and pills ... I can’t take pills .. and can’t get condoms from the clinic so I am a bit scared now ... “.

The session came to a close shortly after the participant eight had expressed her feelings as patient.

Before asking the doctor and/or the patient to step out of role, and as a means of debriefing, I asked the patient what she is taking with her from the role. Having the doctor present in the room while this was taking place was a means for both doctor and patient to distance themselves from what had taken place within the scope of the session of role-play in order to step back into reality to reflect and learn.

After stepping out of role the group discussed patients’ visits to the clinic. The participants discussed, as a group, how patients are advised about contraceptive use with the aim in mind of preventing pregnancy rather than focusing on the transmission of HIV and/or sexually transmitted infections (STIs) or sexually transmitted diseases (STDs). I deviated from the possibility of this turning into a debate that falls out of the scope of this study by acknowledging it as an interesting observation and then mentioned that this “problem” is not one that could be solved within the scope of “today’s” session.

I asked the patient step out of the room and allowing him/herself to debrief by means of considering how the patient as person would move forward from here. I also mentioned that she would step into the role of the doctor next.

After the patient had stepped out of the room and before the doctor was asked to think about what she is “stripping herself from” as she takes off the coat, I asked how she feels about the session as a means of enabling her to de-role.

Apart from her response that she realises she has a lot to learn in terms of approaching situations, she also remarked that process of medical school is actually empowering her to be able to handle that situation. She ended off by saying: “I feel I can do this ‘doctor-thing’ one day”.

4.6.2. Role-play session two

Doctor: participant eight

Patient: participant three

Zandile presented as a 25 year old professional hockey player who has been experiencing shortness of breath for the past month, as well as chest pain and she gets tired very easily. She is struggling to keep up with the practise sessions and feels that her career is in jeopardy as she is under a lot of pressure. She is also struggling to keep up with household duties and looking after her kids. She feels frustrated about suffering from something that could possibly affect her career permanently.

Due to the fact that participant three was still in the process of enrolling and had not entered into the role-play as “patient”, as facilitator out of role, I intervened by asking about more background pertaining to her family with particular focus on her relationship with her mother. In response to the question as to whether her mother shared in Zandile’s dream to become a hockey player, and inspired her to follow this dream, the answer was a positive yes.

I asked the question relating to the relationship between Zandile and her mother because of the fact that during the introduction to the patient’s background, the patient placed much focus on the pressure of possibly not being able to follow a career in hockey anymore. I intuitively felt that someone with a family would not feel so strongly about a sports-orientated career and proposed another reason for the immense pressure Zandile places on herself with regards to being successful in her career as hockey player. I wondered where this pressure comes from.

I posed question to participant three before the session of role-play started instead of facilitating the role-play so that this question could be asked by the observing participants so as not to influence the MoE approach of the observing participants in any way.

Before asking the doctor to enter, and the participants step into role, I asked a last question with relation to Zandile's relationship with her mother. I asked if she would have asked her mother to come to the consultation with her, which was answered negatively, she would however have told her mother that she was coming to consult.

When the consultation started becoming a matter simply of following a questions/answer mode, with not enough personal engagement on the part of the participants, I decided it is time to create some tension. I stepped into role in order to introduce of an element of surprise by expectantly entering the role-play as the mother of the patient.

The patient, the doctor as well as the observing participants were so surprised when the mother entered the session that the action stopped for a moment. I felt that stepping into role as the mother, might have been an error in judgement; especially given the fact that I entered as one wanting to ensure that my daughter receives the correct line of treatment in order for her to continue with her career as professional hockey player.

Both participants recovered quickly from their shocked surprise. Participant three, who portrayed the role of the daughter, Zandile, took on the role as daughter in her mother's presence. Participant eight in her role as doctor took control of the situation by asking the "patient" is she was comfortable with her mother being present. Before the consultation could continue, however the action was stopped by participant one who asked how the doctor feels about the mother entering, thus also introducing the strategy of hot seating.

There was some laughter, which, given the situation, might be regarded as a break in the action and in belief. However, the doctor's response brought the focus back to the situation by focussing on the patient's reaction about not being comfortable with the mother's presence. The doctor admitted to not being comfortable because she could sense that her patient was not entirely comfortable either.

After the mother had left the room, the consultation took on a different turn as the mother was incorporated as part of the patient's history. This incorporated the strategy of the time, before, after and within where the doctor becomes aware that there is more to a patient than the illness s/he presents with. This allowed for a more holistic view of the patient as a human being. The doctor's focus shifted from asking questions merely pertaining to the illness to a more personal history taking, which takes the mother into account and the patient opened up and spoke much about her relationship with the mother.

I re-entered the room as teacher out of role, which had a slight impact until the participants in the action realised that I am moving towards the chair assigned as the chair I would sit on

when out of role. The patient felt uninhabited enough to discuss her relationship with her mother as though I were not even present.

Following the mother's appearance and the flow the consultation was taking, allowed for questions from the floor to be more focused on the patient's feelings. Therefore, even if the mother entered as overbearing and bombastic, it did have an impact on the feeling/empathetic connection between HCP and patient as it opened up some personal background. This background added a human dimension to the patient in front of the doctor.

Incidentally and with no prior intent, the overbearing mother brought in the strategy of man in a mess¹⁴. This strategy refers to people dealing from within a state of desperation (O'Neill, 2015:2). According to Sayers (2013:20) man in a mess "involves all participants in a common 'frame' ... facing a significant dilemma". Facing a significant dilemma means that the participants are "trapped in the experience" and in order to find their way out, they need to "pull out new information" and this is when they "plump to what they didn't know they knew" (Wagner 1999:45). It is one of the moments that learning occurs.

Experiencing a sense of desperation in another is bound to evoke some feeling. The mother brought in an aspect that placed the patient in a difficult position in her personal life. Following the mother's appearance, there was much interest from the doctor and from the floor in Zandile's personal life. The participants showed interest in aspects relating to whether she has siblings. There were questions pertaining to her relationship with her mother, and the role her mother had played in her becoming a professional hockey player. The patient could not only answer, but could elaborate on all questions. I realised, once again that the character background created at the beginning of the session, had been sufficient preparation to create a sound background.

The doctor's reaction while the mother was interfering was one of confusion and throwing the entire flow of the consultation in disarray. In other words, the mother placed the strategy of man in a mess not only on the patient, but on the doctor as well. I was amazed about the fact that the mother's appearance was eventually accepted with such ease and incorporated as a part of the patient's life outside the consultation. I was also positively impressed with the fact that the mother's appearance, allowed for more in depth in probing to the "patient's"

¹⁴ Neither the term man in a mess (Sayers 2012: 23-25) nor the code of brotherhoods are used in this study with the aim of any definition of gender. These terms are used with regards to strategies as employed and named by Heatchcote (Wagner 1999 48-52) and refer to all participants, irrespective of gender, with regards to the strategies of applied drama that were introduced.

background as it immediately placed the patient in context of a person with a background rather than just someone presenting with an illness. The appearance of the “mother” fostered an empathetic engagement between the “doctor” and “patient” as the “doctor” could relate to the patient with more caring and empathy.

4.6.3. Role-play session three

Doctor: participant one

Patient: participant two

The scenario was about a widow, Miss Naledi. She is a foreigner and has two children. Recently she started experiencing numbness in her left arm. She is worried because her only form of income comes from washing people’s clothes and cleaning. She will not be able to work if she loses the use of her one arm.

During this session of role-play, a strategy was introduced that was neither planned nor initiated through me as facilitator in any way. The doctor entered the consultation session as extremely arrogant and uncaring. This came as a surprise, especially coming from one of the participants who showed much insight and sensitivity during observing and through the questions s/he had asked. By entering the consultation room as an arrogant doctor, participant one brought another dimension to the drama – by changing the style of role-portrayal, he brought a new source of energy and awareness - without changing the objective of the session.

After I had called the doctor in, participant one entered the consultation room with the white coat slung across his arm, stethoscope hung around his neck and the body language resembling that of someone who thinks the only person mattering in this world, is he himself. This became apparent through the way he carried himself and by focussing only on what he deemed important. As doctor in role, participant one decided to turn his back on the patient bluntly while closing the door and focussed only on the route to follow in order to reach the chair where he would sit. He nonchalantly greeted the patient, referring to her as ‘sissy’, apologised for not wearing the coat as it is a bit tight and loosely and slung it over the back of the chair, while indicating to the stethoscope that was hung around his neck in order to prove that he is indeed a doctor. He introduced himself, flung himself down in the chair, sat down in a most unprofessional, and relaxed manner. His first question to the patient asking how he can help her “today” – before obtaining as much as the patient’s name – was asked with the least possible interest.

As the patient started speaking, he rudely interrupted her in order to wash his hands ... he sat down with no change in attitude whatsoever, rather the opposite. I interfered by asking the straightforward questions as to "what are you doing?" I wanted deep belief in the role on the part of the doctor and aimed at guiding the action towards to patient. I wanted to know if participant one believed he would learn anything from this session by acting this way. His response was a positive "yes".

Although the doctor's arrogant attitude irritated me as I could not see how this could yield any positive results concerning an empathetic connection between the doctor and his patient, I realised that I needed to withdraw and withhold expertise. I had to allow the participants to believe that they are in control in order to keep them fixated and interested in the action taking place. The doctor continued with is arrogant approach by focussing his attention on the patient and asking her to continue by asking: "Yes, patient?" Addressing a patient in such a manner is definitely not a realistic approach. It served to underline the arrogant approach that the doctor had.

Participant seven introduced the strategy of thought tracking by asking the "patient" how the doctor's approach makes her feel. Participant two admitted that this approach made the patient feel that the doctor is not interested in her as a person, but only interested in what he is doing. She stated that the fact that he started washing his hands after the consultation session had begun, made her feel uncomfortable. Participant eight asked the "doctor" what he thinks the patient feels regarding the posture he had adapted when seated. The doctor admitted that the "posture" he had adopted is "completely unacceptable" and that it scares the patient. Yet he did not change anything.

As answer to the strategy of hot seating and me asking the doctor how he was feeling. His answer was simply: "I feel horrible". He continued by saying that "the sad reality is that there are so many doctors who are like that actually". He stated that perhaps he was doing the role-play in this way "to put it across" to himself that he never ever becomes someone who does that or "treats patients in that fashion".

As the consultation continued, the doctor went a step further by interrupting the patient at a crucial moment when she was describing her feelings in order to and answer his cell phone. He kept the conversation short but a few sentences later after the patient continued telling him about how she was feeling, the doctor took information that the patient gave and used it to steer the conversation in a direction that revolved around his successes in life. At this point, it became obvious, that the patient started showing signs of frustration. She shook her head, looked down and started fumbling with her hands. Participant seven stopped the role-

play and introduced the strategy of thought tracking by asking participant two how she was feeling as patient. Participant two responded by stating that she does not understand why the doctor was telling her “all this stuff” and that it made her feel horrible about her life in general.

When the doctor answered the question from observing participant four as to why he was telling the patient so many details about himself, he admitted it to being due to inferiority within himself that he had to make up with exterior aspects of success to prove that he actually had some worth. I regarded this as a sign that participant one had created enough background to his role as doctor to allow himself to fully engage with the role, which means that metaxis is taking place.

One of the first questions posed to the doctor after the role-play session had come to a close, was indicative of what I had observed about the observing participants being personally involved. Participant six asked the doctor how he feels about himself outside of the character that he was portraying. He related that he had been in a consultation similar to this one where he thinks the doctor had a “psychological problem”, which is sad because people do not understand why they are there – they simply go “through the motions” of talking to the patient, because it is their daily bread. He thought it sad if the doctors could not care less and care “literally” for the pay check.

A part of the feedback from participant one, was that he reiterated that being a doctor does not make you superior to anyone else and this is the lesson he would like to take with him from the role-play.

4.6.4. Role-play session four

Doctor: participant two

Patient: participant one

Participant one portrayed Jerry Kosane. He is married and has two children, but he is gay. He presents with burning urine and his left testicle is swollen. His wife wants to engage sexually, but he experiences pain during “that period”. His other homosexual partners are also demanding his attention. He would like to be treated for the symptoms he has.

Participant two stepped into the consultation session as doctor. She left the door open behind her, which was a definite sign of disrespect for the privacy of whatever the patient needed to share.

She also flirted with the patient by playing with her hair and showing obvious flirtatious non-verbal signs such as using a gentle voice and taking on a very posture that was indicative of more than a doctor-patient relationship. Participant three asked the patient how this made him feel. The patient admitted to “going with this” because it makes him feel comfortable. In this instance, I had to force myself to withhold expertise and to allow the action to follow as it was being improvised, although it became apparent that there was not much of a connection between the doctor and the patient at this stage.

The patient was not opening up to the doctor through means of sharing any more information than to answer the questions the doctor asked. I introduced the brotherhoods with the hope of getting the patient to open up towards the doctor by asking the patient if he believed there were other men in his position as a gay man who was stuck in marriage with a woman with children. The answer was affirmative, and on further probing through thought tracking, by asking the question about how he thinks this makes them feel, the participant explained that if men are together they are “o.k” because that’s their world. But once they go back to the sad reality that their lives are in, they go back to what society is expecting and they move on.

Observing participant six asked whether the doctor felt she was connecting with the patient. Even though the doctor felt the connection was not ideal as there were obviously things the patients was not telling her, she felt there was enough of a connection between them.

Observing participant eight asked the doctor if there are things she is choosing not to entertain or whether she is purposely ignoring some of the underlying messages the patient was conveying verbally. The doctor’s answer was that she did not actually hear what the patient was saying, which is a sure sign of no empathetic engagement at all as she is obviously not even interested in listening properly.

The role-play was interrupted again after a short while. Observing participant six asked the patient if he feels “rebuffed by the doctor”. He stated that he feels that she is not listening to him, there is a problem behind the problem and he is not being heard because the doctor is more concerned about “the clinical problem”.

This was an interesting session that left me frustrated as it was obvious that the taxonomy of personal engagement where the participants should become more involved was moving in the opposite direction and no questions that were posed nor answers given, were having any positive influence in changing the situation into a more favourable one concerning an empathetic engagement between patient and doctor.

I decided to step into role and introduce an element of surprise as well and tension. I stepped out of the room and entered a while later as receptionist, reminding the doctor that there are a lot of patients waiting, hoping that the introduction of an element of tension will assist in moving the drama forward.

The doctor's reaction was not positive at all. She responded to the receptionist with an attitude that escalated into friction between the doctor and her receptionist. The session was over shortly after the receptionist had left the room with the words: "Doc, just hurry up". In hindsight, this was an occasion during the training session of role-play where I allowed for my personal frustration to infiltrate into the drama, which might possibly have affected it negatively.

After the session had ended I asked the doctor if there is anything she would have done differently, her response was that she would have paid more attention to the patient himself. She felt that she had not explored "certain things" because of a lack of professional attitude and caring. If there had been more of that, she feels, she would have gotten more information from the patient. I asked what she felt, she would have gotten. Participant two made specific mention of his sexuality and that she was not certain if he is really has a wife or if he is really gay. She admitted to not "actually getting to that". She mentioned that she would have gotten to the bottom of why he really came to see her and if there might have been an underlying problem.

Participant four wanted to know why the doctor did not ask her patient directly whether he is gay "or something". Participant two responded by saying that she would have "picked it up" had she paid more attention to him as a person. She wanted to know from participant four "Do you get me?". Her answer made it clear to me that, instead of answering the question, she was defending herself.

This was an area of concern for me as it was clear that participant two was not open to internalising the questions, in order to learn what she might have done differently. She was more concerned about defending her attitude. In this instance it also became clear to me why she responded towards her "receptionist" with arrogance.

This consultation between doctor and patient was a prime example of what occurs when there is no empathy on the part of the HCP. It left me frustrated. I did not know how to use this session as a learning experience by not embarrassing or negatively criticising participant two in front of the group by directly referring to the fact that had she, in her role as "doctor"

approached the patient with more empathy, she would have gotten all the information she needs.

However, following this session, there was a lot of feedback from the floor – opinions were voiced, questions were raised; all relating to the fact that there was no empathetic connection between the “doctor” and her “patient”. The participants highlighted the areas of concern through questions.

Participant eight asked the “patient”, as gay man who is married, if he felt comfortable with the way the doctor handled the situation or if it would have been better if the doctor had explored more with regards to his sexuality. Participant one admitted that the doctor was more interested in herself and that there was not much of a “connection that was built”. He admitted that he would have probably gone to see another doctor whom he could speak to more about the “social dynamics” that he finds himself in.

Participant seven posed the question to the group how, as a doctor, one would best approach the question to a patient whether he is gay without “throwing it out”. This led to a group discussion with no conclusive answer except that it would depend on how the patient presents him/herself.

Therefore, even if the consultation session apparently did not seem to have gone as intended, it did stir something in the participants. I realised that it is good that I did not directly infer that, had participant two approached the patient with more empathy, he would have opened up and she would have gotten the information she required. It reminded me that the participants, not I, were the experts in this instance.

4.6.5. Exchanging of DVD

While I was out of the room in order to exchange the DVD to ensure enough recording space for the next four individual sessions of role-play that were to still take place, the participants discussed much. The discussion related to more general consultation skills such as breaching certain subjects, how to ask your patients certain questions or how to deal with a situation where a patient refuses to take an HIV test. That the discussion between the individual sessions that had very little to do with the study itself is indicative of the fact that there are many aspects the students still struggle with. Not only could they use some guidance in this regard, but I believe that this discussion flowing from the training session of role-play in itself was creating a learning opportunity for the students that could not have been foreseen.

The training session of role-play allowed the participants to realise which questions they still have, it was also showing them that they are not the only ones struggling with certain aspects pertaining to the consultation process. In addition, discussion between each other allowed them to find answers amongst themselves that they could relate to.

4.6.6. Role-play session five

Doctor: participant four

Patient: participant seven

The patient shared her story about Precious, a domestic worker from Limpopo displaying symptoms of TB. Participant seven had worked out the background to the scenario in much detail. As participant seven was giving the background information pertaining to the role she is about to portray, it became evident to me that, not only was the participant's accent changing, there were also slight changes in body language and non-verbal cues as she adopted an outward expression of the patient she is about to portray.

I became a little concerned that this might influence the portrayal as it takes on an outward show of "acting" instead of remaining an internal process. I reminded the participant not to focus too much on the accent and the outward portrayal.

The session started as a consultation between doctor and patient that focussed mainly on the symptoms the patient presents with, it was a clinical consultation. In order for the creation of a more empathetic connection between the doctor and patient and being able to work only with what has been presented this far, as facilitator out of role, I asked the doctor if she knew what was meant by one of the explanations the patient gave in an attempt at describing the pain. The doctor did not know. Making use of the strategy of edging in, where the participant is forced to look for answers, I asked if she had the opportunity to ask the question again, what would she ask, she still did not know.

I asked if she would like the opportunity to ask the questions again. The doctor asked the patient to describe the pain more. The patient described the pain in a similar manner as the previous time, saying that it felt like her back was being chopped like someone chopping wood with an axe. The doctor admitted to still not understanding and moved back into the seemingly comfortable ground of the clinical, aspects relating to the symptoms portrayed and the social background of the patient: a seemingly perfect consultation, focussing on the clinical with no empathetic engagement between doctor and patient.

Once again, I had to withhold what I felt, might be my expertise as I was very aware of the fact that this situation is very close to the one I find myself in during my working environment. I had to be careful not to want to influence the flow of the drama though a pre-conceived notion of how I think it ought to be going. By withholding expertise, I allowed the participants to remain the experts in this moment. By doing so, I incorporated the MoE approach again.

The doctor herself stopped the action and admitted in a whisper that she could not think of any more questions to ask. This might be interpreted as asking for some assistance and could be the result of the action of the patient being on an outward level.

Assistance came from the floor. Observing participant eight wanted to know if the doctor could not possibly explore more with regards to the patient's family history in order for the doctor to understand where the patient comes from. I asked how participant four feels about the question. Participant four answered out of role, saying that she felt that it is a viable question, but she is not sure of what questions to ask. I cut her short when she wanted to explain why. This is one strong point where I felt the need to steer the process. This was wrong. I should have handled the situation very differently and should have allowed the participant as doctor in role to remain in the position as expert by being allowing her to express what she felt.

In order to get the participants back on track. I asked why participant eight had asked that question. Participant eight said she feels that the doctor focussed more on the clinical rather than following up on the social aspects that patient is sharing – even without being asked for them.

The doctor explained out of role, stating that she felt there was more of a problem with the fictitious employer, but was unsure about which questions to ask in order to investigate this specific relationship in more depth.

Participant eight asked how the patient feels the doctor in treating her? The patient responded by saying, she felt the doctor was trying, but that she was not really listening.

Through the process of thought tracking, participant six asked the doctor how she feels about the interaction, because she seems uncomfortable. The doctor admitted to feeling uncomfortable. She senses that there is more behind what the patient is telling her and that she felt she should get to the information behind the words that were being shared. Being unsure of how to get to that information, made the doctor feel uncomfortable.

Following this disclosure by the doctor, the last minute of the consultation was spent on investigating the patient's relationship with and feelings towards her mother.

The session ended by participant eight asking the "patient" if there was anything more she would have liked to have told the doctor. Participant seven said that she would have liked to have gained more information pertaining to her illness and how to deal with her employer.

I asked participant four if there is anything she would have changed. She admitted that she should have been more relaxed in order to interact with the patient and "build a good rapport".

4.6.7. Role-play session six

Doctor: participant seven

Patient: participant four

Participant four presented as a 36 year old lady who had been married for about ten years. She is presenting with vaginal bleeding and lower abdominal pain. The fact that she and her husband do not have children, is putting strain on her relationship with her husband and his family. She is very worried that the vaginal bleeding is indicative of her not being able to bear children.

When the consultation started focussing on the clinical aspects, participant three asked the doctor how she would "counsel" a patient who is obviously concerned about the fact that not falling pregnant, is influencing her relationship with her husband and his family negatively.

The doctor answered out of role as a student of medicine that she first needs to find out about the dynamics between her husband and the financial standpoint before she can counsel the patient. In retrospect, I should have asked her to answer this question in role by acting out what she is explaining in words.

Observing participant six came to the rescue by asking if the doctor were to start again, what way would she find to connect to the patient more. The participant portraying the role of the doctor regarded this as a very good question.

The doctor admitted about being more concerned about the "presenting problem" as opposed to the social problems, which is exactly where the lack of an empathetic connection between doctor and patient found its origin. The doctor admitted to thinking merely along the

clinical route rather than being concerned with the well-being of the patient as a human being. She admitted to the fact that she is not sure.

During the discussion that was taking place, observing participant five responded that the doctor could, in fact, not know what the patient had been going through. The best she could do is to “do the best she can do to help this patient” with the experience she has at her disposal and allowing her imagination to go as far as it can go in order to imagine what it feels like to be the patient’s position. This is the best the doctor can do for now in order to reach the connection with the patient that she would like to have.

The role-play continued with the doctor asking the patient about “how things are at home”. This is quite a big step away from focussing merely on the clinical.

The patient opened up about her deteriorating relationship with her husband, which allowed the doctor to start posing questions about how the patient feels. In spite of interruptions and this session of role-play taking on a very different direction, something seemed to be working.

Following the patient opening up about her feelings, participant one stopped the action and commented on the observation that the doctor had stopped writing (or taking notes about the patient) and had given the patient a “look”. Participant one wanted to know what that look meant the doctor gave the patient. The doctor admitted that she felt like crying. The doctor felt that listening to the patient reiterate how she does not feel like enough of a woman, because of the fact that she cannot have children, was painful.

Participant one asked, how to move forward on professional scale from that emotion that the doctor finds herself in, in such a way as to still assist the patient.

I felt this was a crucial point that was reached during the training session of role-play as becoming emotionally involved with ones’ patients is exactly what the students of medicine are warned against. This fear of getting too “close” to the patient is a big hindrance in the empathetic connection between HCP and patient as it tends to let HCP and students of medicine steer the conversation away from anything that might be touching on emotions or feelings. In addition, in doing so, it hinders the patients’ sharing of feelings right from the outset on.

The doctor continued by asking about whether the husband had consulted anyone about the fact that his wife cannot fall pregnant. A brilliant move so as to move the blame away from the patient, however, the patient admitted that the husband, as well as his entire family,

believes that she is at fault and that he should “find another wife” who could bear him the children he desires. The doctor struggled to move on from there and time for the session of role-play was up.

In-depth discussion from the floor followed relating to the fact of how much easier it is to talk about clinical matters. And how good the students are at getting the history of main complaint associated symptoms. Instead of focussing on the whim that there may be a problem.

Participant six volunteered, “I do this all the time, I see the social problems, but I don’t gauge them because I feel that I cannot get emotional. As though I am not allowed to show emotions before patients, which is probably what you are feeling now”. The aforementioned is an example of both brotherhoods and dropping to the universal as all the participants – both observing well as those who were actively partaking in the session of role-play – connected on a level way beyond the scope of the session of role-play. Not only could they relate to their behaviour when dealing with patients, but also to the behaviour generally adopted between HCP and patient when there is a shying away of addressing the patients’ emotional needs.

The role-play stopped at such a crucial moment. All the observing participants were in a situation where they wanted to see how they could move forward from a situation where the HCP becomes emotionally involved and how to move back to being professional in order to clinically assist the patient.

Participant one wanted to know: “How do you then move forward [from an emotional connection] and then still clinically assist the patient ... It [this session of role-lay] makes you sit in peoples’ shoes and try to see things and revisit them in a different fashion”.

The entire group felt that they do not know how to deal with an empathetic connection and then move forward in order to reach a clinical diagnosis. They spoke about feelings of helplessness because they cannot physically do anything assist the patient. They also felt that some patients do not want your advice.

In order to bring the discussion back to the session of role-play and reflecting on what had taken place, I adopted the strategy of thought tracking by asking the patient how she feels. Participant four responded by saying: "I need to be free where I can release all the problems, but we have to deal with the problems [this is] difficult because doctors are running from problems. So the patient doesn’t know: do they know what I am going through?"

The fact that so much of the discussion following the role-play was about not knowing how to continue with the session, I asked the doctor if she could ask her patient one more question, what would it be? Participant seven responded by saying that she would ask about a support structure and whether the patient has someone to talk to or someone to confide in. She continued by sharing some personal information about an aunt who cannot fall pregnant.

I used this personal connection to the patient's situation and brought in the strategy of brotherhoods by asking the "doctor" how she felt now in comparison to when the interview ended. Participant seven broke into song and shared some lyrics about being someone's friend.

I felt that we were getting somewhere in resolving some of the problems that the participants have about dealing with patients' personal stories and used the strategy of edging in by asking if she had to do the interview again, how she would do it. Participant seven responded by relating back to what was discussed during the enrolment phase and the meaning that the white coat holds. She said that she would take coat off [figuratively] and become more of a friend than a doctor. She would "come down" to the patient's level.

I felt that the session had reached its end and asked the participants to debrief in order to move onto the last two individual sessions of role-play.

4.6.8. Role Play session seven

Doctor: participant five

Patient: participant six

Scenario seven dealt with 16 year old Issobel Stevens who lives with her mom. About six months ago, she started getting a rash all over her face. She now has areas of light pigmentation and itching. She felt very self-conscious about it at school and is now home schooling. She has lost all her friends. She is feeling down about the future because she feels she is not looking so beautiful anymore and she wanted to be a model.

From my point of view, scenario seven was the most difficult scenario to deal with. The doctor started by placing all focus on the clinical symptoms and the history of the illness. Although the patient volunteered a lot of personal information and talking about her feelings openly, the doctor remained focussed on the clinical symptoms by asking questions like when the illness started or whether the patient ate anything out of the ordinary. Both questions were answered negatively on the part of the patient.

The patient continued by elaborating on her fears and feelings about the rash sharing with the doctor that she thought she might have skin cancer. The doctor showed no personal interest not through body language or any non-verbal communication. She turned her face away from the patient and showed disdain by muttering the words, "O God".

My heart went out to the patient and in an attempt to assist the doctor with creating a more empathetic connection, I applied the strategy of hot seating by asking the doctor what she was thinking about the moment she is finding herself in. Unintentionally I might have placed the doctor in the situation of man in a mess as she was obviously looking for answers that did not come. She could not answer the question.

After a lengthy silence, participant one asked the patient what she thinks about the doctor's interaction. The patient feels "she is confused".

Participant three asked the doctor about her impression of the patient and how she feels concerning the way the patient is presenting herself and interacting with the doctor. The doctor felt that the patient was making up things. That is why she was "not entertaining her".

Participant seven interrupted the session and asked why the doctor did not explore the patient's family dynamics. The doctor admitted that she did not regard it as important.

From here, the session became one of a doctor becoming more and more patronising towards her patient. She used comments like: "When you grow up one day" and that she is a doctor who believes that "kids should not really have an opinion", which are definitely not conducive to an empathetic doctor-patient engagement. The patient felt that the doctor was being very "parenty". She said that the doctor is "not hearing me, pushing her opinions on me".

Later the doctor even became derogatory towards the mother, stating that she cannot look after her daughter properly because she is a secretary at a law firm. Insinuating that the mother is not of a good enough calibre of a person because she does not want anything better for herself.

The rest of the consultation followed the same line with the doctor being arrogant. The patient and doctor started arguing as each of them was trying to state their case. I found the session extremely frustrating. I could not think of any strategies to employ to salvage the situation. When there was half a minute left, I intervened and asked that they fix the situation, whatever they do to it "just fix it".

The doctor concluded by saying that she would just give the patient the medication. The session ended in the patient stepping out of role and saying: "I don't feel like she's helping me! I don't want her medication; I actually just want to leave".

After the patient had stepped out of the room to derole, participant one summed the situation up in the following manner. He said that he likes the different portrayals of what doctors can be like "... it makes us really aware of ourselves ... once you get the license, this kind of teaching goes out of you and your true self come in ... and the true self turns out to be such a horrible person and the lack of [caring] for a patient and it's all about you that's something that very important for me here".

In an attempt to understand why the doctor adopted that kind of role, I asked what made her adopt that kind of role as doctor. She replied that she wanted to go "with a different kind of role" but she adopted that kind of an attitude because "It's easy [easier] to do that to a child than it is to do it to an adult".

4.6.9. Role-play session eight

Doctor: participant six

Patient: participant five

Mary Mapele is a 27 year old human rights lawyer. She is a "pastor's child" who is also married to a "pastor's child". She is presenting with a blue eye and a broken nose. She cannot tell anyone that her husband beats her because he is also a pastor's child and they have a big church to run. Because of her career as a human rights lawyer, she helps a lot of people in the same position she finds herself in. Therefore, she feels she cannot tell anyone that what is happening to them, is also happening to her. The stigma attached to a pastor's child means that she has to "be perfect" and has to protect her husband and her father's reputation in order to be able to continue to build the congregation and the church her father and her husband's father had started.

The consultation flowed well. There was a natural and immediate positive connection between the doctor and the patient. When the patient felt that the doctor was coming too close by asking whether she was completely alone when she got her blue eye by "bumping into a wall", the patient backed away by asking the doctor to hurry up as her husband was waiting outside.

The doctor was not phased at all and continued asking questions that Heathcote would classify as questions that deepen insight (Wagner, 1999:56). By asking such detailed questions, the participant portraying the role as doctor introduced the strategy of slowing the action down by asking of the “patient” to explore her problem in more depth. Unknowingly she also introduced the strategy of edging in by expecting the “patient” to fight for answers in an attempt at covering up the abuse she has to deal with.

The interview was reaching a point where it was flowing like a general consultation session between doctor and patient with no actual learning taking place. Tension needed to be introduced. Observing participant seven suggested that the one male participant enters as husband.

Just before the strategy of creating tension through the introduction of another character could be introduced, observing participant three introduced the strategy of thought tracking by stopping the action. S/he asked the doctor how she feels at this point in the consultation session with regards the patient not responding to where the participants see she is wanting to go. The doctor admitted that she was feeling “a bit frustrated” as she was not getting through to the patient, because the patient is trying to protect husband by not saying anything. The “doctor” admitted to not wanting to be “pushy”, so she filled the consultation with casual conversation, hoping the patient would become comfortable enough to disclose more information. The consultation continued in the same manner as before, it was not going anywhere – tension needed to be introduced.

The male participant [one] in the group took on the role as husband. He knocked and came in. The doctor handled the situation very well by explaining to him that she would like to examine the patient a little more and asked him to please allow her and the patient some more time to bond. He agreed and left.

The strategy of thought tracking was introduced through observing participant seven asking how the husband’s entrance made the doctor feel. Her response was: “Very afraid and very nervous”. The “doctor” was concerned about how she would get the “patient” to talk to her now? She felt thrown off guard. Where she previously thought: “I can do this, I can get her to talk” now she felt that the “patient” would withdraw more.

In order to bridge that gap and by incorporating the MoE approach, I asked whether there is a way the doctor could use the husband’s intrusion in a way this to get through to the patient. The doctor remarked that she notices that Mary is a bit tenser now and asked how she felt about her husband coming in. Mary responded by saying: “Just o.k.”.

The doctor introduced the strategy of edging in by asking a series of questions that forced the patient to fight for answers. Such as asking the patient if she wanted her husband to stay. When the patient responded negatively, the doctor asked whether there is any particular reason she didn't want him to stay?

A long sigh, a slight shake of the head and a very soft "no".

The doctor clarified "Nothing specific".

The doctor continued by making use of the strategy of edging in by stating: "He said that you should say the right things. Do you know what the right things are?"

The patient's response was: "Because you are always supposed to say the right things".

What follows is a slightly condensed version of how the conversation continued. I am writing in quite a lot of detail as it perfectly exemplifies the strategy of edging in and shows how this enabled the patient to open up.

Doctor: 'Why are you always supposed to say the right things?'

Patient: "Being the child of pastor makes you different. Pastor's kids are supposed to do things in a certain way – you just have to do things in the right way".

Doctor: "What are these things and what are the things that you are not supposed to say?"

Patient: "Anything to embarrass my husband in front of anyone".

Doctor: "What could potentially embarrass him?"

Patient: "He tells me what embarrasses him and what doesn't".

Doctor: "In the past what has he said you would do that would embarrass him?"

Patient: "As a woman you don't share your family information with anyone outside".

Doctor: "If you have shared this information, what do you think he would do?"

Patient: "You don't want to know".

Doctor: "Well, I would like to know if you are comfortable with telling me".

Patient: "See my husband is a very lovely person – event though sometimes he hits me – he just wants me to do things in the right way".

This is where the session ended.

Feedback from the floor was that the doctor did brilliantly in getting the patient to speak. Participant three admitted that in answer to the question of how to get a patient to open up, “this is the way you get a patient to speak”. This session showed that the participant was not afraid to delve into the patient’s emotions and feelings. Something that had been a topic of much discussion earlier on. This session proved that participant six had overcome some of her fears when dealing with patients on this level.

Participant three asked the patient: “Did the fact that your husband came in have an effect on you eventually caving in and talking?” She acknowledged that, if he had not come in, she would not have said anything ... “he was here and touched me and I was afraid”. She says that she could not have kept that feeling hidden for a long time.

Following the last session of role-play. I asked to complete reflection sheets immediately to capture in writing how they felt and as a means to debrief.

Reviewing of the recording brought another aspect into consideration: although identification plays a strong focal point in the engagement in the drama, Morgan and Saxton (1989), also warn that in cases where the participants do not act out a role as facilitator supposes it should be done, does not necessarily mean that the participant did not engage with the role.

In this case, commitment, which forms the next step in the taxonomy of personal engagement, might also have come from the observing participants. This notion does fall out of the scope of the strategies to be employed within the session of role-play. However, given the fact that the observing participants do form part of the session through means of being invited to ask questions pertaining to the action taking place, they can be regarded as part of the session of role-play.

Taking the above into consideration, it shows that the observing participants dropped to the universal. They connected to the doctor by regarding the universal aspects that were portrayed when they find themselves in a similar situation of a consultation session where they are struggling to find the right questions to ask.

The brotherhoods could also be considered as a strategy here where the observing participants find common inner experiences that link them to what the doctor seemed to be going through. Brotherhoods is a term that Heathcote assigned when the participants connect to other people that find themselves in a similar situation. "It represents all those who behave in a certain way, or hold a particular belief and was intended to help participants to understand more about what motivates human behaviour" (Sayers 2014:8).

4.7. Role-play and after

After a time span of four weeks, I conducted the post-training survey. I asked the participants to complete the JSPE (S-version) again as well as answering another set of reflection questions dealing with what they observed in relation to empathetic behaviour in the clinical setting.

The span of four weeks between the session of role-play and re-introducing the JSPE (S-version) was two-fold. Firstly, it would allow enough time to ascertain the retainment of the qualitative effect of the session of role-play on the participants' levels of empathy, as stated by my co-supervisor Prof. C.W. van Staden, who, given his credentials, is an expert in the field. Secondly, four weeks is sufficient time to mitigate the possibility of the participants' comparing their answers during the second completion of the JSPE (S-version), to the first, from a subjective point of view in order to influence the results by completing the tool in the way they think might render the results more positively.

The post-training reflection took place four weeks after the session of role-play on eight September 2017. Question one dealt with what the participants had observed in themselves and others, following the session of role-play.

Apart from two participants that interpreted the question dealing with the session of role-play, the general response was that the session of role-play afforded the participants the ability to be more aware of their own feelings, as well as being more aware of their own and their patients' body language. They realised that empathy can be learnt and that an empathetic engagement makes it easier to build rapport.

One of the participants mentioned that s/he finds it difficult not to feel sorry for the patient and that s/he ends up being sympathetic rather than empathetic. She did not define the difference between the two in writing.

On answering what has changed in relation to the use of empathy when dealing with patients, the response was a very favourable one. In general, the participants feel more comfortable with the display of empathy towards their patients.

Another participant finds it difficult to distinguish between sympathetic versus empathetic behaviour (as described above) feels that s/he is displaying too much emotion towards his/her patients and that this will make the patients feel hopeless. S/he says that s/he would like to distinguish his/her personal 'issues' from those of his/her patients.

The next question dealt with the effect of empathy on patients. The participants remarked that [following the role-play] the patients feel more cared for, they trust the participants more and feel more comfortable. This allows them to open up towards the participants more. This helps the participants understand the patients better; they receive more information, which assists in arriving at the correct treatment plan for better health outcomes.

Finally, the participants reflected on the qualitative effect the role-play session has on them as future HCPs. Although being a HCP is an enormous responsibility, many of the participants feel that, they are less alone in their endeavours now and that it is a shared responsibility. The session of role-play has also given them the surety that medicine need not be hard and rigid, but that they can become the kind of HCPs they want to be. They are now able to see the patient more holistically.

Theme extraction following the reflection rendered positive results as the participants revealed less internal struggle regarding engaging with patients empathetically. The results also showed positive growth in their confidence as HCPs. In short, they feel that the session of role-play equipped them with the tools to care for their patients better. Even the participant who seemed to be struggling, says s/he started practicing what s/he has learnt through the session of role-play and this yields better outcomes as his/her patients share their problems more openly and more freely with him/her than prior to the session of role-play.

The comparison of pre-and post-training JSPE (S-version) scores less desirable in certain instances as three of the eight participants' results showed a decline in empathy. Pre-and post-training scores will be compared by making use of the mixed-method approach through means of a convergent parallel design. The results and findings will be discussed in chapter five.

The reflection questions answered in questionnaire three took place during the same session when the JSPE (S-version) was completed in order to analyse the qualitative effect of role-play on the empathy levels of the eight participants.

4.7.1. Theme extraction: post-training

Post-training narratives were dealt with similar to the pre-training narratives. Participants' written reflections on their experiences and perceptions regarding the training session of role-play were analysed by means of theme extraction. The themes include, amongst others: (a) improvement as HCP, (b) improved self-awareness, (c) empathy allows patients to open up, which leads to (d) holistic patient care, and (e) a deeper understanding of patients, and finally (f) awareness of areas that can be improved on (see Table 5, Themes: post-training).

Table 5. Themes: post-training

Themes	Subthemes
Improvement as HCP	<ul style="list-style-type: none"> • Incorporation of empathy • More confidence • Well-rounded physician
<ul style="list-style-type: none"> • <i>"We are more comfortable with showing empathy and less afraid to explore a patient's personal problems" ... "I've also incorporated the use of empathy a lot more into my interview style".</i> • <i>"... able to scrutiny my seniors and correct their mistakes internally so I do not make the same mistakes with my patients".</i> • <i>"This will make me a well-rounded physician in the future" ... "It's allowed me to improve as a care giver for the rest of my career" ... "I really think it has changed/strengthened my care for patients ..."</i> 	
Improved self-awareness	<ul style="list-style-type: none"> • A better view of the HCP they are and want to be • More aware of own emotions and those of patients
<ul style="list-style-type: none"> • <i>"I was able to see myself as the kind of physician I've always wanted to be and that made me realise that I can actually become a better physician ..."</i> • <i>"I realised that after the role-play we all became more conscious of the way we communicate with patients. We were aware of their body language and when they were expressing personal problems or concerns ..."</i> 	
Empathy allows for patients to open up	<ul style="list-style-type: none"> • Patients feel more comfortable and trust the HCP more • They open up and disclose more information

	<ul style="list-style-type: none"> • Possibility of better adherence to treatment
<ul style="list-style-type: none"> • <i>“It [empathy] makes them [the patients] feel heard, understood and in an amazing way some patients feel better already even way before you give them medications and the trust that exist makes them follow instructions very well and take medications as they were supposed to ...”</i> • <i>“Patients feel and know when I interact with them from a place of empathy. They open up more allowing for better treatment for themselves ...”</i> • <i>“The patients seem a lot more comfortable around me, and they are far more willing to share more details of their experiences during illness as well as their general social circumstance ...”</i> 	
Holistic patient care	<ul style="list-style-type: none"> • Seeing the patient as a total person in a context with a history that influence the patient’s medical condition
<ul style="list-style-type: none"> • <i>“That in totality it is a shared responsibility, and not only seeing what is presented in front of you but to see the patient as a whole ...”</i> • <i>“The role as a future physician is to always look at the best care of my patient that being covering also every of aspect of health with every patient as to deal with patient holistically ...”</i> 	
Deeper understanding of patients	<ul style="list-style-type: none"> • Appreciate the fact that emotions and experiences influence patients’ lived experience of being ill
<ul style="list-style-type: none"> • <i>“I’ve become much more understanding of patients, where they come from, where their understanding of their illness is ...”</i> • <i>“This is all channelled by me talking and understanding them better.”</i> 	
Awareness of areas of that could be improved on	<ul style="list-style-type: none"> • Work more on not becoming too emotionally involved • Remain objective
<ul style="list-style-type: none"> • <i>“Even though I tend to be emotional ... I noticed that I became too involved/attached to my patients problems and because of that I would become stuck in terms of progressing in the consultation session ...”</i> • <i>“It is very easy to be a healthcare provider who is trapped in their own experiences, self, emotions ...”</i> 	
Shared responsibility	<ul style="list-style-type: none"> • Patients become more involved in the process

<ul style="list-style-type: none"> • <i>“This reduces the responsibility I have as a physician and makes the patients more likely to have inputs and views on the best management plan available for them because people are not the same and are their circumstances ...”</i> 	
<p>Need for training</p>	<ul style="list-style-type: none"> • There are different ways of displaying empathy • Empathy can be taught
<ul style="list-style-type: none"> • <i>“I’ve noticed that we all have different ways of showing or rather, how we feel about what empathy is but the main common point was that we all have empathy and we see this as a very important skill in our practice ...”</i> • <i>“ ... that empathy can be learnt and it can be trained ...”</i> 	

4.7.2. JSPE (S-Version) results

The post-training JSPE (S-version) was analysed through data transference, by following the same method that was used during the pre-training analysis (see chapter 4). The results presented as follows:

Table 6. JSPE (S-version) results

		Questions																				Total score
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
Participants	1	7	7	4	7	7	1	7	7	7	7	7	7	7	7	7	7	7	1	6	7	124
	2	5	7	5	7	5	5	7	5	6	6	6	7	7	7	6	6	7	3	7	6	120
	3	4	7	3	7	4	5	7	6	6	6	2	6	5	6	6	7	5	4	7	6	109
	4	7	7	7	7	1	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	134
	5	7	7	7	7	7	3	7	7	5	1	7	7	7	7	7	7	5	3	7	7	122
	6	7	7	3	7	7	6	7	7	7	6	7	7	7	7	7	7	5	6	7	7	131
	7	7	7	4	7	3	4	7	7	7	6	7	7	7	7	7	7	4	4	7	7	123
	8	7	7	4	7	6	2	7	7	6	7	7	7	7	7	6	5	5	5	6	7	122
																						out of 140

Pre %	Post %	Final Comparison %
68,571	88,571	20
83,571	85,714	2,143
82,857	77,857	-5
97,857	95,714	-2,143
78,571	87,142	8,571
82,142	93,571	11.429
89,285	87,857	-1,428
82,857	87,142	4,285

An additional and unforeseen occurrence was a discussion that took place at the end of the session of role-play following the completion of the set of reflection questions.

4.8. Implementation of the mixed method parallel convergent design

The final stage of data analysis made use of the mixed method parallel convergent design. This design allows for qualitative and quantitative data collection to take place at the same time. I arrived at the qualitative data through the description of session of role-play and through the extraction of themes. The quantitative data were derived through the analysis of the JSPE (S-version). The mixed part of the methodology comes in at the end stages when I will be merging the quantitative data with the qualitative data. I compared both pre-and post-training sets of data. This entails both sets of themes extracted following reflection. I imbedded the pre-and post-sets of qualitative data in the sets of quantitative data in order to provide a supporting role (Creswell 2009:208).

For the aim of this study no cross-referencing were done between the reflection sheets and the results of the JSPE (S-version). In other words, I did not compare the results of the

reflection sheets to the completion of the JSPE (S-version) concerning the questions asked and answers marked from the individual participants. This required an in-depth analysis, which lies outside the scope of this study. The aim of this study is to investigate the qualitative effect of role-play on the empathy levels of students of medicine. It does not ask for areas of individual change.

Following the first set of reflection questions that dealt with what the participants have observed concerning:

- empathetic behaviour in the clinical setting
- the effect of empathy on patients
- the difficulties they experience with regard to begin empathetic
- the effect that these difficulties have on the patients
- and what they would like to see changed

The main aspects that were referred to (see Figure 4) relate to the negative role models they have in HCPs where empathy is concerned and the struggles they experience between academic pressure and attending to patients. They mentioned exploitation on the part of the patient in instances where they attempt to display empathetic behaviour towards the patients. Reference was made to feelings of insecurity and guilt when they witness the loss of empathetic engagement between the patient and themselves as a means of trying to cope with all of the above. Mention was made of the need for education on the part of the HCPs, the patients as well as the students concerning empathy within the clinical setting. The participants did acknowledge the positive effect that an empathetic engagement has on the patients, leading to a better diagnosis.

The second set of reflection questions were less general than the questions entailed in the first set of reflection questions. The questions in this set of reflections were directed more towards the participants themselves. They were more focused on what they observe in the clinical setting, as these questions were aimed at exploring the qualitative effect of role-play on the empathy levels of the participants.

In comparison to the first set of reflections, the second set of reflections on the part of the participants delivered more favourable results. No more mention was made of the pressures of academic life or what they observe in other HCPs regarding the lack of empathetic behaviour towards patients. The participants placed strong focus on improved self-

awareness. The participants are now aware of how they react towards patients and the responding reactions they receive from the patients. They have lost their fear of displaying empathy. They place more focus on the positive effects that empathy has on the patients. The participants observe that patients open up towards them more, allowing for better diagnosis, the correct line of treatment as well as better adherence to treatment on the part of the patient. The participants view the patients more holistically now.

One of the strong messages that came through during the discussion is the fact that they realise that something has to change in the structure of the hospital setting, but that they are also aware of the fact that they are incapable of doing anything to change this. In their reflection, the focus has shifted from something that needs to be changed to an awareness that they need not follow what they observe. Instead, the participants feel they can become the HCPs they would like to be.

There is an increased self-awareness of areas that need to be improved on and the participants have become aware of the fact that the responsibility of treating the patient is not theirs alone, but that it is a shared responsibility. If the patients do not do their part, they cannot be healed. This strongly links to the notion that the participants feel lighter.

Initially I was slightly confused by the quantitative of the JSPE (S-version). Although the results were generally favourable, results showed a decline in empathy in three of the eight participants. I would have liked to compare the individual JSPE (S-version) responses with what took place in the individual role-play sessions. However, due to the fact that the students used individual markers instead of names, there was no way I could know for certain which JSPE (S-version) answers belong to which participants. I did however compare the pre-and post-questionnaires of the three participants who showed a decline in empathy. The variation is so slight it renders the change as insignificant.

4.9. Chapter conclusion

This chapter is dedicated to the training session of role-play. I described the outline of the session as it had been set out and explained what took place during each of the individual sessions of role-play. I elaborated on the lesson plan to be implemented and explained what is supposed to occur during every phase of the lesson plan to be implemented.

The session of role-play, as training, forms an important part of the study. I elaborated on the phases introduced and what took place during the individual sessions of role-play in much detail. From there on, I moved to the participants' reflections. I compared pre- and post-

training scores pertaining both to theme extraction following reflection as well as pre-and post-training scores attained through the JSPE (S-version).

Finally, through the implementation of the Mixed Method Parallel Convergent Design I attempted an integration of what the study set out to achieve. In chapter five, I will conclude the study. I will discuss the findings, incorporate aspects of limitations and will make suggestions pertaining to future studies or research.

Chapter 5: Conclusion

5.1. Chapter introduction

This chapter provides a brief outline of each of the chapters of the study. It looks at the research question and the objectives that were set out to be achieved. The chapter incorporates aspects such as limitations and bias in order to reach a conclusion.

Suggestions for future research will be touched upon before concluding this chapter and the study in its entirety.

The research approach made use of the mixed-method convergent parallel design. In this design, both qualitative as well as quantitative data are collected at the same time. Both sets of data are analysed separately according to their specific requirements. In this case, the qualitative data was analysed through theme extraction, while quantitative data was analysed through the means of data transference. Both sets of data were compared in order to reach a conclusion.

As stated throughout previous chapters, the importance of empathy in healthcare has been receiving increasing attention in recent years. This study aimed at exploring the use of the process drama strategy of role-play to facilitate the training of empathy skills in healthcare education

5.2. Research objectives

The aim of this study was to explore how process drama facilitates the training of empathy in healthcare education. The research design was divided into four phases in order to reach the objectives that were set out.

Chapter one, two and three addresses phase one, which includes the review of scholarly work relating to empathy in healthcare and healthcare training, as well as reviewing prior research on applied drama/theatre in the context of healthcare and to identify the ways in which the medical curriculum for fifth years engages with the facilitation of empathy skills at SMU.

In chapter one, I positioned the study within the field of empathy in healthcare. The curriculum at SMU, where this study took place, was briefly reviewed in order to identify whether any focus is placed on the development of empathy levels on the medical students enrolled at SMU. My position as researcher within the study was clarified. In chapter one, I also dealt with the research question, stipulated the research objectives, described the

research approach and the outlined the participant profile. Ethical clearance was addressed. After a breakdown of the chapters, emphasis was placed on the significance of the study.

Chapter two focussed on empathy in healthcare and the importance thereof. Following a clarification of the concept, I drew on the theories Karl Jaspers' relating to why HCPs have lost the empathetic connection to their patients. Jaspers' publication "Der Artzt im Technischen Zeitalter" [The doctor in a technological age] (1958) was incorporated as seminal source. This chapter further provided a brief overview of neuropsychology with specific focus on the role that mirror neurons play in an empathetic connection.

In chapter three, I placed focus on the concept of AT. I investigated all areas of this field that pertain to this specific study. I described where process drama lay within the field of AT and described the process of role-play with specific focus on metaxis. I looked at the importance of the process of enrolment and discussed the structure and strategies to be employed. In chapter three I also created an outline according to which the session of role-play were to be structured. The status of the facilitator was also addressed.

Chapter four addressed phase two of the study. It dealt with the establishment of levels of empathy of eight fifth year medical students by making use of written reflections pertaining to what students of medicine observe and experience regarding empathy within the clinical setting between HCPs, their peers and themselves in a pre-training setting.

I summarised reflection questions one, described the process and results of theme analysis and I discussed and compared the pre-and post-training themes. In this chapter, I also described discussed pre-and post-training results of the JSPE (S-version).

In chapter four, I discussed the completion and results of the JPSE (S-version). The process of drama training, with emphasis on the applied drama strategy of role-play to explore the qualitative effect of role-play on the empathy levels of fifth year medical students made up phase three of the objectives set out initially. The background that contextualises this objective was set out in chapter three where I investigated the workings of process drama and role-play. Chapter four outlined the actual training through the process drama strategy of role-play.

Phase four compares pre-and post-training results in order to reach a conclusion. This objective is discussed later in this chapter.

5.3. Findings

In order to apply the mixed method approach of the convergent parallel design, qualitative and quantitative data are gathered simultaneously. The first session of data gathering took place on 31 May 2017 where the participants were asked to complete the JSPE (S-version) scale as a means of quantitative analysis. Qualitative data was gathered during the same session by means of reflection in writing.

The training session of role-play took place the fourth of August 2017. These formed no part of the process of data gathering, but were implemented as a means to invoke internal insight regarding the participants' empathetic engagements with patients in the clinical setting.

The second session of both qualitative and quantitative data gathering took place four weeks after the training session, on the eighth of September 2017. Pre-and post-training scores were compared by making use of the mixed-method approach through means of a convergent parallel design.

The qualitative results were favourable. Following the training through role-play, the participants feel more confident in themselves with regards to becoming the kind of HCPs they would like to be. They also feel less threatened and more capable to display empathy towards their patients. The display of empathy has a very positive effect on the patients. They trust the participants more and share more personal information, which renders a proper diagnosis and better adherence to treatment.

The fact that the qualitative results proved so favourable can be ascribed to the fact that role-play, as a function of process drama, allows for inner learning to take place. In process drama, the participants are afforded the opportunity to investigate and question the inner workings of their minds. During the session of role-play in this study, the participants were enabled to "act out" what they are thinking and feeling. This session made use of improvisation where no reactions were regarded as right or wrong and the participants could explore how they would act or respond in a situation that offers a safe space for exploration, because it stood apart from the "real world". In this fictional world, the participants were free to feel and express what might not be regarded as acceptable in the world where they deal with patients and other HCPs who all have their personal expectations and needs. It is this freedom to feel and express that offered an opportunity for the participants to explore, come into contact with and learn from their own inner workings. This is where learning took place.

Metaxis forms a strong central part of role-play. In the state of metaxis the participants entered a space in-between the real and fictional. They oscillated between these two states of existence. In this space there were no expectations of accepted “outward display”. This freedom to simply “be” offered the participants the opportunity to bring their experiences from the “outside world” into the world of the role-play. During the session of role-play the participants brought the aspects that they struggle with in their daily dealing with patients and other HCPs in the clinical setting into this safe space. They delved into and, through improvising, explored their insecurities in order to not only find answers, but also gain confidence by breaking through the barriers they dare not cross when dealing with actual patients and/or other HCPs in the clinical setting of their working lives. In this regard, role-play arguably stimulated metaxis - offering the necessary critical distance to review their decisions, actions and interactions, as well as immersion in a fictional context ‘as if’ it was real.

In the fictional world of role-play, the participants could allow themselves to be responsive openly and freely to the “patient” opposite to them. This allowed for the neuroscientific aspect of mirror neuron activity to take place, which forms the central point of feeling empathy towards another. The participants were not concerned about the dangers that they were warned about when showing empathy towards their patients. In the safe space that role-play offered, the participants could freely explore the workings of empathy between HCP and patient. In doing so, not only did they experience the effects that empathetic engagements with patients bring forth, but they were also afforded the opportunity to investigate and work through the emotions and effects that such a connection has on them as HCPs. In turn, this enabled the participants to break through the barriers of fear of an empathetic connection when dealing with patients. Furthermore, the fictional world of role-play also allowed the participants to investigate and test response and/or coping strategies when an empathetic connection between HCP and patient has been established without “real life” consequences should they make a mistake.

Another aspect that contributed to the positive qualitative findings, is the strategy of the MoE that was employed. As a teaching methodology, MoE works with the experience and knowledge students bring with them into the sessions. This stands in strong contrast to didactic teaching where knowledge is imposed on students from an objective view of what they should be taught. As opposed to didactic teaching, MoE asks of the students to share what they already know and makes their prior knowledge part of the learning experience. As such, MoE offers them agency and a means to connect the familiar with the unfamiliar. In

doing so, the students arguably gained insight into areas that were open for further exploration in order for learning to take place.

As facilitator of the individual sessions of role-play, I did not impose knowledge about empathy and the positive effects that an empathetic connection between HCP and patient has in order for the students to use this acquired knowledge through the adoption an outward display of what they think such a consultation might look like. Instead, I afforded the students the opportunity to ask themselves where their areas of concern lie as well as asking of them to think of what they would like to improve on. As a result the session of role-play, where the learning took place, dealt with the aspects pertaining to an empathetic connection between HCP and patient that the students wanted to learn about, rather than focussing on what I thought they should be taught. The MoE approach allowed for the learning to become a personal process. Personal learning is an optimal teaching strategy as it contributes to personal growth. Incorporating the MoE approach, in combination with the applied drama strategy of role-play, rendered positive qualitative results.

In opposition to the favourable qualitative results, the quantitative results showed a decline in empathy in three of the eight participants. I ascribe this partly to an awareness in the participants themselves. Through the individual sessions of role-play, they became aware of where they lack in an empathetic engagement between themselves as HCPs and the patient. This rendered them more critical concerning their levels of empathy and they scrutinised more when completing the JSPE (S-version) during the post-training phase of the research.

The negative results in three of the eight participants could also be ascribed to the fact that the participants were tired at the end of their fifth year of study. Three of them arrived late for the final session and were obviously under tremendous pressure. The possibility cannot be ignored that, in a haste to complete the questionnaire, they did not pay particular attention to the questions that were scored in reverse.

The qualitative results were more favourable. Following the training through role-play, the participants feel more confident in themselves with regards to becoming the kind of HCPs they would like to be. They also feel less threatened and more capable to display empathy towards their patients. The display of empathy has a very positive effect where the patients are concerned. They trust the participants more and share more personal information, which renders a proper diagnosis and better adherence to treatment.

5.4. Limitations

As SP facilitator, role-play between students of medicine and Simulated/Standardised Patients (SPs), forms a large part of my working week. I did not take enough time to distinguish between a session of role-play where the training of consultation skills is the main focus versus a session of role-play where the creation of an empathetic connection between HCP and patient is core. I could have placed more emphasis on the process of enrolling as a first step within the process of scaffolding and activating the taxonomy of personal engagement, where one action is introduced in order to form a foundation for the next to follow. It deserved more attention.

The instructions pertaining to the session of role-play and the development of scenarios might not have been clear enough. By introducing an exploratory activity to introduce the role-play to let everyone see and experience how it works, rather than explaining what is about to take place, would have been more effective.

Introducing the role-play through an exploratory activity could have also served to make the participants feel more at ease about the aspects of improvisation, which forms an integral part in the learning process that takes place during a session of role-play.

Taking the limitations with regard to this study into consideration, it could have been beneficial if I, as researcher, spent more time on familiarising myself with strategies to be employed in a session of process drama. This could have afforded me with the tools to scaffold the session of role-play in order for the participants to be more personally engaged. I am, however, still not certain that this would have benefitted them with emotionally coping when returning to the clinical setting following the training session of role-play.

Another aspect that could have influenced the training session of role-play negatively, was the limited time we had to our disposal. More time would have allowed more exploration into the development of the scenarios and less time on setting the background of how role-play works. A different balance of choice may have yielded different results in line of what the students experienced with regards to metaxis and the taxonomy of personal engagement.

The session was quite facilitator-driven. This might have impacted in the spontaneity that the participants brought with them negatively. With more time, I could have facilitated a session where students drove action and development of the scenarios.

As researcher, I might have been too strongly influenced by the answers in the first set of reflection questions. The questions in these reflection sheets dealt with what the students

observe and/or experience in the clinical setting concerning empathy. Through these reflections, it became apparent that the students are faced with a lot of difficulties. I was somewhat concerned that engaging in role-play and forming a too strong empathetic connection with the role as patient, might hurt the students on emotional and/or psychological level. The need I felt to protect them in this regard might have influenced their engagement to their roles negatively.

I could also have placed more focus on Jaspers' publication "Der Arzt in technischen Zeitalter" (1958) where he describes why HCPs have become more focussed on the technicalities of medicine instead of placing focus on the patient. Incorporating these aspects into the training session of role-play might have aided the participants in attaining a more patient-centred approach during the individual sessions of role-play. This could have rendered the individual sessions of role-play as sessions that allow the participants to step out of the confinements of the *modus operandi* of consultation between the HCPs and patients they presently experience and could have afforded them more space to explore their own unique set of habits for the duration of the training session of role-play. Exploring their own unique ways of dealing with patients and seeing the effects could have aided in giving them confidence with regard to their own HCP abilities when dealing with patients in the clinical setting.

In hindsight, and knowing more about how the process of role-play works as a whole, I would have the confidence to address the issues mentioned above during the individual sessions of role-play. I would have allowed the participants more room to investigate and find their own answers. For the purpose of this study, however, I felt the need to allow the participants to find measures of displaying empathy without the distress and fear they experience when trying to do so.

Another significant limitation to this study is the fact that comparing JSPE (S-version) results with individual reflections, lies outside the scope of this study. This would ask for further analysis with regards to incorporating the individual sessions of role-play in order to ascertain the reason for change within every individual.

The final set of reflection questions could also have been revised to adhere more to the outcome of the individual sessions of role-play after the participants had re-entered the clinical setting following the training session of role-play.

5.5. Bias

The fact that the study was introduced as one dealing with “interhuman connections” might have given rise to the fact that students who are more prone to a special interest in the HCP-patient connection volunteered for this study. These would be students who possibly possessed more inherent interest in an empathetic engagement between HCP and patient from the outset on.

This fact might be the reason for what I perceive to be the open, insightful and sensitive responses to the first set of reflection sheets, dealing with what the students had observed regarding empathetic behaviour in HCP, their peers and themselves within the clinical setting. Therefore, the first set of reflections should not be regarded as a realistic resemblance of what is taking place within the clinical setting, but should rather be seen as insight into what some of the students of medicine experience or need to learn to deal with during their years of study.

5.6. Recommendations for future research

The fact that the qualitative results were so favourable, proves that the retainment of empathy during the years of studying medicine and how the introduction of humanities during years of study could assist in this regard, deserves more attention.

Furthermore, approaching practicing HCPs with regard to empathetic engagement to their patients could be of great value. Research in this regard could focus on aspects relating to the facts that prevent them from displaying empathy. They could be asked to relate how they feel about these limitations and how it affects them on personal as well as professional levels. The findings from this research could form the basis of invoking much needed change concerning the empathetic engagement between the HCP and his/her patients.

I would like to build on this study as a means of introducing the importance of humanities into the medical curriculum at SMU. This study will be concluded by a publication explaining what was done and a discussion of the results.

5.7. Conclusion

The importance of introducing humanities into the medical curriculum is a topic that has been receiving increased attention on international level over the course of the last years. Yet institutions that recognise the importance are sparse, in spite of the fact that research has not only expanded on the importance, but also proven the positive outcomes.

This study aimed at investigating the qualitative effect of introducing a training session making use of the applied drama strategy of process drama on the empathy levels of eight fifth year medical students at SMU. The first study conducted in South Africa measuring the qualitative effect of empathy in students of medicine in South Africa was undertaken during 2008. Since then, no other studies have been conducted in South Africa relating to the qualitative effect of role-play on levels of empathy within the healthcare setting.

The problem presented was the lack of empathy between HCP and patient in the clinical setting. Focus was also placed on the effect that this behaviour has on the students when they start working with patients. Furthermore, I briefly addressed that fact that training in empathy forms no part of the medical curriculum at SMU and made reference to the fact that students of medicine graduate with less empathy than when they enrolled.

The study was introduced to investigate the use of process drama to facilitate the training of empathy skills in healthcare education. The positive results indicate the importance of introducing aspects of humanities into the medical curriculum in order for medical students to graduate with confidence in themselves as HCPs. This study proves that role-play can assist students of medicine to display empathy when dealing with patients in the clinical setting. It also proves the positive results on both the part of the patient as well as that of the student when they are capable of displaying empathy when dealing with patients in the clinical setting.

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Appendix A: Permission to use the JSPE

Louise Schweickerdt

Subject: FW: Requesting permission to use JSPE (S-Version)
Attachments: Empathy for Students (S Version 2.3).pdf; Scoring Algorithm.pdf; User's Guide_INT.pdf

From: empathy svc <empathy@jefferson.edu>
Sent: Friday, 29 April 2016 5:16 PM
To: Louise Alker <louise.alker@smu.ac.za>
Cc: Mohammadreza Hojat <Mohammadreza.Hojat@jefferson.edu>; Jonathan Cass <Jonathan.Cass@jefferson.edu>
Subject: RE: Requesting permission to use JSPE (S-Version)

Hi Louise:

Thank you for your e-mail agreement. That is all we need. Thank you for the explanation of your research study. You have our permission to make 10 copies of the JSE –S-version for the single not-for-profit study that you described. I have attached a copy of the scale, the User's Guide and the scoring algorithm.

We wish you luck with your research! Please keep us informed of your progress.

Best,
Shira

From: Louise Alker [<mailto:louise.alker@smu.ac.za>]
Sent: Thursday, April 28, 2016 10:05 AM
To: empathy svc
Cc: Prof CW van Staden; Marie-Heleen Coetzee
Subject: RE: Requesting permission to use JSPE (S-Version)

Dear Ms Shira Carroll

Thank you for your quick and positive reply.

After conferring with my supervisors all aspects seem to be well. The study will be of a more qualitative than quantitative nature.

I have read through and understand all your conditions. My project meets the criteria.

I hereby confirm that I will respect your terms and commit myself to adhering to them strictly.

Does the above suffice?

Would you like me to respond to each condition separately in your email below?

Or should I sign next to the conditions and scan a copy of the signed document through to you?

I am excited about the study beginning to come together. And am grateful for your amiable reply so far.

In looking forward to your response.

Kind regards
Louise

Appendix B: Example of the JSPE (S-version)



Jefferson Scale of Empathy

Medical Student version (S - version)

Use a **ball-point pen**. Mark one response for each item below.
 For **ID Code**, write numerals completely inside the boxes, one numeral to a box.
 Leave **Optional** fields blank unless otherwise instructed.

Name _____

ID Code

--	--	--	--	--	--	--	--	--	--

Date ____/____/____

Age:

- < 22 22-24 25-27 28-30 31-33 34-36 > 36

Gender:

- Male Female

Year of Medical School:

- 1st year 2nd year 3rd year 4th year > 4th year

Which specialty do you plan to pursue? [Please choose **only one**]

- | | | |
|--|---|---|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Dermatology | <input type="checkbox"/> Emergency Medicine |
| <input type="checkbox"/> Family Med./General Prac. | <input type="checkbox"/> Internal Med. (see below) | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Orthopaedic Surgery | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Physical Med./Rehabilitation | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Preventive Medicine | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Surgery (see below) | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Undecided | |

Medical Sub-specialty: [Please choose **one** if your primary specialty interest is Internal Medicine]

- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Critical Care/Pulmonary | <input type="checkbox"/> Endocrinology |
| <input type="checkbox"/> General Internal Medicine | <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Hematology/Oncology |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Undecided | |

Surgical Sub-specialty: [Please choose **one** if your primary specialty interest is Surgery]

- | | | |
|---|---|--|
| <input type="checkbox"/> Cardiothoracic | <input type="checkbox"/> Colorectal | <input type="checkbox"/> General Surgery |
| <input type="checkbox"/> Transplant | <input type="checkbox"/> Trauma/Critical Care | <input type="checkbox"/> Vascular |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Undecided | |

Optional field #1

--	--	--	--

Optional field #2

--	--	--	--

Please continue on the back --- Do not write below this line





Jefferson Scale of Empathy

Medical Student version (S - version)

Instructions: Using a ball-point pen, please indicate the extent of your agreement or disagreement with *each* of the following statements by marking the appropriate circle to the right of each statement.

Please use the following 7-point scale (*a higher number on the scale indicates more agreement*):

Mark one and only one response for each statement.

1-----2-----3-----4-----5-----6-----7
Strongly Disagree *Strongly Agree*

- | | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Physicians' understanding of their patients' feelings and the feelings of their patients' families does not influence medical or surgical treatment. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Patients feel better when their physicians understand their feelings. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. It is difficult for a physician to view things from patients' perspectives. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Understanding body language is as important as verbal communication in physician-patient relationships. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. A physician's sense of humor contributes to a better clinical outcome. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Because people are different, it is difficult to see things from patients' perspectives. ... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Attention to patients' emotions is not important in history taking. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Attentiveness to patients' personal experiences does not influence treatment outcomes. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. Physicians should try to stand in their patients' shoes when providing care to them. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. Patients value a physician's understanding of their feelings which is therapeutic in its own right. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. Patients' illnesses can be cured only by medical or surgical treatment; therefore, physicians' emotional ties with their patients do not have a significant influence in medical or surgical treatment. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. Asking patients about what is happening in their personal lives is not helpful in understanding their physical complaints. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. Physicians should try to understand what is going on in their patients' minds by paying attention to their non-verbal cues and body language. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. I believe that emotion has no place in the treatment of medical illness. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. Empathy is a therapeutic skill without which the physician's success is limited. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. Physicians' understanding of the emotional status of their patients, as well as that of their families is one important component of the physician-patient relationship. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. Physicians should try to think like their patients in order to render better care. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. Physicians should not allow themselves to be influenced by strong personal bonds between their patients and their family members. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. I do not enjoy reading non-medical literature or the arts. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. I believe that empathy is an important therapeutic factor in medical treatment. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Appendix C: Informed letters of consent



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

2016

Dear (name of participant).....

**INFORMED CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY:
THE EMPATHETIC PHYSICIAN: USING PROCESS DRAMA TO FACILITATE THE TRAINING OF
EMPATHY SKILLS IN HEALTHCARE EDUCATION.**

You are invited to participate in a research study conducted by Ms Louise Schweickerdt under the supervision of Prof Marie-Heleen Coetzee, Drama Department at the University of Pretoria (UP) and Prof CW van Staden, Weskoppies Hospital, (UP).

This study has been approved by Prof GA Ogunbanjo as the Director of the School of Medicine. He has given his consent that the research project, involving 8 MBChB V students, may be conducted at Sefako Makgatho Health Sciences University (SMU).

Description of the research:

This research study aims at exploring the effect of role-play on the empathy levels of the participating students.

Drama Department
University of Pretoria
Pretoria 0002 South Africa

Tel. Number 012 4202558
Fax Number 012 3625281

Email address Yvonne.rabie@up.ac.za
www.up.ac.za

Confidentiality and anonymity:

In pre and post sessions, following an intervention session through role-play, you will be asked to reflect on various aspects of empathetic behaviour. The sessions of role-play will be video recorded and you will be asked to complete the Jefferson Scale of Physician Empathy (JSPE) (S-Version). All data collected will remain confidential and your participation will remain anonymous. Your identity will not be revealed as codes for identification will be used for the JSPE (S-version) as well as for the reflection sheets.

Your contribution is important to ensure the success of the research study. Your participation in this research study is, however, voluntary. You are in no way obliged to participate. Should you decide to withdraw, all data pertaining to your participation will be destroyed. You will not be penalised in any way should you decide to withdraw.

Participation implies the following:

If you choose to participate, it will be expected of you to partake in two feedback and one role-play sessions in total. Session one and three will last approximately 90 minutes while session two will be a three hour session. These sessions will be arranged for times that are most convenient for you amidst your study commitments. You will have access to the dissertation stemming from this research.

The facilitator, Ms Louise Schweickerdt, will lead you and explain every process clearly.

During this study you will be asked to:

- reflect on various aspects of empathetic behaviour
- complete the Jefferson Scale of Physician Empathy (JSPE) (Student version)
- partake in a three hour session of role-play

Potential risks:

You will not be engaged in any harmful psychological, emotional or physical activities. As in any educational situation, should the need arise, the facilitator has

arranged with the resident student counsellor to assist should any incident occur which could lead to the need for specialised help.

Potential benefits:

The potential benefits of this study for the participants will be:

- to gain insight into the use of empathy or the effect of the lack thereof by taking on both the role of the physician as well as that of the patient;
- grow as empathetic HCP through the experience gained through role-play.

You will not receive any remuneration or marks for your work.

Data storage

In accordance with UP regulations, data will be stored in the archive of the Drama Building, Room 2-16 at the University of Pretoria for a period of 15 years. Your permission will be requested again should I want to access the data in storage again for further research.

Contact information:

If you have any questions or concerns about this study or if any problems arise during the research process, please contact:

The facilitator / researcher:

Ms Louise Schweickerdt

E-mail: louise.alker@smu.ac.za

Cell: 083 360 2539

Supervisor details:

Prof. M-H Coetzee

HoD Drama Department

University of Pretoria

Tel: +27 12 4202558

Email: Marie-Heleen.Coetzee@up.ac.za

Drama Building Room 2-2

Prof CW van Staden

HoD Philosophy and Ethics of Mental Health
Weskoppies Hospital
Tel: +27 12 3192295
Email: cwvanstaden@icon.co.za
Auditorium of Weskoppies Building

Please hand the completed consent form in at our first meeting. No participant will be allowed to participate without written unformed consent.

Yours faithfully
Louise Schweickerdt
Researcher / Student

INFORMED CONSENT FORM FOR PARTICIPATION IN THE RESEARCH

STUDY: THE EMPATHETIC PHYSICIAN: USING PROCESS DRAMA TO FACILITATE THE TRAINING OF EMPATHY SKILLS IN HEALTHCARE EDUCATION.

This informed consent form is addressed at the participant of the research study

I(full names and surname) have read this consent letter and I voluntarily give my consent to participate in this study. I also give my consent that the information provided by me through reflection as well as all data gathered from the completed JSPE (S-version) and all data collected from the recorded role-play sessions may be used for research purposes for this study, provided that all sources of data collection be coded in order to protect my anonymity.

Participant's full names.....

Participant's identity number.....Participants' age.....

Participant' s signature.....

Signed at on the day of the month 2016

.....

Appendix D: First set of reflection questions

Reflection 1: Empathy between Healthcare Practitioner and Patient

Identification sign (to ensure anonymity) _____

What have you observed relating to the use of empathy considering:

i) qualified healthcare practitioners

ii) fellow students

iii) you as medical student

when dealing with patients in a hospital setting?

Which effects does empathy have on patients?

Which difficulties have occurred to you or have you observed in being empathetic?

Which effects do these difficulties have on the patients?

What would you like to see changed?

Thank you!

Please do not hesitate to write on the other side of this page should you need more space

Appendix E: Third set of reflection questions

Reflection 3: Empathy between Healthcare Practitioner and Patient

Identification sign (to ensure anonymity) _____

Make sure to use the same identification sign as in reflection sheet 1

What did you observe in yourself and others with regard to the use of empathy following the role-play session?

Following the role-play session, what has changed regarding the use of empathy when working with patients?

Which effects does empathy have on the patients?

Which effects does the role-play have on you as future physician?

Thank you!

Please do not hesitate to write on the other side of this page should you need more space

Appendix F: Application for ethical clearance – Ethics committee (UP)

100
1908 - 2008



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

FACULTY OF HUMANITIES
RESEARCH PROPOSAL AND ETHICS

APPLICATION FOR ETHICAL CLEARANCE

PLEASE NOTE:

1. Researchers using **HUMAN** respondents as sources of information for data capturing, must complete **ALL** the sections
2. Researchers using **OTHER** sources of information for data capturing do not have to complete sections 4.1 and 5 to 9
3. An application is only considered once approval is granted by the Departmental Research Committee and all required documentation is provided
4. An electronic copy of this form is available from <http://www.up.ac.za/academic/humanities/eng/research/research.html> or <http://www.up.ac.za/academic/humanities/afr/research/research.html>

Please type or print legibly with black pen

1. PROJECT INFORMATION			
NAME	Louise Schweickerdt		
STUDENT NO.	96212773		
STAFF NO.	Not applicable		
DEPARTMENT	Drama Department		
FACULTY	Humanities		
Telephone	012 521 4268	Cell Phone	082 360 2539
Fax	-		
E-mail	louise.alker@smu.ac.za		
Professional status (if not a student)	Simulated/Standardised Patient (SP) Facilitator		
TITLE OF STUDY	The empathetic physician: using process drama to facilitate the training of empathy skills in healthcare education.		
SUPERVISORS	Prof. Marie-Heleen Coetzee and Prof C.W van Staden		
SUPERVISOR E-MAIL	marie-heleen.coetzee@up.ac.za cwvanstaden@icon.co.za		
PURPOSE OF THE RESEARCH		ESTIMATED DURATION	
Honours	<input type="checkbox"/>	From	01/03/2016
Masters	<input checked="" type="checkbox"/>	To	31/12/2017
Doctoral	<input type="checkbox"/>		
Non-degree purposes	<input type="checkbox"/>		
Degree (e.g. MA(Anthropology))	MA (Drama)		
ANTICIPATED FUNDING SOURCE (If any)	Applying for DHET TGD		
FIRST APPLICATION	Yes <input checked="" type="checkbox"/>	No	<input type="checkbox"/>
RESUBMISSION	Yes <input type="checkbox"/>	No	<input checked="" type="checkbox"/>

2. OBJECTIVES OF THE RESEARCH - *Please list.*

This study aims to explore the effect that the applied drama strategy of role-play has on the empathy levels of students of medicine and, in effect, how it can facilitate the training of empathy in healthcare education. The reasons for loss of empathy on the both the part of students of medicine as well as the healthcare physician will be highlighted in order to create a backdrop against which this study will be projected.

Objective 1

To review prior scholarship on empathy and the loss thereof in healthcare and in healthcare training.

Objective 2

To review prior scholarship on applied drama/theatre in the context of healthcare.

Objective 3

To identify the ways in which the medical curriculum for 5th years engages with the facilitation of empathy skills at Sefako Makgatho Health Sciences University

Objective 4

To establish levels of empathy among 8 5th year medical students by making use of the Jefferson Scale of Physician Empathy (JSPE) (S-version)

Objective 5

To create a process drama intervention, with emphasis on the applied drama strategy of role-play

Objective 6

To compare pre- and post-intervention results in order to reach a conclusion.

3. SUMMARY OF THE RESEARCH

Please provide a brief overview of the planned research (maximum 250 - 300 words)

Empathy in healthcare has been receiving increasing attention in recent years (McClellan 2014, Suttie, 2015 Zulueta, 2013).

This study will investigate a mode of applied drama/theatre, namely process drama, as a method of training in order to establish what effect role-play has on the empathy levels of medical students.

Eight 5th year medical students at Sefako Makgatho Healthcare University (SMU) who volunteered to partake in this study, will be asked to reflect in writing what they had observed in relation to empathy skills in healthcare practitioners, their peers and themselves. Taking the Hawthorne effect into consideration, where people's actions change the moment they are aware of being observed, the participants will not be forewarned that the reflection will deal with what they had observed in relation to empathetic behaviour. The themes extracted from the students' reflection on empathy, will form the basis of themes that the role-play sessions will be constructed around.

The study will make use of a pre-test using the Jefferson Scale of Physician's Empathy (JSPE) (Student version) to establish the empathy levels of the participants, followed by an intervention through the process drama strategy of role-play. Every student will be offered the opportunity to portray both the roles as patient as well as physician.

The effect of the process drama experience on the empathy levels of the participants will be measured by making use of a post-test using the same JSPE (S-version). The post-test will be introduced 4 weeks after partaking in the role-play in order to mitigate or nullify the notion that students might tweak the answers according to what they believe, the correct answers might be.

The pre- and post-training scores will be compared in order to ascertain the effect that role-play has on the students' level of empathy.

Words: 291

4. SOURCES OF INFORMATION AND/OR DATA

4.1 HUMAN PARTICIPANTS

4.1.1 Where and how are participants selected?

For the purpose of this study

Due to the fact that the study will take place at Sefako Makgatho Health Sciences University (SMU) students in healthcare from the mentioned institution will be selected to partake in the study. The sum group of MBChB V students will be approached. After the study had been explained in depth, 8 students will be selected from a group of volunteers.

4.1.2 If participants are asked to volunteer, who are being asked to volunteer and how are they selected?

For the purpose of this study the sum of MBChB V students will be approached and offered the opportunity to volunteer to partake in the study. 8 Students will be selected from the group who volunteered. Group selection will be homogenous rather than merely convenient in order to ensure there are no large scale cultural, ethical or any other differences in order to avoid unnecessary deviations of outcome.

4.1.3 Will any incentives be offered to persuade the subject to participate?

Yes **No**

If Yes, please specify.

4.1.4 If records of participants are to be used, specify the nature of these records and indicate how they will be selected.

Not applicable.

4.1.5 Has permission been obtained to study and report on these records?

Yes No **Not applicable**

If Yes, letters must be attached.

4.1.6 Characteristics of participants:

Number: 8

Gender: N.A.

Age range: Between 21 and 27

4.1.7 Has permission of the relevant authorities (e.g. school, hospital, clinic) been obtained to conduct research within that organization/ institution?

Yes No Not applicable

If Yes, letters must be attached.

Attached please find letters of permission from:

- i) the director of the Skills Centre at SMU
- ii) Sefako Makgatho University Research Ethics Committee (SMUREC)
- iii) Thomas Jefferson University to use the Jefferson Scale of Physician Empathy (JSPE)

4.1.8 Indicate data collection methods to be carried out with participants to obtain data required by marking the applicable box(es):

- Record review
 Interview schedule (*Attach if available. If not, submit at a later stage, together with initial approval of Ethics Committee.*)

X **Questionnaire**
See attachment iv) Empathy for Students (S-Version 2.3)

Procedures (e.g. therapy). *Please describe.*

X **Other** *Please specify.*

Reflection Sheets

Each participant will be asked to reflect pre and post intervention. The participants will choose identification markers when completing the reflection sheets in order to ensure anonymity.

Reflection Questions for sessions 1-3 are attached. See attachments v, vi and vii.

Video Recording

The role-play sessions will be recorded for possible additional collection of data.

4.1.9 If professional evaluation/assessment and treatment procedures are to be used, is the researcher registered to carry out such procedures? *Please specify*

The participants' levels of empathy will be measured by making use of the Jefferson Scale of Physician Empathy (JSPE) Student version (Example of Scale attached (iv)). The participants' responses will not be analyzed. The difference in empathetic behaviour, following the intervention through role-play, will be looked at from a basic angle so as to describe the effect of role-play on the participants' levels of empathy .

Full permission to use the JSPE has been granted from the Thomas Jefferson University (letter (iii) attached). The analysis of the scale will be achieved through close co-operation of Prof CW van Staden (Weskoppies Hosiptal, UP) who also acts in the capacity of co-supervisor .

No professional evaluation/assessment will be made. No marks will be awarded to the participating students. No treatment procedures will be carried out.

4.1.10 If the researcher will not personally carry out the procedure, state name and position of person who will.

N.A.

4.1.11 Is a life history used as information source?

Yes **No**

Is permission required for the disclosure of the source?

Yes No **Not applicable**

If Yes, has permission been obtained? (Attach proof)

If No, explain

4.1.12 Are the opinions of experts obtained?

Yes **No**

Is permission required for the disclosure of the source?

Yes No **Not applicable**

*If **Yes**, has permission been obtained? (Attach proof.)
See attached letters.*

*If **No**, explain.*

4.2 OTHER SOURCES OF INFORMATION AND/OR DATA

4.2.1 Document Analysis

Yes No

The written reflection sheets will be analyzed through qualitative means. The video recordings might also be transcribed as additional source of data.

4.2.2 Are the documents in the public domain?

Yes No **Not applicable**

*If **Yes**, please disclose.*

*If **No**, has permission been obtained to study the documents?*

Yes No **Not applicable**

*If **Yes**, attach approval.*

5. INFORMED CONSENT

- 5.1 Attach copy of consent form(s) printed **on the official letterhead of the Department** within which the research resides.

Informed consent form attached (viii)

- 5.2 If participants are under 18, or mentally and/or legally incompetent to consent to participation, how is their assent obtained and from whom is proxy consent obtained? *Please specify.*

NA

- 5.3 If participants are under 18, or mentally or legally incompetent, how will it be made clear to the participants that they may withdraw from the study at any time? *Please specify.*

NA

- 5.4 If the researcher is not competent in the mother tongue of the participants, how will you ensure the participant's full comprehension of the content of the consent form? *Please specify.*

The participants are all enrolled at an English speaking University. Should any concepts on the JSPE (S-version) form be unclear, they will be explained in depth until such a time as all uncertainties pertaining to the exact meaning of what the question entails, have been cleared.

6. RISKS AND POSSIBLE DISADVANTAGES TO THE PARTICIPANTS

- 6.1 Do participants risk any potential harm (e.g. physical, psychological, legal, social) by participating in the research?

Yes **No** *If Yes, answer 6.2.*

- 6.2 What safeguards will be taken to reduce the risks? Please specify

The participants will not be engaged in any harmful psychological, emotional or physical activities; the focus of the intervention will be placed on personal empathetic growth. Activities in, and approaches to, the educational sessions fall within the domain of the applied drama strategy of role-play. In case of any unforeseen emotional occurrences, where specialized assistance may be advisable, the facilitator or any of the participants will be able to contact the resident counsellor psychologist for professional help.

Letter of resident student counsellor attached (ix).

6.3 Will participation or non-participation disadvantage the participants in any way?
Yes **No** *If Yes, explain.*

The only possible of advantage of partaking in this study will be a change in the display of empathetic behaviour on the part of the participants. In order to ensure that there is no disadvantage regarding non-participation, a next opportunity of experiencing the possible change in empathetic behaviour through a same process of role-play will be offered at a later stage to the same group of students. This ensures that the students who do not participate in the study at this time, are offered the equal opportunity at a later stage.

7. DECEPTION OF PARTICIPANTS

Are there any aspects of the research about which the participants are not to be informed?

Yes **No**
If Yes, please justify.

Taking the Hawthorne effect into consideration, where people's actions change the moment they are aware of being observed, the participants will not be forewarned that the reflection will deal with what they had observed in relation to empathetic behaviour. Being forewarned might impede on the realness of the display of empathetic behaviour, the observation will be tainted and in turn this will affect the ability for objective reflection.

8. BENEFITS TO THE PARTICIPANTS

Will participation benefit the participants?

Yes **No**
If Yes, please describe briefly.

The potential benefits of this study are for the students to:

- a) gain insight into the use of empathy or the effect of the lack thereof through experiencing their personal observations by taking on both the role of the physician as well as that of the patient.
- b) grow as empathetic physicians through the experience gained through role-play.
- c) be empowered on a personal level through connection with their empathetic selves during a session of role-play.

9. CONFIDENTIALITY/ ANONYMITY

- Will anonymity of participant(s) be protected?
Yes No Not applicable

If Yes, describe how.

The participants will be asked to identify themselves by choosing an individual marker in order to retain confidentiality/ anonymity.

9.2 How will the confidentiality of information be assured? *Please describe.*

a) In order to ensure safety from risk of exposure and to keep the participants safe, no one will have access to the raw data collected except the researcher, Prof Marie-Heleen Coetzee (Drama Department, UP) and Prof CW van Staden (Weskoppies, UP), who act in the capacity of supervisor and co-supervisor respectively.

b) Should a participant decide to withdraw from the study for whatever reason, any data gathered from the specific participant will be permanently destroyed as with immediate effect.

10. DISSEMINATION OF RESEARCH RESULTS

10.1 To whom will results be made available?

To the participants and to the academic community. Readers will not be able to identify the participants personally.

10.2 In which format do you expect results to be made available?

Please mark those applicable:

- | | | |
|--|-------------------------------|--|
| <input type="checkbox"/> Doctoral thesis | X Masters Dissertation | <input type="checkbox"/> Honours Research Report |
| X Scientific article | X Conference papers | <input type="checkbox"/> book |
| X Lay article | <input type="checkbox"/> TV | <input type="checkbox"/> radio |
| <input type="checkbox"/> other <i>Please describe.</i> | | |

11. STORAGE OF RESEARCH DATA

11.1 **Please note that** according to the University of Pretoria policy, data must be securely stored for a minimum of 10 years. Where and in what format will the data be stored?

Please specify

In accordance with UP regulations, data will be stored in the archive of the Drama Building, Room 2-16 at the University of Pretoria for a period of 15 years. Permission of the participants will be requested should any person want to access the data in storage again for further research.

11.2 For what uses will data be stored? Please mark those applicable:

- research
- teaching
- public performance
- archiving**

11.3 If data is to be used for further research, how will participants' permission be obtained?

- Informed consent forms**
- Other *Please specify.*

11.4 Have the above issues been addressed in the letter of informed consent?

Yes **No**

12. OTHER INFORMATION

Please describe any other information that may be of value to the Committee when reviewing your application.

- a) In order to ensure anonymity, to reduce risk of exposure and to keep the participants safe, no one will have access to the raw data collected except the researcher, Prof Marie-Heleen Coetzee (Drama Department, UP) and Prof CW van Staden (Weskoppies, UP), who act in the capacity of supervisors to the study.
- b) Should a participant decide to withdraw from the study for whatever reason, any data gathered from the specific participant will be permanently destroyed as with immediate effect.
- c) The researcher hereby states that this study will not account for any marks towards any of the participants' studies.
- v) The researcher also declares that she is not involved with any of the MBChB V students by means of any activities that hold weight with regard to their academic performance during their 5th or 6th year of study.

13. CHECKLIST OF ATTACHMENTS

COMPULSORY:

X Research Proposal

If appropriate:

X Letter(s) of Informed Consent (**on University of Pretoria Letterhead**) with an explanation of the intent of the research

X Permission from relevant authorities (on the institution's letterhead and/or with their stamp) for study to be conducted

X Questionnaire

Interview Schedule

14. SUBMISSION DETAILS

RESEARCHER / APPLICANT

Name in capital letters: **LOUISE SCHWEICKERDT**

Signature: DATE:

STUDY SUPERVISOR

I am of the opinion that the proposed research project is ethically acceptable

Ethical Implications No ethical implications

Name in capital letters:

Signature: DATE:

CHAIR: DEPARTMENTAL RESEARCH COMMITTEE

Name in capital letters:

Signature: DATE:

HEAD OF DEPARTMENT

Name in capital letters:

Signature: **DATE:**

CHAIR: FACULTY RESEARCH PROPOSAL AND ETHICS COMMITTEE

Name in capital letters: PROFESSOR BRENDA LOUW

Signature: **DATE:**

With acknowledgment to Harvard University 1999-2000, and the University of the Witwatersrand 1992

Appendix G: Letter of approval –Research Ethics Committee



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

31 January 2017

Dear Prof Coetzee

Project: The empathetic physician: using process drama to facilitate the training of empathy skills in healthcare education
Researcher: L Schweickerdt
Supervisor: Prof M-H Coetzee
Department: Drama
Reference number: 96212773 (GW20170117HS)

Thank you for the **well written** application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 26 January 2017. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

A handwritten signature in black ink, appearing to read 'Maxi Schoeman'.

Prof Maxi Schoeman
Deputy Dean: Postgraduate Studies and Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail:tracey.andrew@up.ac.za

Research Ethics Committee Members: Prof NME Schoeman (Deputy Dean); Prof KL Harris; Dr L Blokland; Dr R Fassell; Ms KT Govender; Dr E Johnson; Dr C Panebianco; Dr C Pullerit; Dr D Rayburn; Prof GM Spies; Prof E Taljard; Ms B Teebe; Dr E van der Klauwen; Mr V Sihole

Appendix H: Letter of approval – SMU Research Ethics Committee



**Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)**

Molotlegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/3698 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 163 Medunsa 0204

Prof MH Coetzee
University of Pretoria
HOD: Drama Department
Drama Building Room 2-2

Dear Prof Coetzee

RE: REQUEST FOR A LETTER OF PERMISSION TO CONDUCT A STUDY AT SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

Louise Scheickerdt (9621277): MA (Drama)

SMUREC NOTED a letter dated 24 April 2016 requesting permission to make use of eight MBChB V students at SMU to participate in the study of Louise Scheickerdt, an MA in Drama student who is currently enrolled at University of Pretoria.

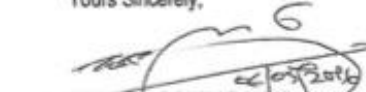
Study Title: The empathetic physician: using process drama to facilitate the training of empathy skills in healthcare education.

Researcher: Louise Scheickerdt (9621277)
University: University of Pretoria
Qualification: MA Drama
Supervisor: Dr CW van Staden & Prof M-H Coetzee

SMUREC **GRANTED** the researcher permission to conduct the above mentioned study at Sefako Makgatho Health Sciences University, but take note that the following documents must be submitted to SMUREC committee before the specified study commences at the SMU.

- Ethics approval / clearance letter from the UP ethics committee.
- Final approved protocol by UP ethics committee

Yours Sincerely,



**PROF GA OGUNABANJO
CHAIRPERSON SMUREC**

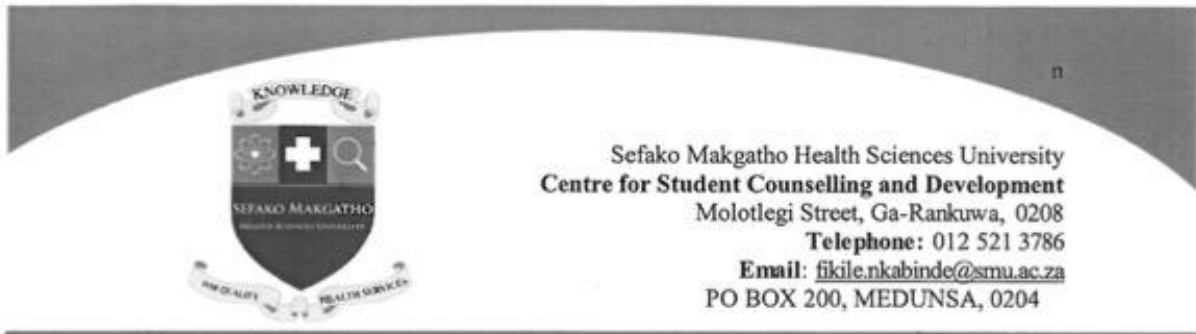
06 May 2016

Cc.: Louise Scheickerdt (9621277)



**SEFAKO MAKGATHO
HEALTH SCIENCES UNIVERSITY
SMU Research Ethics Committee
Chairperson**
Date: 06/05/2016

Appendix I: Letter from resident psychologist

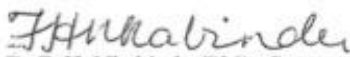


TO WHOM IT MAY CONCERN

A student by the name of Louise SCHWECKERDT, Student number 96212773 MA (Drama), registered with the University of Pretoria approached the Centre with regard her participants.

The Centre for Student Counselling and Development is willing to counsel any of her eight participants should the need arise.

Regards


Dr F. H. Nkabinde (PhD: Commonwealth Open University)
Student Counsellor (Educational Psychologist: PS0028916)
14-04-2016

Appendix J: Strategies to be employed during role-play

Strategies to be employed in an applied drama session of role play			
Dramatic Focus	Strategy	Outcomes	Role of Facilitator
1) Enrolling	MOE	Discussion about themes extracted	Teacher as Facilitator
	Lifting the curtain	Rules of the game	
	Questioning		
2) Role Play	Teacher in role	Control the pace, rhythm and depth	Teacher as Facilitator
		from a space within	
	Mantle of the Expert	Participants' contribution is what drives the session of role play	Questioning
	Evaluation and Assessment	Ensures that participants remain	Deep observation and facilitating feedback through questioning
		involved on the level of personal	

	taxonomy required	
Improvisation	Students find a relationship between reality and his/her own inner life	Flow of drama is natural
Evoking instead of directing through reflective questioning	Retains interest of participants	Allow for participants to direct the flow of the drama
	Participants commit to the drama	
Building Belief	Believe in the “big lie” by focussing on “the particular”	Ask participants to reflect on the hospital environment/consultation room setting they find themselves in.
	Keeps participants engaged	Introducing a group or character from outside the drama
	Leads to identification	
Withholding Expertise	Participants believe they are in control	MoE approach
	keeps them fixated and interested	
Dropping to the universal	connecting to others in a similar situation	Ask specific and goal driven questions

	finding an empathetic connection to the humanness behind any given set of circumstance	
The Brotherhoods	Find what is common in all human beings and through this find means of evoking change	Point out similarities in all HCP
Man vs man, nature, gods or Man in a mess	Creates tension and learning	Introduce an aspect in the patient or the HCP that places them in a very difficult position
Reverse	Allows for the exploration that every situation has two sides	Participants will have the opportunity to portray both the role of the healthcare physician as well as that of the patient
Time before, after and within	HCP is made attend to the fact that patients are more than merely an illness	Teacher introduces an aspect of personal matter that has little to do with the illness the patient came to consult for.
Creating tension	Keeps interest alive	Introduce an aspect like time constraint

Classifying Drama	brings a new source of energy and awareness	Ask HCP to adopt a most professional attitude towards the patient
	distances the players from the action should they get too involved	
Paradox and the universal	HCP realizes that there is more to the patient than meets the eye	The patient might react differently to what is expected in a general situation of its kind that is being presented here.