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Research Note

Audiology Students' Clinical Communication During Simulated Peer Role Play Consultations: An Exploratory Study

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ABSTRACT

Purpose: The objectives of this study were to describe the clinical communication practices of student audiologists during case history taking and feedback giving using simulated peer role play consultations and to explore whether clinical communication skills outcomes can be achieved through simulated peer role play.
Method: An exploratory, qualitative research design was used for this pilot study. A total of four simulated peer role play consultations were video-recorded, comprising two adult diagnostic audiology case scenarios. Eight online interviews were conducted with the student participants following the simulated audiological consultation. Analysis of the video-recorded sessions incorporated an interactional sociolinguistic focus, and interviews were analyzed using inductive thematic analysis.
Results: Findings from the video analysis and interviews were triangulated, with a specific focus on establishing commonalities in terms of communication skills of student clinicians, reflections of their own skills, and the simulated peer patient's reflections on the student clinician's skills. Although variation was noted in terms of case history taking skills, feedback giving was similar among all student clinicians. These communication practices are consistent with findings from related literature on consultations with real patients. Student clinicians reflected on feedback giving as more challenging than case history taking, with room for improvement suggested by the simulated peer patients.
Conclusions: Our findings highlight key questions regarding the use of peer simulation in facilitating the development of communication skills for audiological consultations among student audiologists. We discuss some considerations for using this approach to clinical training more effectively.
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Clinical education in health professions has commonly involved traditional methods of clinical placements, with direct supervision and patient–client contact. However, increases in student numbers and current pressures on health care systems and universities have placed pressure on academic institutions to think creatively about effective, efficient, and sustainable methods of clinical competency training. The use of novel approaches can increase the availability of clinical practice opportunities and offer standardized methods for teaching clinical skills, including communication skills. Simulation-based learning is one supplementary approach that can be used for clinical competency training. It can also reduce the strain on clinical training sites and allows training programs to provide the context needed to support the development of these skills (Hill et al., 2010; Quail et al., 2016; Sheepway et al., 2014; Theodoros et al., 2010).

Training of health care professionals has been a challenge in the South African context. These challenges relate to capacity and logistical challenges resulting from growing numbers of students needing clinical training coupled with limited capacity of training facilities such as

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academic hospitals (Gaede, 2018). Clinical simulation has previously been suggested as a tool for the training of medical students in South Africa as a means of addressing these clinical training challenges (Labuschagne et al., 2014). However, there has been little to no focus on the use of clinical simulation for the training of audiology students in South Africa and other Global South contexts where resources may be limited.

Definition of Simulation

Simulation can be implemented in different ways. It may include role play, the use of standardized patients or manikins, computer-based simulation, and virtual environments (O'Beirne et al., 2020). Alanazi and Nicholson (2017) describe simulation as including two aspects, namely, the simulation environment and the learning experience, with each of these comprising several components such as manikins, case scenarios, standardized patients, facilitators, debriefing, and safe environments. In audiology, simulation has primarily focused on the use of low to mid-fidelity simulations (e.g., role play and standardized patients) rather than on peer simulations. Fidelity refers to how closely the simulated learning environment reflects the actual clinical training environment and related tasks (Dzulkarnain et al., 2017).

Simulation as a Clinical Training Tool

Simulation-based learning has become well recognized in health professional education, more specifically in clinical settings within undergraduate medical curricula (Aljahany et al., 2021). It has also gained some traction in international audiology training programs (Alanazi & Nicholson, 2017; Andre et al., 2021; Dzulkarnain et al., 2015; Wilson et al., 2020) but is still behind in comparison to other health professions (Alanazi & Nicholson, 2023), with little to no focus on the South African context. Although international studies suggest that simulation provides useful opportunities for clinical education in audiology, particularly in terms of increasing students' confidence in clinical skills and exposure to a variety of pathologies, there has been a predominant focus on clinical procedural skills with very few studies focused on communication skills and client or patient interaction during case history taking, feedback giving (communicating assessment findings and discussing recommendations), and counseling (Dzulkarnain et al., 2017, 2019; Hughes et al., 2016; Wilson et al., 2020).

The Importance of Communication Skills for Audiology Students

Communication is the central thread in health care ecologies and systems (Ratna, 2019) and, if managed competently and effectively, it can facilitate a positive therapeutic alliance between clinician and patient (Beck & Kulzer, 2018). There is a growing need to include and strengthen communication skills through training within undergraduate audiology curricula (Tai et al., 2019; Watermeyer et al., 2012, 2015, 2017). Although communication skills training in the audiology field has been explored in a few international studies via traditional methods of clinical training, these studies have not included the use of simulated peer role play as a clinical training tool. It is therefore important to explore whether this simulated method is a useful approach to facilitate the development of communication skills.

Simulation in Clinical Training for Audiologists

The incorporation of simulated patients may be a useful method for teaching audiology students vital clinical communication skills, as it could provide equal learning opportunities to practice and refine these skills before working with real patients (Hughes et al., 2016; Ondo & Spoor, 2020). Simulated patients can be actors, peers, or real patients who are trained to reproduce a clinical scenario while keeping in mind specific learning objectives (Hughes et al., 2016; Nestel & Bearman, 2014).

The use of standardized patients is noted as being effective for practicing communication skills (Ondo & Spoor, 2020). Brown (2017) documented the use of standardized patients as a mid-fidelity simulation to allow students to practice communication skills with patients, improve counseling skills and review and reflect on their communication and clinical behavior when communicating with patients. Hughes et al. (2016) compared seminar training to simulated patient training with first year audiology students and noted equivalent improvement with both methods in students' ability to take case history and provide feedback. Simulated peer role play may be another means of providing students the opportunity to practice communication skills.

Simulated Peer Role Play in Audiology

Simulated peer role play is a more cost-effective form of role play, in which students may be trained to portray patient roles for their peers, allowing for repeated practice of skills (Dalwood et al., 2018; Springfield et al., 2018). Student audiologists and peers can use role play as an opportunity to learn, reflect on, and improve their clinical abilities, including their communication skills. Literature on the use of peer simulation has been limited to health care professional education such as nursing, physiotherapy, and medicine (Dalwood et al., 2020), with only

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one study in audiology including the use of peer role play for client interaction (Wilson et al., 2020). Apart from Wilson et al. (2020) who made use of postgraduate students as simulated caregivers in pediatric audiology consultations, simulated learning in audiology has primarily focused on the use of manikins, standardized patients, virtual cases using computer-based simulation, and virtual reality (Alanazi & Nicholson, 2017; Bakhos et al., 2020; Shaaban & Richburg, 2022; Wilson et al., 2010). These studies made use of questionnaires to explore student perceptions of the simulated learning environment, interviews for reflection of the debriefing sessions, Likert scales to explore pre- and post-training satisfaction, and scoring of clinical reasoning skills. Our study focused on the analysis of video interactions and student reflections through interviews.

Dalwood et al. (2020) concluded that although peer simulation has been shown to have a positive impact on student communication and provides an alternative to including simulated patients in medical education, more research is needed to understand its impact on a wider range of learning outcomes. Sharma (2020) highlights the need for more literature on the best way to go about establishing a sound peer simulation program. There is limited literature on the clinical communication practices of audiology students during peer simulations. Therefore, in this pilot study, we aimed to describe the clinical communication practices and reflections of student audiologists during case history taking and feedback giving in simulated peer role play consultations and explore whether clinical communication skills outcomes can be achieved through simulated peer role play consultations.

Method

Research Design

An exploratory, qualitative research design was used. There was a serendipitous element to our study design, as our initial plan was to explore communication practices of student audiologists with real adult patients during initial consultations, with a specific focus on case history taking and feedback giving. Due to the COVID-19 pandemic, however, consultations with patients as part of the initial consultation clinical practicum were replaced with in-person-simulated peer role play consultations to ensure that students were still afforded the opportunity for clinical training despite not being able to interact with "real" patients. This study involved observational analysis of recordings of peer role-played consultations from a third year adult audiology practicum together with interviews with the students involved.

Ethical Considerations

Ethical clearance was obtained from the university institutional review board (clearance number: M210349) and permission was obtained from the head of department and the university registrar. All participants were provided with written and verbal information about the study and gave written consent. Neither the first nor second author was actively involved with clinical supervision of this practicum. The third author was a fourth year audiology student.

Research Context

The study was conducted at the University's Speech and Hearing Clinic, which is one of the sites at which second, third, and fourth year students conduct their clinical training within the four-year undergraduate audiology program. Practical components typically commence in the second year of study with practical exposure to initial consultations with peers where the focus is on audiological testing and not specifically on communication skills. This is followed by clinical exposure with real patients in a variety of settings (such as public sector hospitals, clinics, and the university clinic) in the third and fourth years of study. The purpose of the audiology initial consultation practicum is to afford students opportunities to conduct diagnostic audiological assessments and provide necessary management.

Historically, students have been encouraged to bring a peer or a family member for an audiological assessment should a patient cancel their appointment, to ensure continuity of training opportunities. Although students typically conduct initial audiological assessments on peers in their second year of study, this group of students may not have had sufficient opportunity to do so due to the COVID-19 pandemic. Because this approach to clinical education was implemented under emergency conditions during COVID-19, none of the simulated peer patients (SPPs) received training specifically on role play or acting as a simulated patient. Although the students receive a counseling course that typically spans 4 weeks, it focuses on general theoretical principles and does not include scripts for providing audiological counseling.

The learning objectives of the clinical practicum from which we drew our data included, among others, obtaining case history information through appropriate follow-up questions, giving appropriate patient feedback and counseling and providing appropriate, case-specific recommendations and referrals to ensure holistic management. These learning objectives were not the primary objectives but were part of the overall aim of the practicum, which was to develop clinically and culturally competent

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audiologists with the knowledge and skills to perform diagnostic audiological evaluations and provide effective audiological management to the adult population.

Students who played the SPPs in the simulated peer role-played consultations were guided using written scripts (see Supplemental Materials S1 and S2). There were two case scenarios that differed in terms of age, occupation, and pathologies but had the same objective of providing sufficient case history information to guide the SPPs. Students were not given an audiogram but rather a brief outline of what the assessment results could look like. The tentative diagnosis for Case 1 (Supplemental Material S1) was a cholesteatoma in the right ear, and the diagnosis for Case 2 (Supplemental Material S2) was a perforated tympanic membrane in the right ear. Case 1 was used in the second and fourth interaction and Case Scenario 2 in the first and third interaction. These scripts were developed by the third year clinical coordinator in the department. SPPs were provided with the script to review 10 min before the consultation together with the case history information that they had to relay as the patient in terms of activities, social history, medical history, and audiological history. They were also provided with information on what to ask during the feedback giving session. For example, "Ask if you need to wear a hearing aid because you are concerned about the cosmetic appeal." They were allowed to refer to the script during the consultation to ensure that information was relayed accurately and there was cohesion between all aspects of the consultation. Student clinicians (SCs) were not provided with scripts.

Participants

Participants were selected through convenience sampling. All students in their third year of study were invited to participate. Eight students consented, four of whom played the role of the SC and four played the role of the SPP. All participants were female, between 20 and 21 years of age.

Data Collection

Data were collected during the third year audiology initial consultation practicum and included the following:

1. Four video-recorded, simulated peer role play interactions, comprising case history taking and feedback giving aspects of initial adult diagnostic audiology assessment consultations. The average length of the case history taking and feedback giving aspects of the initial consultation was 7 min and 6 min, respectively.
2. Eight semi-structured interviews were conducted online by the third author with each of the participants following the simulated audiological consultation. Interviews were audio-recorded via Microsoft Teams with automatically generated transcripts. The average length of the interviews with students was 6–7 min.

The interviews with SPPs commenced with an open-ended question related to their experience of the consultation with the SC. Questions posed to SPPs included whether they felt that they were able to comfortably express themselves and their concerns related to their hearing, whether they were satisfied with the information provided, aspects they found easy or difficult to understand during feedback giving, their comfort with asking questions, and what communication skills they felt that the SC could improve on (see Table 1).

Interviews with SCs similarly commenced with an open-ended question where they were asked to describe how the consultation went. Other questions included their thoughts about the case history taking and how it went, the communication strategies they felt facilitated case history taking and feedback giving, what they did to ensure that the SPP understood the feedback provided, what they thought went well, and the challenges experienced (if any; see Table 2).

Data Analysis

Analysis of the video-recorded consultations incorporated an interactional sociolinguistic focus (Knoblauch & Tuma, 2011). We have previously used this method,

Table 1. Interview questions used with simulated peer patients (SPPs).

• Tell me about your session today with the SC.
• What are your concerns about your hearing?
• Do you feel that you were able to comfortably express your concerns at the start of the session?
• Do you feel that the questions asked by the SC allowed you to express your concerns about your hearing?
• Did the questions probe into relevant areas related to your concerns?
• Were you satisfied with the information provided to you at the end of the session?
• Did you understand the information provided to you by the SC?
• Which aspects did you find easy to understand and which aspects did you find difficult to understand?
• Did you feel comfortable asking questions during the consultation?
• What do you feel the SC did well during the session?
• What are the communication skills that you feel the SC could improve on?

Note. SC = student clinician.

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Table 2. Interview questions used with student clinicians (SCs).

• Tell me how the consultation went today.
• Do you feel like you managed to obtain a thorough case history?
• What communication strategies facilitated the case history taking with the patient or peer?
• What strategies or communication practices were used when providing feedback based on the patient's or peer's results?
• What did you do to ensure that the patient or peer understood the feedback that was being provided?
• What did you think went well with regard to case history taking and feedback?
• What challenges did you experience during case history taking and feedback provision (if any)?

which proved beneficial for the analysis of short video clips (Watermeyer et al., 2012, 2015, 2017). This method of analysis involved noting specific communication practices and verbal content used by student audiologists, with a focus on SCs' information giving and communication strategies when conducting case history taking and providing feedback to SPPs. We were particularly interested in analyzing how and whether SCs were able to link and respond to points raised by the SPP in the case history part of the consultation later in the feedback session after testing.

Transcripts of the interviews were automatically generated via Microsoft Teams. These transcripts were refined by the first author prior to data analysis. The interviews were analyzed using principles of inductive thematic analysis (Braun et al., 2019).

Findings from the video analysis and interviews were then triangulated. We specifically focused on establishing commonalities in terms of communication practices of SCs, reflections of their own practices, and the SPPs' reflection on SCs' practices.

Trustworthiness and Rigor

Credibility was ensured through regular debriefing sessions among authors, while transferability was ensured through the convenience sampling of participants. A detailed record of the methods and design of the study was kept for purposes of dependability. Confirmability was achieved through regular auditing and discussion between the authors. The data were initially analyzed by the third author and reviewed by the first and second author to ensure trustworthiness.

Results

Results are presented firstly in terms of the general trends related to the students' communication practices as observed in the videos of the simulated consultations, followed by reflections of their own communication practices and reflections by their peers as noted from the interviews. Two of the consultations made use of the script for Case 1, and two made use of the script for Case 2. The communication practices of SPPs during case history taking and feedback giving were not analyzed in this study as they typically followed the scripts and prompts provided in the scripts, with little to no deviation from these. We were also more interested in how peer role play impacts on the SC's acquisition of communication skills.

General Description of SCs' Communication Practices During Simulated Consultations With SPPs

As was the case with SPPs, SCs also appeared to follow a "script-like" approach to communication. This script-like approach involved a standard method of communicating information, with limited tailoring of information when having to integrate case history information provided by the SPP during the feedback session.

With regards to case history taking, all SCs commenced the consultation with an open-ended question and concluded this aspect of the consultation by providing the SPPs with an opportunity to express any concerns. However, there was some variability between consultations. Although three of the four SCs probed relevant areas, questions were not always asked in a logical order and, in some instances, a checklist, rote approach was used. In one of the consultations, the SC appeared disengaged in comparison to the SPP who provided detailed responses, elaborating on aspects that may have been missed by the SC.

All but one of the SCs commenced feedback giving in a similar manner, starting with an explanation of the anatomy of the ear. All SCs then proceeded to explain the audiological results in relation to each test and/or in relation to the part of the ear that the measure was used to assess. The audiogram was used in all consultations when providing an explanation of the pure-tone audiometry findings, with three of the four SCs vaguely integrating case history information toward the middle or end of this segment of the consultation. Case history information was sometimes loosely related to the audiological results, with one of the SCs only referring to the symptoms provided during case history, and another only referring to case history information at one point during the consultation (when explaining the pure-tone audiometry results). Two SCs concluded the feedback giving with recommendations, which comprised stating a list of recommendations or advising the SPP on what to do next. These recommendations did not lend themselves to discussion or to shared decision making between the SC and SPP.

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Students' Reflections on Communication Skills During Simulated Consultations

All SCs and SPPs were interviewed, where SPPs were expected to provide responses from a patient's perspective. However, two SPPs demonstrated uncertainty as to which perspective to respond from. For example, "Just to clarify, am I now speaking as the patient?" (SPP4), "Should I speak from the patient's perspective?" (SPP3). There were three themes that emerged from the interviews with SCs and SPPs, namely, (a) room for improvement with case history taking skills, (b) providing feedback is challenging despite "patient" familiarity, and (c) room for improvement with feedback giving.

Theme 1: Room for Improvement With Case History Taking Skills

During the interviews, SCs focused on how they conducted the case history taking component of the consultation, their improvements in case history taking as a SC, and the need for future improvements in this area. SPPs, on the other hand, focused on the positive aspects of the SCs' case history taking practices, followed by suggestions for improvement.

SCs' reflections on their own case history taking practices were mixed, with some positive aspects coupled with hesitancy. SC1 mentioned, "But I think with practice, so far I think I'm coming along pretty okay." Similar responses were noted by the other three SCs, for example, "Uhm I think the session went relatively well" (SC2); "Uhm the consultation went okay, I'm not gonna complain, from case history . . . " (SC3); "I think . . . well. It went well but not that great." (SC4)

SPPs' overall reflections regarding case history taking by SCs were positive, with a few points of critique accompanied by suggestions for improvement. The positive aspects were related to the relevance of questions and probing of specific areas. All SPPs expressed that the SCs asked relevant questions, for example, "I think [name] did really well as, you know, the student audiologist. I think that she asked really good case history questions that covered things" (SPP1); "She asked all the questions that she could to get enough information about my case" (SPP2); "Yes, she did ask me about my social life. She did ask me how it was affecting me and she did ask about symptoms" (SPP3). SPP4 responded by stating "Yes, she did" when asked about whether relevant areas of case history were probed.

Three of the four SCs indicated that their case history taking practices have improved in terms of probing into relevant areas and relying less on a checklist-type approach to asking questions, for example, "In terms of case history, I don't know, I feel like I [have] done a bit better than I used to" (SC1); "I think I did cover like the necessary basis and what to probe into. I definitely did" (SC2); "the consultation went okay I'm not gonna complain from case history and feedback" (SC3). There was also mention from two students (SC1 and SC2) of having conducted case history in a conversational manner, their use of open-ended questions, and incorporation of patient-centered care principles into their communication with the SPP.

Despite mention of improvement in case history taking, two SCs reflected on what they could have done differently, specifically in terms of probing into relevant areas and including open rather than closed-ended questions. SC1 mentioned, "I feel like there were certain things that I could have probed on a bit more. I only realized after the session . . . I could have asked more open-ended questions instead of really closed ended questions." SC4 stated, "I could've asked more questions, I could've communicated better with the client." SPP3 mentioned the need for more probing into relevant areas, and SPP4 indicated the need for the SC to demonstrate more interest in the SPP. Furthermore, SPP1 suggested that questions could have been more tailored rather than general, whereas SPP2 felt that questions could be more open ended in nature.

Contrary to the reflections by other SCs, one SC mentioned that she did not feel it necessary to reflect on her communication and interaction skills due to familiarity with her peer and the standardized scenario: "I don't think I paid as much [attention] to any non-verbal cues or body language. Mostly because I felt like it wasn't all that necessary and it, it was you know, something from a script . . . it was a standardized thing, and it was more with my partner."

Theme 2: Providing Feedback Is Challenging Despite "Patient" Familiarity

In comparison to case history taking, all SCs noted challenges with giving feedback despite familiarity with their peer as the SPP. SC1 suggested that giving feedback was more challenging than case history taking: "Case history, I don't think there were any particular challenges. I think in feedback, I don't feel like I was able to give the results back in a way that was cohesive enough . . . or in a way that was, short enough so that the patient understood what I was saying." Challenges experienced by SCs included the ability to be cohesive and succinct, simplifying information without the use of jargon, balancing the amount of information shared while providing sufficient explanation to ensure understanding, and explaining a potential diagnosis to the patient without alarming them into thinking its "big" (SC4). SC4 also mentioned feeling "stiff" rather than flexible in her interaction with the SPP, as well as feeling overly familiar with the simulation

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process and it being different to a consultation with a real patient.

Theme 3: Room for Improvement With Feedback Giving

Interview data from SPPs corresponded with self-reflections by SCs regarding challenges and improvements to feedback giving. Their suggested improvements were to avoid the use of jargon, provide comprehensive information pertaining to recommendations, and adopt a more patient-centered approach to interaction. Two SPPs (SPP1 and SPP3) made mention of the explanation of the anatomy of the ear as positive aspects to feedback, which may be due to their own similar practice, their understanding and familiarity (as students) with the anatomy of the ear, or their inability to reflect as the patient. These sentiments were echoed by some SCs who felt they had achieved simplification of information by using the picture of the ear and an explanation of the audiogram. For example, "I used the picture . . . also just taking out the audiogram to outline what is it that I'm talking about, for them to also see" (SC3); "What I did is I took out a pic of the ear and I explained the ear in, you know as much detail as necessary. Showing her all the tests we did and why we did them, her actual audiogram and her results, helped" (SC2).

Although SPPs expressed satisfaction with the feedback provided by the SCs, there were more points for improvement related to feedback giving. For example, SPP1 suggested the need to be aware of the use of jargon: "I think she used one or two words that kind of associate more to the practice of audiology that I as a patient wouldn't necessarily understand because I don't have that background knowledge." Similarly, SPP2 mentioned, "There were a few instances where I was a bit confused about some of the words she used, but I did ask for some clarification."

SPP3 suggested the need for more information pertaining to the recommendations, "maybe about the hearing aids, I don't know which ones I would need. Would I need to go back to the clinic to get more information on that? Will they know which ones I will need? or . . . I don't— I don't really know. I'm confused with that." SPP4 expressed some hesitancy in providing input but suggested that the SC could have been more open and forthcoming with a need to be more patient centered, "showing more interest, cause it almost felt as though I was— I was a burden or like she didn't want to see me or I'm wasting time. More patient-centered. Using those skills."

Discussion

Findings from our study provide insight into students' communication practices during simulated peer role play consultations, as well as self- and peer reflection on these communication practices and taking on the role of a patient. Overall, our study findings indicated variability in case history taking skills among SCs. A script-like approach to feedback giving was observed, with occasional integration of case history information. Reflections by SCs regarding their case history taking practices were mixed, with some hesitancy about whether they thought it went well. Contrary to these reflections, overall reflections by SPPs were positive in terms of the relevance of the SCs' questions, with a need for improvement in terms of probing into relevant areas. Feedback giving was noted as a challenge by all SCs, particularly regarding balancing the amount of information while being cohesive and succinct and avoiding jargon. Similarly, SPPs raised the aspect of jargon and suggested the need for more comprehensive information pertaining to the recommendations. The use of a script-like approach to feedback giving noted in the videoed interactions was viewed as positive by SPPs and some SCs, particularly with regards to the explanation of the ear and audiogram. SPPs appeared to struggle to embody the role of the patient during reflection.

The communication practices of SCs in this study are consistent with findings from previous studies comprising interactions between qualified audiologists and real patients attending initial consultations, where extensive information related to the anatomy of the ear and audiogram was provided (Watermeyer et al., 2012, 2015, 2017). Although students may default to these practices because they feel familiar and "safe," they often lead to confusion among patients and do not aid in addressing their primary concerns and understanding of audiological findings. A more recent study with audiology students revealed similar practices before communication skills training, with notable changes post-training in terms of foregrounding the audiological results, diagnosis, and recommendations (Kanji et al., 2023). Despite the SPPs' familiarity with audiology in the peer role play scenarios, SCs still defaulted toward providing too much information. The excessive use of jargon and the need to ensure patient understanding were also highlighted through reflections by both SCs and SPPs. Our findings confirm those of other authors, for example, Pritchard et al. (2021) who studied peer role play in physiotherapy. Although flowing conversation and clear responses to questions posed were noted as improvements among physiotherapy students, negative communication behaviors included the use of jargon, misunderstandings, and confusion (Pritchard et al., 2021). Conveying too much information and the use of jargon may be due to the SC's familiarity with a peer or may be influenced by a lack of peer role play training and communication skills training, neither of which were addressed as part of the clinical practicum or employed as part of the methods for this study.

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Our study findings raise a broader question related to whether simulated peer role play interactions allow a sufficient platform, a "safe space," or a less intimidating environment to practice communication skills. These considerations are useful for simulated learning in contexts with increasing constraints in terms of funding and resources, particularly as recruitment and training of paid simulated patients (actors) may prove to be costly and real patients may not always be readily available (Keiser & Turkelson, 2017; Mandrusiak et al., 2014; Sharma, 2020). Despite these considerations, there are mixed findings on whether simulated peer role play facilitates the teaching and subsequent improvement in communication skills among health care professionals. An earlier study with first year medical students reported simulated peer role play to be valuable in terms of learning communications skills, as it provided opportunity for rehearsal with relative safety and allowed students to experience perspectives of the patient and interviewer. Unhelpful aspects included the lack of realism and the inability to transfer the skills learned to real situations (Nestel & Tierney, 2007). Findings from a study exploring physiotherapy students' perspectives and experiences of peer simulation (following completion of an online simulation-based program) indicated that students perceived this form of simulation to be surprisingly realistic and found it to be a valuable learning experience before interacting with real patients (Pritchard et al., 2021). Bagacean et al. (2020) compared medical students' verbal and nonverbal communication via student role play versus with an actor-simulated patient. Although their study findings demonstrated no significant difference between both approaches in terms of global communication skills, students were noted as having interacted more appropriately with the actor in terms of gathering background information and closing the sessions with future planning. Students were also noted to adapt their language and pay more attention to the actor as opposed to their fellow colleagues who would be on a par with them in terms of clinical knowledge and know what to anticipate. Similar findings were also noted in earlier literature where teaching of communication skills via standardized patients yielded better assessment outcomes in comparison to peer role play (Schlegel et al., 2012). Hence, there is a need to consider the notions of familiarity and realism within simulated peer role play interactions.

Evidence from our study shows that some students struggled to reflect from a patient's perspective. Thus, increased empathy may not always be achieved in simulated peer role play even though it has been shown to improve the empathy skills of pharmacy students, for example (Denvir & Briceland, 2023). This difficulty was evident in the reflections where some students viewed communication skills as unnecessary to focus on given that it was a standardized consultation, where SPPs were uncertain as to whether to reflect as a patient or a fellow SC, and their experiences were noted as being different from a consultation with a real patient. Alinier and Oriot (2022) suggest that when there is an absence of perceived realism, students may find it challenging to immerse themselves in a scenario and may experience difficulty responding as if they were confronted with a real scenario. These authors provide some solutions to addressing the challenge of realism through the inclusion of presimulation debrief activities and preparing students to engage with simulation activities with a holistic focus on technical, professional, and communication skills.

Although the simulated interactions analyzed in our study allowed some opportunity for students to practice case history taking and feedback giving, it is not equivalent to them having had the opportunity to communicate with a real patient as evidenced by some of the reflections from the students. The use of simulated peer role play may be a cost-effective option in a context such as ours where access to clinical placements and availability of clinical educators is challenging. However, it cannot be implemented in a haphazard manner without sufficient student preparation.

Implications

Preparation of students is required to ensure successful engagement from students and an effective learning process. This preparation should involve sufficient training for them to engage in the simulation and truly step into the role of a real patient. Prebriefings should be important to inform students about the limitations of the simulated scenario and to prevent misunderstanding. They can also help clarify the expectation of the activity as students may often focus on the technical skills required for clinical procedures and not incorporate other aspects related to professional conduct, behavior, and communication with the simulated participants (Alinier & Oriot, 2022). If communication skills are one of the outcomes of simulated tasks, this needs to be made explicit to students. Nestel and Tierney (2007) offer guidelines for the effective use of simulated role play to develop patient-centered interviewing or case history taking skills. These guidelines include clearly stated aims and objectives, provision of sufficient time for preparation for roles, an explanation of the benefits of playing all roles, and opportunities for written reflections and debriefing. Briefing is also beneficial for provision of context, so that students can relate to the simulated scenario as a real clinical encounter. This would have been particularly useful for the students in our study, as it was their first peer-simulated experience. Various aspects of the simulated activity should be explored immediately after completion of the activity. Pritchard et al. (2021) provide an overview of a simulation-based program,

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which may also serve as a useful guideline for inclusion within undergraduate curricula, particularly regarding preparation and debriefing. It may also be useful to embed simulation in a developmental approach to communication skills training, so that students are able to move toward using these skills in real-life contexts in a scaffolded way.

We have provided a workshop on clinical communication skills to other cohorts of students, which is typically focused on the importance of communication in audiology consultations, layers of complexity and uncertainty, and a reflective exercise based on a simulated feedback session in an audiological consultation by the Ida Institute (n.d.). It would be useful to continue with this training and for it to be more explicitly embedded within the undergraduate curriculum, at points when students start engaging with clinical work, so that it may also afford opportunity for reflection and transition from theory to practice.

Future studies should focus on analysis and reflection of the simulated interaction, as well as on students' reflection on simulated experiences. It may also be beneficial to explore how students perform pre- and post-receipt of simulation training as simulated patients.

Limitations

Due to the rapid changes during the COVID-19 pandemic and the urgent need to ensure that students obtain clinical hours through clinical practice, students were not trained to be simulated peers. Although this is a limitation, it is also a point of reflection for future simulated learning activities, as students cannot be expected to take on the role of a simulated patient or standardized patient without training or solely via the use of a script. The study, which was exploratory in nature, also included a small sample size. The study did not explore the differences in clinical communication skills with and without the use of simulated role play, although we have been able to compare the findings of this study to others conducted with SCs at this university (Kanji et al., 2023). We acknowledge the limitation of having students respond as patients during the interview that could have been better facilitated with a debrief with the clinical educator.

Conclusions

Simulated peer role play can provide opportunities for students to practice communication in undergraduate curricula. However, implementation of these simulated peer role play consultations requires the objectives of simulation to be clearly defined for students. In addition, sufficient training, prebriefing, briefing, and debriefing need to be provided to students for them to play and reflect on the role of the real patient. An intentional inclusion of communication skills training would also prove beneficial to students.

Data Availability Statement

All data generated or analyzed during this study are included in this published article.

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