

# Assisting medical students to conduct empathic conversations with patients from a sexual medicine clinic

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**Objective:** To describe an exercise, the structure and content of which assists medical students to conduct potentially embarrassing conversations concerning sexual health which require expression of empathy, to integrate previous learning, to identify their further learning needs, and to develop and test strategies to meet these needs.

**Method:** Students' role play, sequentially, speakers (patients) and listeners (clinical students) in a "carousel," in which all students are engaged at all times in a sequence of pairings which change at rapid intervals. Half way through the exercise, students reflect on the experience, identify difficulties and successes, and develop and share strategies for experimental use in the second half of the exercise.

**Results:** Qualitative comments from the written student evaluations are reported.

**Conclusions:** The exercise provides a formative student centred approach to the integration and further development of previously learnt knowledge and skills of value for promoting sexual health education. It is useful for educators interested in promoting more open and informed learning about sexual health.

We describe a learning approach to the integration of skills, knowledge, and attitudinal development in the context of a potentially difficult clinical situation concerning sexual health. The exercise has been developed over a 10 year period, with 20 third year preclinical undergraduates in each year on a course, the organisation, student selection, staffing, and assessment of which have been described previously.<sup>1–5</sup> Sex, gender, reproduction, and sexuality form one part of the course syllabus of lectures, seminars, workshops, and projects being offered in these areas.<sup>3,4</sup> In general, exercises of the sort described here precede theoretical and academic work. However, we have developed this exercise for use when students have worked together intensively over two terms to develop communication skills, increase awareness of their own attitudes and values, and increase their understanding of relevant sex and gender issues. This previous work includes practising communication skills in pairs<sup>2</sup> and with actor patients with video feedback. They have also had opportunities to explore and use sexual language (vernacular, idiomatic, and slang) in several contexts, and to discuss sexual behaviour which they believe falls within or outside social norms.<sup>1,3,4</sup> They have been given the opportunity to privately review their own sexual development and gender identity, and shared what they will with a partner. The exercise described here encourages them to integrate their previous learning, skills, and attitudinal work as a prelude to direct encounters with patients.

## METHOD

The exercise is presented to the students with the following explicit aims.

- (1) To use clinical scenarios to explore how you might react professionally to sexual situations
- (2) To attempt to empathise with patients in particular situations through role plays
- (3) To identify what responses/behaviours might be helpful to you and to the patient and why
- (4) To try out some of these behaviours.

The exercise lasts for about 2 hours and it is useful to have a break half way through as the role plays are very intense.

One (or two) facilitators supply cards outlining scenarios (see box) plus, with the appropriate cards, a cervical diaphragm, condoms, femidoms, an IUCD, and bulldog clips. The basic organisation of the exercise uses a "carousel" format.<sup>6</sup>

The organisation of the role play should take into account the need to give clear instructions, to manage the timing, to create a "professional" atmosphere so that students take the process seriously, and to provide support for those who are overcome with embarrassment or incompetence. The facilitators place 10 chairs in a circle facing outwards, well spaced to make maximum use of the room and so that sound spillover between neighbouring chairs is not a problem. A further 10 chairs are placed opposite to them facing inwards.

The students are divided into two groups of 10. Facilitators explain that one group of 10 will role play patients. Each of these is given an envelope containing a card with a scenario on it and any props necessary. After they have opened and read their scenarios, each is asked to note down their immediate responses. They then take 5 minutes in silence to get into role. As this is an empathy exercise, the more they can get into role, the more effective the exercise will be. All scenarios begin with the following instruction:

"Read the situation below and then devise a persona with whom to empathise. You can develop this persona during the three runs of the role play but start now, using as prompts the following questions:

What is your name and what is your social situation?

How old are you?

Where do you live?

With whom: what are their names?

What is your life style?

What is your background and personal history?

What are names of the important people in your life?"

When ready to begin the role play carousel, each of them sits on an inward facing chair, mixing the order so that men are spread among women.

The other 10 are to role play clinical students for whom patients have been organised by the sexual medicine clinic so as to gain experience. They are invited to think themselves

### Examples of role play scenarios

Some scenarios are marked “for males,” others “for females,” others work equally well for either sex. The first scenario is described in detail and the rest are sketched.

You are:

- (1) A young woman who is due to have an education session about how to fit a cervical diaphragm. You are anxious about what this involves as you have heard it is very painful. You want to ask the clinical student to explain in detail to you what exactly your cervix is and what will happen to you. You have a diaphragm in your pocket which was given to you at an earlier visit, but you have not experimented with putting it in. Now is a chance to talk about this situation.
- (2) A young homosexual man who has only just “come out,” but doesn’t know how to use a condom.
- (3) A 53 year old woman who has started to experience considerable pain having intercourse.
- (4) A man in his fifties who has been having difficulties passing urine and who has been told that he may have an enlarged prostate. The diagnosis may involve a rectal examination.
- (5) A woman who gains her only sexual thrill from masturbating herself. You want to find out about different ways of masturbating and which is most stimulating.
- (6) A male with a small nodule on the left testis and anxious about it.
- (7) A female who is worried that your vagina smells badly and will put men off.
- (8) A woman interested in having an IUD fitted.
- (9) A male of 20 who has been worried since school friends made fun of you in the showers because your penis bends over to the left when it is stiff.
- (10) A person who gains great sexual excitement from having your sexual partner attach bulldog clips to your nipples, penis, and scrotum (man) or nipples, labia, and clitoris (woman). If they are then pulled on or squeezed the pain is exquisitely sexual. However, you are now rather bruised and worried you have done permanent damage but you feel a deep need to go on doing it.
- (11) A man or woman who has a boyfriend who has asked you to perform oral sex for him but you have not done this before. You want to know what you should do with his “cum.” Is it safe to swallow or should you spit it out?
- (12) A male or female who is 13 and has begun a sexual relationship with a man of 20. Your parents have found out and are angry with you. They have sent you to the doctor for some contraceptive advice.
- (13) A 21 year old woman who has been married for 3 years. You have been having an affair for the past 3 months, and have just done a pregnancy test and found out you are pregnant, and both you and your husband will know it is not his. You want the baby, but have come to ask about having an abortion.
- (14) A male 18 year old rent boy who uses a cocktail of drugs. You have come because you are worried about HIV as you usually have unprotected sex.

into the situation and prepare mentally: “How are you going to initiate the session? How might you structure it?” They each sit opposite one of the patients at random, mixing genders as far as possible.

Each pair then has 5–7 minutes of contact. When the facilitator calls time, they stop immediately wherever they are in the exchange. Each “clinical student” then moves one place to the right for a second 5–7 minutes with a new patient, and then to the right again a further 5–7 minutes with a third patient. Meanwhile, the patient remains in the same role for each new consultation with a different “doctor” and does not break role until all three periods of 5–7 minutes are over.

Once this first set of exchanges is complete, students “de-role” actively by moving around, and declaring themselves not to be the person or role they have been playing. Then “clinical students” form pairs and “patients” form pairs for 10 minutes to consider these questions:

- What did I learn about my *personal feelings* about having to talk openly about sex?
- What was easy?
- What presented difficulties for me?
- Did any of my *attitudes* or *assumptions* that came out in the process surprise me?
- Were my *reactions* professional?

These pair reviews are followed by a plenary session with facilitators, which moves from reviewing their feelings and attitudes to identifying specific behaviours that might or might not be useful professionally to help them and the patients cope with sexual subject matter. We encourage them to describe how these behaviours will help deal with the feelings and attitudes raised. This discussion aims to turn behaviours into strategies and to encourage the students to adapt and personalise them.

After a short tea break, students swap roles and set up as before with new patient cards, and the role play carousel runs

for a further 21 minutes. Students then spend 15 minutes in a group of four (two patients and two students per group) to identify, with specific examples, what worked and why. A final plenary session ensures that extra learning from the second sequence is shared, and students consider how they may apply it when they are clinical students.

### RESULTS

Student written evaluations provide an indicator of their learning.<sup>5</sup> Almost all comment on how effectively the structure of the exercise contributes to their learning, indicating how good their analytical grasp of learning methodologies had become during the year, and several make suggestions for change:

“It was very useful that we each got three goes at talking to patients, as this allowed us to learn from our mistakes very quickly and to vary our strategy.”

“The day would not have worked as well if it had been towards the beginning of the course . . . in my future career, I will have to deal with matters of a sexual nature in a much more exposed, hazardous climate. This workshop is an extremely good basis upon which to build my strategies to deal with sexual issues effectively.”

“The role play was incredibly useful and . . . showed very well what strategies worked better to make the patient feel more at ease. It was also very useful to see three doctors, since that made it much easier to see what worked or not.”

“It was very rewarding trying to analyse what it was they [clinical students] had done which made me let go and feel free to speak easily.”

“I would have liked to have heard some individual feedback, on how my patients felt about ME . . . this would obviously have taken more time, but to have heard (for example) what the three best and improvable aspects of my approach were—would have been of more use to me.”

They were also commenting on how the learning strategy also informed their thinking about possible consultation strategies:

“By discussing our learning following the exercise in small groups we were able to share and learn from each other’s experiences. It was also reassuring to find that we had had similar difficulties. This may suggest that it could be important to present yourself to the patients as just another person, rather than as some austere professional figure.”

“Experience will help me to deal with such problems in a more professional manner, but the form of today’s workshop allowed me to consider the position from which I am starting and therefore helped me to understand my own reactions and emotions.”

“A big challenge for me but I feel that I gained a lot of useful insight.”

Most also expressed the view that they learnt very different things from being both patients and medical students. Playing patient roles taught them very powerfully about what they needed from a consultation:

“Playing the patient role was . . . informative . . . I found that my empathy did grow as I explained the story for the second and third time. This was an effective way of putting us in a position to experience the feelings a patient might have upon presenting to a GUM clinic.”

“I found it much easier to tell them [clinical students] when they did not seem embarrassed.”

“When I was finding it difficult to explain what I meant there was a tendency to patronise me, which I think it is equally important to avoid.”

“It was good to have a go at both same sex and different sex interactions and I was struck by what a difference that made to me, both as a patient and as a clinical student. It was definitely more awkward and more embarrassing when I was discussing a problem with a man.” (Female quote)

“I did get very engrossed in my role, to a quite alarming extent. One of the things I noticed was that I had a clear plan of where I wanted the consultation to go and what had to happen for me to be satisfied by it, but because of my embarrassment I was not prepared to steer it.”

“One of my pretend clinical students was really cheerful and told me that I could either talk about my problem or about anything else . . . I found it really hard to actually tell her the problem which I was quite surprised about, since I had found it relatively easy with the other two students, and also because I knew I was acting and it wasn’t a real problem. It just didn’t seem like a safe, receptive atmosphere. If it had been a real situation, I wouldn’t have told her and would have just sat there feeling really uncomfortable. I learnt from this how easy it is to get off on the wrong foot by the first words that you say. You can’t be really serious when you begin to talk to someone either, because you don’t know what frame of mind they are in. I think you have to be pleasant and look ready to listen, but not too cheerful and not too serious.”

“Above all, this empathy exercise taught me to approach patients in GUM with caution—I was being so difficult [as a patient], I didn’t think any strategies would have worked. The last student was, however, very good dealing with my worry that it was [testicular] cancer, by not belittling or exaggerating the risk. She was also less overtly caring and confident than the previous two, and I think this paradoxically helped my persona relax. So one’s strategies must be adaptable to each new patient, hard though this is. The role play certainly gave me plenty to think about.”

“When acting as a patient, I was surprised by the intensity and seemingly genuine nature of the emotions that some of the clinical students evoked. Realising that this could occur merely through simulation of a situation emphasised how vulnerable patients are, especially when talking about problems of a sexual nature and how crucial a sensitive and appropriate reaction is. Responding to the cues of the patient—for example, using their language, respecting the degree of detail they wish to impart, is pivotal in conveying respect and gaining the patient’s trust”

In contrast, playing the clinical student role informed them about their own needs and limitations, both personal and professional:

“I always thought I was liberal minded but talking to people about their sexual experiences made me realise that I am not as open minded as I might like to think.”

“It brought home to me how important it is to try not to bring your personal opinions into a consultation, however difficult. I can’t just say don’t do it unless there is medical reason.”

“The most important learning for me from this exercise is in knowing my own limitations, and dealing with them before the situation becomes too difficult. I found that I did have great difficulty listening sensitively to the ‘patients’ talking about their sexual health problems, and this probably was because I found it embarrassing.”

“If I now get into a situation that I don’t think I can handle because of personal issues then I have a duty to get the patient someone who might be better at dealing with them than me.”

“I was confronted with the dilemma of whether to disclose my sexuality to a patient. I was questioned whether my motives for this were self directed or patient directed, but I genuinely believe that if I had a sex related problem which could be better answered by another gay man, I would value advice more from a gay doctor. I don’t think it’s fair that Asian or female doctors, for example, are able to benefit from their ‘minority’ status by offering empathy, whereas I’m apparently not. I still don’t know what to do about this dilemma, and it alarmed me how quickly the problem, which I’d hoped to be able to avoid, arose in this context. More seriously, I’m not sure what to do if a patient asks me whether I’m gay. I don’t have a problem answering the question honestly, and in order not to do so I’d have to lie or avoid the question, both of which would damage the relationship with the patient. But then telling the truth might. I’m having real problems with this one; it just goes round and round in my head. I think I need some help coming to a suitable answer. Any ideas? By the way I’m grateful that the issue was brought to my attention by the workshop rather than by a patient! At least this way I can come to a working solution by the time it matters.” (This evaluation was followed up by facilitators)

“I think that I would find it inappropriate for a doctor to refer to him/herself to make me feel less embarrassed because that would remove the protective professional barrier.”

“I felt a key factor was gauging the right level for the patient’s worries . . . or gauging their feelings and level of embarrassment in discussing sexual matters. It was uncomfortable as a middle aged woman with an embarrassing pain to hear people use explicit clinical phrases and blunt personal questions, but as a young sexually confident woman another student felt she was being medicalised and treated as strange by the way her ‘doctors’ referred to her problem as if she must be embarrassed.”

"A lot of the strategies seemed to be good for some patients and terrible for others . . . for instance with a patient who just wanted an IUD, I was too tentative and too reassuring, because I'd just had a patient who needed that approach. I need a beginning that is suitable for all problems, embarrassing or not. Using the word 'personal' instead of 'embarrassing' may be of some help here."

It was interesting that the conditions developed in the group enabled their mutual learning about sexual diversity and their own difficulties to extend into the processing after the carousel itself:

"One has to be careful what you assume, as what you might find strange is normal for someone else. I said that I found something very hard to deal with and gave a story to illustrate, but my partner was then brave enough later to say that they enjoy the practice I had just said was abhorrent. I really respected them for this."

## DISCUSSION

Medical education in the United Kingdom is undergoing considerable change, driven largely by the recommendations of the education committee of the General Medical Council,<sup>7</sup> which encourages more student centred and problem based learning approaches as well as requiring attitudinal issues to be addressed. Sexual health is a sensitive area for both skills and attitude development. Some approaches to the issue of skills teaching in this area have been reported.<sup>8,9</sup> We have focused on attitudinal education and have been developing use of structured experiential work as one approach, of particular value where strong emotional and personal issues arise in medicine.<sup>1</sup> The provision of a safe environment in which students can express concerns and then develop strategies for addressing them is an important component of this approach. Structured reflection on values, attitudes, and emotions can precede or follow other sorts of informational or skills based learning.<sup>5</sup> Here we use such an approach as an integrating device, although the same approach as described here can be adapted for use early on in a course to raise issues for consideration (see, for example, Johnson and Henderson<sup>1</sup>).

This intensive and challenging exercise yields rich learning about attitudes, behaviour, and values. It works best when the group is well formed, and meets within an explicit contract to support experiential learning by responsible behaviour. It requires facilitators who can themselves talk easily about sexual matters, and can support those students who find it difficult or who become self critical as they discover that they have more difficulties in applying previous learning than they anticipated. It is a sound preparation for initial sessions in a

GUM clinic before exposure to patients and the performance pressure which that experience can bring. Details could easily be adapted for other embarrassing or otherwise difficult exchanges.

The experiential approach used in this exercise is particularly suited to the integration by medical students of the attitudinal, knowledge, and skills elements of training. However, surprisingly little use of this approach has been reported in the United Kingdom.<sup>1,3,4,10</sup> considering the emphasis being placed by the education committee of the GMC on such learning.

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## STATEMENTS

Both authors have developed, applied, and tested this version of the carousel for the purposes described here. No paper resembling the enclosed article has been or will be published except in *Sexually Transmitted Infections*. No funding is involved and so there are no conflicts of interest.

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