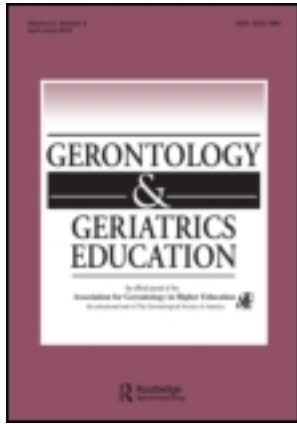


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### Medical Readers' Theater: Relevance to Geriatrics Medical Education

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## Medical Readers' Theater: Relevance to Geriatrics Medical Education

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*Medical Readers' Theater (MRT) is an innovative and simple way of helping medical students to reflect on difficult-to-discuss topics in geriatrics medical education, such as aging stereotypes, disability and loss of independence, sexuality, assisted living, relationships with adult children, and end-of-life issues. The authors describe a required MRT experience involving third-year medical students on their Family Medicine clerkship and volunteer residents from a nearby continuing care retirement community. Evaluation of the program shows positive benefits to student and senior participants in terms of greater awareness of each other's perspectives and improved communication.*

**KEYWORDS** *readers' theater, geriatrics medical education*

The use of theater-based pedagogical strategies in medical education goes back at least four decades, with the introduction of simulated patients in the late 1960s (Barrows, 1968). Standardized patients, now in widespread use in medical student training, rely on detailed scripts performed by a trained

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actor who not only enacts the history of present illness and physical symptoms, but also portrays identifiable affective dimensions and communicative styles in an interaction with a real medical or other health professional student (Erby, Roter, & Biesecker, 2011). Other forms of theater-based education have also been incorporated into health professions education, such as improvisational theater (Newcomb & Pardue, 2004; Riddlesperger, 2007), interactive theater (based on theater of the oppressed; Boal, 1979) (Kumagai et al., 2007), and attendance at medically themed live theatrical performances (Deloney & Graham, 2003; Ross, Heys, & Galley, 2010; Shapiro & Hunt, 2003).

Theater is considered to have particular advantages in the medical education environment. The one most often mentioned is that it encourages emotional engagement and moral imagination, as well as conceptual and knowledge learning (Arawi, 2010; Newcomb & Pardue, 2004; Riddlesperger, 2007; Torke, Quest, Kinlaw, Eley, & Branch, 2004). Because imaginative entry into other lives forms the core of any theatrical performance, engaging in this modality encourages students to exercise empathy ("What would it be like . . . ?" "How would it feel if . . . ?") (Case & Brauner, 2010). Compared to being passive spectators at a lecture, for example, students-as-audience become "entangled" in a dramatic scenario yet have sufficient emotional distance to simultaneously engage in critical analysis (Arawi, 2010). More than one half the students viewing a performance of the play *Wit*, about a woman dying of ovarian cancer and her-often callous physicians, reported it to be much more useful than traditional educational modes such as lectures in conveying information and stimulating reflection about end-of-life issues (Lorenz, Steckart, & Rosenfeld, 2004).

Further, in contrast to the standardized patient encounter, which typically occurs between a single student and a single patient, theater allows for more voices to be present, thus incorporating multiple perspectives that further encourages empathy and identification with the other (Kumagai, Kakwan, Sedique, & DiMugno, 2010; Newcomb & Pardue, 2004; Riddlesperger, 2007). Not only are there often more characters presented in the play itself, but the audience is a communal rather than an individual entity, thus developing a sense of group identification (Homan, 1994). Live theater also allows for the possibility of direct audience interaction with the actors (Bell, Wideroff, & Gaufberg, 2010; Savitt, 2010), a dynamic way of directly probing different points of view. Other scholars (Kumagai et al., 2010; Matharu, Howell, & Fitzgerald, 2010) note the disruptive potential of live theater to "unbalance" the audience's conventional thinking by creating cognitive disequilibrium about sensitive topics, such as race, class, sexual orientation, and gender, that explores their implications for social justice. Matharu et al. (2010) reported that students seemed to work particularly hard in this forum to fully understand characters very different from themselves in terms of values, priorities, and life experience.

Medical Readers' Theater (MRT) is a variation on readers' theater, a technique used by actors to emphasize vocal expression rather than visual storytelling (Coger & White, 1973) and by K–12 educators to improve student literacy and fluency (Sloyer, 2003). In readers' theater, readers do not memorize lines but read expressively from a script, without costumes, blocking, props, or other visual support. Similarly, in MRT, participants are not expected to be trained actors. No memorization or staging or advance preparation is necessary, as participants read from scripts provided by facilitators. Skits take no more than 10 to 15 minutes to present. Those not directly involved in the skit serve as the audience. Performance of the skit is followed by a group discussion ideally facilitated by a physician and a nonphysician medical educator. MRT is appropriate for many medical educational venues and is usually positively evaluated by participants. It is especially useful in exploring the human dimensions of health care.

Professor Todd Savitt from East Carolina University, who pioneered MRT, contended that it has an immediacy that makes listeners pay close attention and become emotionally involved in the action (Savitt, 2010). Some medical educators believe that MRT offers a particularly valuable method of encouraging reflection in students (Bell et al., 2010; Savitt, 2010). Savitt (2010) used MRT to address topics such as the patient–doctor relationship, medical professionalism, bias and prejudice, organ donation, chronic illness, death and dying, and aging. Other medical educators have used MRT to explore issues of power in medicine (Fetters, 2006) and end-of-life care (Torke et al., 2004). Dr. Guy Micco, University of California, San Francisco School of Medicine, introduced MRT as a method for teaching medical students about the challenges of aging and mounted MRT sessions involving students and seniors (Micco, personal communication, October 11, 2008). MRT has been described as an “aesthetic” teaching strategy (Newcomb & Pardue, 2004) because it encourages creative thinking and the discovery of personal meaning in an experience. Like other forms of theater-based teaching, MRT appears to encourage concern for patient-centered care, enhancement of empathy, opportunity for reflection, and greater connection with other learners.

At University of California, Irvine School of Medicine (UCI-SOM), we decided that MRT offered interesting possibilities for introducing medical students to some of the complex attitudinal and emotional issues involved in caring for aging patients. Medical students can learn facts and figures about older patients, but it is often the human connection that really promotes understanding of the whole spectrum of the aging process. Such broad-based understanding is especially important for students who may have little contact with older people except on hospital wards, where they encounter individuals who are often extremely sick with multiple medical problems. We believed MRT could provide a foundation for bringing medical students and elders together, not as student-doctors and patients, but as individuals sharing an interest in the social and health issues implicated in aging.

The goals of the MRT program at UCI-SOM are to provide an opportunity for students/seniors to interact with each other around issues of significance to both, such as those listed above; to reflect on each others' perspectives; to have an enjoyable, memorable interaction between two groups that normally do not have much contact; and to think about how what is learned in the MRT session can be translated into the clinical context. Specifically, we wished to discover whether exposure to MRT could exert a positive influence on students' insights about aging and health-related issues, could deepen students' understanding of older persons' perspectives about aging, and could suggest ways of interacting effectively and respectfully with older patients. We were also interested in whether participation in MRT could have an effect on seniors in terms of their influencing medical students' attitudes toward older persons, helping them to reflect on issues related to aging, and suggesting ideas for improving interactions with their own physicians.

## METHOD

### Sample

Participants were 98 medical students (48 females) in Year 1, and 103 medical students (42 females) in Year 2. We did not collect information on student age or race/ethnicity. Twenty residents (13 females) from a local continuing care retirement community (CCRC), Regents Point (RP), also participated, 9 of whom (6 females) attended MRT sessions regularly. The remaining 11 attended at least one session. Regents Point residents were between age 70 and 90 years.

Our MRT program involved the partnering of several entities, including the Program in Geriatrics, the Program in Medical Humanities & Arts, the Department of Family Medicine, and Regents Point (RP), a CCRC located near the University. RP is home to 400 residents, offering a continuum of care from independent living to skilled nursing. It also has a Alzheimer's/dementia wing. The facility has a longstanding relationship with the School of Medicine, in that volunteers from RP participate in many educational activities such as panels on aging and serving as standardized patients.

Participants in the MRT program include rotating groups of 8 to 10 third-year medical students who, as part of the Family Medicine Clerkship, are required to attend the session, a PhD medical educator with a background in psychology and humanities who serves as the facilitator, a geriatrician, and 8 to 10 interested RP residents. RP residents were recruited through an informational presentation at a resident meeting (Years 1 and 2), recruitment fliers, and word of mouth. They receive no compensation for their participation. Although the students are different each session, a core group of five to eight RP residents returns on a regular basis, supplemented by a few new residents each time. The facilitator has many years' experience leading

|   |
|---|
| Introductions of students and Regents Point residents—10 min<br>Warm-up exercise (dyads and triads) (Surprise me!; Truth or Lie?; Most Important Qualities in a Doctor; Similarities Contest)—20 min<br>Discussion of warm-up exercise (large group); themes of ageism, assumptions, stereotyping—15 min<br>Students and residents volunteer for skit roles—5 min<br>Reading of skit—15 min<br>Discussion of themes of skit and sharing of personal experiences—20 min<br>Summary and wrap-up—5 min |
|---|

**FIGURE 1** Outline of typical Medical Readers' Theater session.

educational small groups, and participated in two workshops led by Todd Savitt, the founder of MRT.

The MRT structure consists of one required 1½ hour session/month as part of the third-year family medicine clerkship (see Figure 1). All students receive a packet at the start of the session that includes salient facts about the percentage of patients age 65+ in every major medical specialty; as well as one to two academic articles that address the particular topic under consideration for that session. The session begins with introductions and a warm-up exercise in which the group breaks into dyads or triads consisting of one to two medical students and an RP resident. Examples of warm-up exercises include “sharing one thing about yourself you think the other person would be surprised to learn,” “writing down two truths and one ‘lie’ about yourself and seeing if your partner can guess which is which,” “residents describing what is most important to them in a physician,” and a contest to see which team can identify most things in common between student and RP resident.

Students and RP residents then volunteer for roles in a geriatrics-themed skit (see Figure 2 for a list of skits and topics; see the appendix for an example of a skit). Because most skits were adapted by JS or written by JS and BC, only two skits were purchased online. Of the 11 scripts utilized in Year 1 (we repeated one script twice), we used 10 in Year 2 and added 2 new scripts. Students and residents with no reading role make up the “audience.” After the “performance,” all participants join in a group discussion led by the medical educator and geriatrician, which first concentrates on issues raised by the performance, then segues into what students can learn from RP residents' personal encounters with the issue under consideration. These issues include aging, disability, doctor–patient relationships, stereotyping of older patients, communication barriers, loss of independence, end-of-life, dementia, and health care for aging individuals. Students and residents are encouraged to role-play different ways of communicating with each other about the topic under discussion and have an opportunity to see the effect that these various approaches produce on others. Each discussion concludes

"Emily" (adapted from "Lousy on Admission", from *Travels*, by Michael Creighton) – ageist stereotypes, patient autonomy  
 "That Which is Left Unsaid" (adapted from short story of the same name by Loreen Niewenhuis) – end-of-life decisions, cancer, doctor–patient–family relations  
 "A Medical Diptych" (adapted from short story of the same name by Ronald Pies) – sexuality and aging, death and dying, doctor–patient relationship  
 "Pills" by Beverly Cho – assisted living; medications; complementary medicine  
 "Clara's Cruise" by John Boland – medical decisions re end of life, family dynamics  
 "Getting Ready for the End" by Johanna Shapiro – POLST, Advance Directives for Healthcare, family dynamics, doctor–patient–family interaction  
 "Driving Mrs. Dayzee" by Johanna Shapiro – driving in the elderly; family dynamics; physician's role in revoking driver's license  
 "Old Ladies' Table" (adapted from short story of the same name by Louise Farmer Smith) – assisted living; dementia; social support  
 "When My Mother Stopped Breathing" (adapted from short story of the same name by Liz Rosenberg) – family dynamics; death and dying; letting go  
 "Toenails" (adapted from a short story of the same name by Richard Selzer) – physician value of service to the indigent  
 "Silences" by Brandon Daughtry Slocum – coping with recent widowhood  
 "Frank's 75<sup>th</sup> Christmas" by Brandon Daughtry Slocum – adjusting to retirement, aging  
 "Wings" (adapted from a play of the same name by Arthur Kopit) – coping with the aftermath of a severe stroke; doctor–patient relationship

**FIGURE 2** Geriatrically themed skits — University of California, Irvine School of Medicine.

with a "summing-up" that explores implications of the topics addressed for providing optimal health care to elderly patients.

We collected student evaluations after each session. There was no pretest administered because the evaluation was a standard educational assessment used to determine the students' response at the conclusion of the teaching session. Student evaluations used a 7-point Likert-type scale to determine students' perception of the usefulness of the experience, insights gained into aging and caring for elderly patients, and understanding of older individuals' perspectives about a range of issues. RP residents were assessed 10 times during Year 1 (Sessions 1–10) and twice during Year 2 of the program (Sessions 3 and 8). We repeated administration of the senior questionnaire in Year 1 for educational reasons. Because we were using different scripts and making session-by-session adjustments in the format and getting-acquainted exercises, we wanted regular feedback from the seniors who had at least partial continuity from session to session, which the students did not. Because a core group of residents as well as new residents attended the MRT sessions, and because resident evaluations were anonymous, we were unable to determine whether a given evaluation was completed by a returning or a new RP resident. Residents' questionnaire used a 3-point scale to assess the extent to which participating in MRT improved their ability to communicate with their own physicians, made them feel they had made a positive difference in how medical students would treat older patients in

the future, and helped them to reflect on difficult issues of aging. Student and resident questionnaires also asked about the enjoyability of the MRT experience.

### Data Analysis

Statistical tests were conducted using SPSS Statistics (Version 19). Four of five student questions employed 7-point Likert-type scales, whereas one question used a yes/no format. The residents' responses used a 3-point Likert-type scale. Because Likert-type data do not have a regular metric (i.e., the equivalence of the interval between agree vs. disagree, and disagree vs. strongly disagree cannot be determined numerically), we used Pearson's chi-square analysis to compare student responses from Years 1 and 2 (Table 1) as well as senior participants' responses from Years 1 and 2. In the analysis of data from seniors, we used the combined data from Sessions 3 and 8, Year 1 with the combined data from Sessions 3 and 8, Year 2, to compare equivalent periods of time (Table 2).

This project was reviewed and approved by our Institutional Review Board.

**TABLE 1** Student Evaluations of Medical Readers Theater: Comparison of Years 1 and 2

| Responses <sup>a</sup>   | Year 1    | Year 2    | Pearson<br>chi-square | Significance<br>(2-sided) |
|--|-----------|-----------|-----------------------|---------------------------|
|  | n (%)     |           |                       |                           |
| Overall rating   |           |           |                       |                           |
| 6-7  | 67 (75.3) | 66 (75.0) | .002                  | 1.000                     |
| 1-5  | 22 (24.7) | 22 (25.0) |                       |                           |
| New insights about aging/<br>caring for geriatric patients                   |           |           |                       |                           |
| 6-7  | 63 (70.8) | 64 (72.7) | .082                  | .868                      |
| 1-5  | 26 (29.2) | 24 (27.3) |                       |                           |
| Improved understanding of<br>elders' views of lives/health<br>care           |           |           |                       |                           |
| 6-7  | 65 (73.0) | 69 (80.2) | 1.263                 | .288                      |
| 1-5  | 24 (27.0) | 17 (19.8) |                       |                           |
| Issues relevant to geriatric<br>health care presented in<br>enjoyable manner |           |           |                       |                           |
| Yes  | 81 (97.6) | 80 (98.8) | .315                  | 1.000                     |
| No <sup>b</sup>  | 2 (2.4)   | 1 (1.2)   |                       |                           |
| Session useful in terms of<br>future   |           |           |                       |                           |
| 6-7  | 62 (69.7) | 67 (76.1) | .938                  | .399                      |
| 1-5  | 27 (30.3) | 21 (23.9) |                       |                           |

<sup>a</sup>7-point Likert-type scale from 1 (*poor*) to 7 (*outstanding/very much*), except as noted.

<sup>b</sup>Two cells have expected count less than 5.



**TABLE 2** Senior Participants' Views of Medical Readers Theater (MRT): Comparison of Years 1 and 2<sup>a</sup>

|   | Year 1           | Year 2           | Pearson<br>chi-square | Sig.<br>(2-sided) |
|---|------------------|------------------|-----------------------|-------------------|
|   | ( <i>n</i> = 16) | ( <i>n</i> = 18) |                       |                   |
|   | <i>n</i> (%)     |                  |                       |                   |
| Session improved my understanding of how to communicate more effectively with doctors     |                  |                  |                       |                   |
| Agree   | 4 (25.0)         | 13 (72.20)       | 8.343                 | .015              |
| Somewhat agree  | 10 (62.5)        | 5 (27.8)         |                       |                   |
| Disagree  | 2 (12.5)         | 0                |                       |                   |
| This session helped me feel I made a difference in how students will treat older patients |                  |                  |                       |                   |
| Agree   | 8 (50.0)         | 14 (77.8)        | 2.862                 | .091              |
| Somewhat agree  | 8 (50.0)         | 4 (22.2)         |                       |                   |
| MRT helped me reflect on some difficult issues in healthcare                              |                  |                  |                       |                   |
| Agree   | 11 (68.8)        | 18 (100)         | 6.595                 | .015              |
| Somewhat agree  | 5 (31.3)         | 0                |                       |                   |
| MRT was an enjoyable way to interact with medical students and I would participate again  |                  |                  |                       |                   |
| Agree   | 16 (100)         | 18 (100)         | N/A                   |                   |

<sup>a</sup>At each session, questionnaires were completed by both returning and first-time seniors (see Method).

## RESULTS

### Student Evaluations

Of all third-year students 89.1% were represented at the MRT sessions. Of the total number of possible students, approximately one student per session was excused for a vacation day, illness, or personal emergency. All students who attended the session completed an evaluation form. Because student evaluations were anonymous (in accordance with standard curriculum assessment procedures at our institution), we were unable to conduct analyses by gender or race/ethnicity. There were no significant differences between student evaluations in Years 1 or 2 (Table 1). Overall students evaluated MRT sessions highly in terms of developing new insights, understanding the perspective of elders, presentation of relevant geriatric issues, and utility and value for future clinical situations (Table 1). Positive narrative responses on the evaluations focused on the creativity of the experience, the way it stimulated discussions of potentially difficult-to-discuss topics, the opportunity to interact with seniors and hear their perspectives, the encouragement to actively reflect on and problem solve the care of the elderly, and challenging assumptions and stereotypes. Negative narrative responses

**TABLE 3** Examples of Student Narrative Comments by Year

---

Positive  $n = 74$

- Wonderful opportunity to interact with seniors (51) (years 1, 2)
- Insightful to hear other perspectives (38) (year 2)
- Input from seniors was informative and insightful (32) (year 1)
- Creative way to examine end of life issues, sexuality, retirement, professional burnout, medical mistakes, and other difficult-to-discuss topics not discussed in medical school (23) (years 1,2)
- Refreshing to share life stories (17) (year 2)
- Challenged us to reflect on the care of elders (14) (year 2)
- Reminder not to generalize, make assumptions (12) (year 1)
- Interesting to hear RP residents explain aspects of the skit that are relevant to their current lives (8) (year 1)
- Valuable educational experience all students should have (7) (years 1,2)

Negative  $n = 12$

- More focus on seniors' experiences with/view of doctors needed (8) (year 1)
- Not enough on residents' perspectives; more time talking to residents (6) (years 1,2)
- More issues relevant to geriatric medicine needed (year 1) (6)
- Reading fiction is a waste of time, does not advance an understanding of medicine (3) (year 1)

---

were skeptical of the use of humanities in medical education, and expressed a desire to spend more time talking to the seniors (Table 3).

### Senior Evaluations

Seniors participating in the experience found the MRT sessions valuable and enjoyable. In both years, 100% of respondents agreed that MRT was a positive experience and they would like to participate again. Residents' attitudes toward MRT improved significantly in the Year 2 on two of the four questions (ability to communicate with personal physicians and ability to reflect on difficult issues associated with aging; Table 2). Residents provided few narrative comments on their evaluations but expressed concern in Year 1 about the length of the skits, and in Year 2 about encouraging the students to participate more actively in the discussion (Table 4).

**TABLE 4** Seniors' Narrative Comments

---

Positive  $n = 15^a$

- Informative, thoughtful, open discussions with medical students (9) (years 1,2)
- Good insights into health care, aging, and doctors (8) (years 1,2)
- Hearing students' and fellow residents' various opinions and views (8) (years 1,2)
- Ability to interact and influence future doctors (10) (years 1,2)

Negative  $n = 8^b$

- Scripts and/or discussions too long (3) (year 1)
- Wish students would talk more (5) (year 2)

---

<sup>a</sup>Total number of questionnaires with at least one positive written comment.

<sup>b</sup>Total number of questionnaires with at least one negative written comment.

## DISCUSSION

From a theoretical perspective, we believe that MRT offers an important supplement to the more passive, didactic forms of knowledge and information transmission prevalent in medical education. Learning theory (Kolb, 1984) argues that the most effective skill acquisition occurs when the educational method employed is active and experiential, and when it develops and transforms the learner. MRT accomplishes the aims of active and experiential learning by enabling medical students to construct knowledge from a process consisting of a) concrete experience, which involves learning by doing (participation in role-play as reader or audience); b) reflective observation, which involves thinking about the learning experience (facilitated discussion); c) abstract conceptualization, which involves drawing conclusions based on the experience and observation (the summing up of implications for future practice); and d) action involving application of new information and experience (enactment of learning in other contexts) (the latter recommended to students, but currently with no supervised follow-up.)

### Influencing Student Attitudes

At the start of each MRT session, we ask students how many are considering a career in geriatric medicine. Over a 2-year period, we identified exactly three students who planned to become geriatricians. Admittedly, these were third-year students with often only vague intentions about specialty choice. Nevertheless, this evidence follows disturbing national trends that indicate though the population ages, the numbers of residents interested in geriatrics specialization is decreasing (Institute of Medicine, 2008). Therefore, one of our goals was to challenge stereotypes about aging by humanizing and individuating older persons through the skits utilized and the interactions with seniors.

Follow-up conversations with participating students led BC, then a fourth-year student, to conclude that, in fact, students held more positive views of older patients after participating in the MRT session. Specifically, students were surprised at and appreciative of how open older individuals were to talking about "sensitive issues," how interesting, funny, and mentally acute they were, and how rich their life experiences had been. In discussing health care issues with the seniors, students were impressed by their knowledge about their own medical conditions, about the Medicare system, and about healthcare in general. Students believed that the MRT experience improved their ability to interact and communicate effectively with older patients in nonstereotypical and noncondescending ways.

## Collaboration Between Seniors and Medical Educators

The facilitators discovered that older people can become skilled and insightful medical educators. Over a period of several months, the regular core of RP residents transformed from rather reluctant and awkward participants to individuals who understood the educational goals of the session and initiated discussions and made self-disclosures to advance these goals. We hypothesize that the increased level in commitment to the MRT program and the greater confidence and competence of the senior participants in themselves as “medical educators” contributed to the heightened satisfaction reported in Year 2 of the study.

We observed that it is empowering for older persons to become collaborators in an MRT performance. Based on his own experience using collaborative theater, Homan (1994) concluded that the group effort of an ensemble, of patients and students working together, provides a model of team problem-solving that incorporates rather than excludes the patient. We discovered that older individuals, who often report being ignored or marginalized in a youth-oriented society (Vincent, Tulle, & Bond, 2008), experienced a similar sense of being heard and attended to through the experience of MRT.

## Value for Geriatricians?

Although not formally assessed in this study, MRT might offer insights and benefits for participating geriatricians as well. One geriatrician involved in several MRT sessions felt that MRT provided a revealing glimpse into the lives of generally healthy, functional older adults in an elder community and helped her see how important social issues are in the lives of these residents. She was also struck by the degree of frustration residents expressed with medical care. She further noted that sessions provided insights into the thinking, beliefs, and attitudes of medical students regarding the lives of older adults. Finally, she observed MRT helped her to consider her own beliefs, and attitudes regarding elder care and regarding medical students.

## Beyond Talking

We also believe that MRT provides a beneficial supplement to “simply chatting” by “drilling down” into difficult-to-discuss issues that might not come up in casual conversation. Several students commented that they would have preferred spending the entire time “just talking” to the RP residents, rather than engaging in the skit. Although casual conversation is a valuable form of engagement, in our experience bringing together students and seniors simply for informal interaction can remain at a superficial level. The added

value of the MRT script is that it initially tackles a difficult issue “in the third person,” so that students and seniors alike can begin to explore the issue as it affects fictional characters. This provides a sense of safety from which it is easier to segue into deeper, more intimate personal experiences.

### Clinical Implications

Finally, we speculate that what happens in an MRT performance has relevance for actions in the real world. Deloney and Graham's work (2003) with the drama *Wit* led them to conclude that watching a dramatic performance combined with guided discussion can influence learners toward attitude change. Similarly, we think it is possible that participating in MRT performances can help students reconsider their attitudes and interactions with older patients. In this study, students and residents reported that they believed their health care–related communication skills to have improved as a result of participating in the session. Informal interactions with students after the MRT session suggested they believed that they would be more comfortable talking with older patients; and especially in addressing sensitive topics such as sexuality, cognitive decline, physical disability, fears, anxieties, and depression. Similar conversations with RP residents indicated that they too felt better prepared to address difficult issues such as loss of independence, sexuality, death and dying, and end-of-life care with their physicians. In addition, residents also felt they would be more likely to express their emotional needs in medical encounters; seek clarity and specificity when discussing bad news; appreciate the humanity of their doctors, as well as their risk for burnout; be more sensitive to physician time pressures; and try to build a trusting relationship with their doctors. We believe this perceived improvement in communication skills resulted because MRT provided the opportunity to not only read a given skit, but also practice alternative ways of interacting and assessing how the various characters responded to different approaches.

### Limitations

This study was conducted at a single institution, which may limit the generalizability of its findings. The evaluations of students and residents were brief and therefore may not have elicited negative and positive responses of participants. We did not assess student knowledge acquisition about geriatric health care issues; and, as noted, we did not assess students' or residents' attitudes prior to participating in the MRT experience. As discussed earlier, the seniors' responses were contaminated by a repeated measures problem and by the fact that returning residents completed multiple questionnaires. Further, because RP is a CCRC, which tend

to attract a different socioeconomic class of clientele than generic multilevel care facilities, it is possible that higher income and education levels in the participating RP residents influenced our results. Also as noted, we did not assess geriatricians' reactions to the experience.

## CONCLUSION

Despite its limitations, the results from this 2-year project suggest that MRT is an enjoyable and interesting way for students to learn about issues of relevance to older patients. It involves active, experiential learning that makes it more likely learners will integrate and remember their experience. MRT engages learners emotionally as well as cognitively and gives them a personal connection with older adults. As a result of the MRT session, students reported acquiring new insights into aging and geriatric healthcare, better understanding of the perspective of older patients on life and on health care, and useful applications for future clinical interactions; whereas seniors stated that the sessions gave them ideas about how to interact more effectively with their own physicians and helped them reflect on difficult issues, such as disability and end of life.

We believe that, because of the discussion and mini-role-plays following each skit performance, students and residents begin to develop practical skills for communicating with each other. However, although we encouraged students verbally to apply their experiences in MRT with actual geriatric patients, at present we have only anecdotal reports from students to confirm this application of learning from one context to another. Ultimately, innovative learning is only valuable to the extent that it results in improved patient care. Additional research must determine this crucial link. Future research should also assess the self-reported attitudinal shifts in a more objective manner, and determine whether they persist over time and how they are translated into actual clinical interactions with geriatric patients.

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APPENDIX—*DRIVING MRS. DAYZEE*

by Johanna Shapiro

## Characters

Mrs. Dayzee  
 Emily, daughter  
 George, son  
 Dr. Garden

- Narrator:* Mrs. Dayzee is an 86-year-old widow accompanied by her daughter Emily and son George on a visit to her primary care doctor, Dr. Garden.
- Dr. Garden:* Hello Mrs. Dayzee, Emily. (to George) And you are Emily's husband?
- George:* Emily's brother, George Dayzee.
- Emily:* He's just visiting. (*meaningfully*) He doesn't live here full time. He lives in New York.
- Mrs. Dayzee:* (*fondly*) George is my baby.
- Emily:* Mom, he's almost 60 years old!
- Dr. Garden:* It's nice to meet you. I'm your mother's primary care doctor, Dr. Garden. Mrs. Dayzee, weren't you in here just a few weeks ago?
- Mrs. Dayzee:* (*uncertainly*) I think so. Has it been that long?
- Emily:* Mom, you remember. You had a bad cold. I wanted to make sure it wasn't bronchitis.
- Mrs. Dayzee:* (*helpfully, to Dr. Garden*) I had a cold.
- Dr. Garden:* So how can I help you, Mrs. Dayzee?
- Mrs. Dayzee:* I don't need to be here. I feel fine today.
- George:* You're looking great, Mom!
- Emily:* (*irritably*) Now, mom, you know we discussed all this in the car. I'm very worried about you driving. Ever since you were diagnosed with MCI—doctor, what does that for again? Now *I* can't remember (*laughs nervously*).
- Dr. Garden:* Mild cognitive impairment.
- Emily:* Right. Well, mom, ever since then I just haven't felt comfortable with you behind the wheel.
- Mrs. Dayzee:* Emily, I'm just forgetful. It's natural. I'm 86.
- George:* I think your driving is great, Mom.
- Emily:* (*aside*) That's because you haven't seen her drive. If you think her driving is so "great," why did you tell *me* to drive over here?
- George:* (*uncomfortably*) Just faster.
- Dr. Garden:* Mrs. Dayzee, how are things going generally?
- Mrs. Dayzee:* Oh, fine, fine, I'm fine.
- Emily:* I've had to take over paying her bills.
- Mrs. Dayzee:* Well, the print is so small, I can't read them anymore.
- Narrator:* Emily mouths to Dr. Garden: "She's confused."
- George:* Just get her a new pair of glasses.
- Emily:* Her glasses are fine, George.



*Mrs. Dayzee:* I still do my own shopping and errands, (*turning to Emily*) without your help, thank you very much, missy.

*Dr. Garden:* Do *you* notice any problems driving, Mrs. Dayzee?

*Mrs. Dayzee:* Well, not really.

*Emily:* Mom, how can you say that? You've had more scrapes and fender benders than I can count.

*Mrs. Dayzee:* Emily, that old car is just hard to maneuver. It's an old boat. Yes, I did knock over Mrs. Johnson's trash can once—well, a couple of times—but you'd think I demolished her house, the fuss she made. And you see Emily, I still know how to use a word like "demolished"! (*to Dr. Garden*) I was an English teacher, you know.

*Dr. Garden:* I remember. I have to watch my p's and q's around you!

*Emily:* (*not to be deflected*) What about those dents on the driver's side? They weren't there last week.

*Mrs. Dayzee:* I bumped into a couple of posts in the parking garage. Honestly, I think they're making the stalls smaller these days!

*George:* Don't worry about it, mom, I've done exactly the same thing.

*Emily:* (*pulls out her trump card*) What about what happened on the freeway?

*Narrator:* Mrs. Dayzee is silent.

*Dr. Garden:* What happened, Mrs. Dayzee?

*Mrs. Dayzee:* It was just the one time.

*Dr. Garden:* (*gently*) Can you tell me what happened?

*Mrs. Dayzee:* I was driving on the freeway and suddenly I just didn't know where I was. I got off as fast as I could and called Emily. She made me get one of those cell phone thingies. At first I couldn't remember how to use it, but then I figured it out and she and Joe—that's her husband—came and got me.

*Emily:* I drove her home.

*Mrs. Dayzee:* It was at night, it was dark. I just got confused. I haven't driven on the freeway since then, and I won't. I can just stick to the neighborhood.

*Dr. Garden:* Mrs. Dayzee, I'm glad you've come in to talk about this; and I'm glad your children are here to support you (*looks meaningfully at George*). I'm concerned about you; and I'm concerned that your daughter is concerned. The people who know you best are often the ones who know when it might be time to reconsider driving.

*Mrs. Dayzee:* (*anxiously*) I am NOT going to stop driving! Then I'd be completely dependent on Emily to get around.

*Emily:* Mom, you know I don't mind driving you places.

*Mrs. Dayzee:* (*sharply*) That's not the point! I want to drive myself. (*Her voice rises*) *I want to drive myself!*

*Narrator:* Emily looks at Dr. Garden helplessly.

*Dr. Garden:* Mrs. Dayzee, I'm going to refer you to an occupational therapist at the hospital who can conduct a comprehensive driving evaluation. If they think you can still drive, you can enroll in an AARP safe driving class to improve your skills.

*Mrs. Dayzee:* What if I don't pass? I'm no good with tests.

*Dr. Garden:* Then I'm afraid I'm required by law to report your condition to the county health department. They'll contact the DMV, and they will revoke your license.

*Mrs. Dayzee:* (*agitated*) No, no. I won't be evaluated. I won't go. You can't make me.

*Emily:* Mom, please calm down.

*George:* Now look what you've done, Emily. You've upset mom.

*Mrs. Dayzee:* Dr. Garden, what if I promise not to drive on the freeway? I could only drive once a week, combine all my errands and shopping, do it all at once.

*Dr. Garden:* Mrs. Dayzee, I can see you're upset. Help me understand what's bothering you.

*Mrs. Dayzee:* (*whimpering a bit*) I don't want to lose my independence. I don't want to have to rely on my daughter. Next it'll be a nursing home.

*Emily:* Mom, that's not fair! You know I'll do whatever I can to keep you at home as long as possible.

*Mrs. Dayzee:* (*ignores Emily*) I'm losing everything. First my husband. Now driving. Next it'll be my home. (*She pauses*). I don't want to lose my independence.

*Dr. Garden:* It feels like you're losing everything.

*Mrs. Dayzee:* Yes, that's it. That's it.

*Dr. Garden:* Well, I don't want you to lose your independence. And neither does Emily. Or George.

*Emily:* No I don't, Mom.

*George:* The doctor is right, Mom.

*Dr. Garden:* But we all want you to be safe. Right, Emily? Right, George? So let's talk together about what we can do to help you keep a sense of independence, but make sure you're not at risk as a driver. Let's take first steps first. Would you be willing to go to the hospital for an evaluation?

*Mrs. Dayzee:* (*defensively*) I won't stay overnight.

*Dr. Garden:* You won't have to stay overnight.

*Mrs. Dayzee:* Then I'll go. (*She pauses*). Hmmm, we have to go on the freeway to get to that darn hospital.

*Emily:* (*quickly*) I'll drive you, mom.

*Mrs. Dayzee:* I think *George* should drive me. Emily needs a break, and after all, George, you're my baby!