

# Chapter Eight

## Using the Performing Arts to Encourage Emergence

*“Now, when so many certainties have become so many doubts, when so many dreams have withered on exposure to sunlight, and so many hopes have become so many deceptions – now that we are living through times and situations of great perplexity, full of doubts and uncertainties, now more than ever I believe it is time for a theatre which, at its best, will ask the right questions at the right times. Let us be democratic and ask our audiences to tell us their desires, and let us show them alternatives. Let us hope that one day – please, not too far in the future – we’ll be able to convince or force our governments, our leaders, to do the same: to ask their audiences – US – what they should do, so as to make this world a place to live and be happy in – yes, it is possible – rather than just a vast market in which we sell our goods and our souls.”*

(Boal, 1992. p. 247.)

In this chapter I tell the story of how I began the process of using my experience and knowledge of theatre-in-education and theatre for development in my practice as a facilitator of health care improvement. In relation to the Boal quote above, I believe that living the value of a passion for compassion is my way of doing this. I also share the research process I engage in as part of my work, how this then influences my devising process and the creation of a piece of theatre. Each piece of theatre discussed in this chapter is unique and each contributes to the development of the next as my practice and knowledge and understanding of my practice is extended.

As so often happens in life several events came together that prompted me to ask myself in what way could I develop the creative workshops even further. I was beginning to believe that there was a real possibility of introducing the concept of theatre for development into my work in organisational development. I began to look for an opportunity to take this further and had identified several areas where I felt that it would enhance

the work I was already undertaking. The first of these events occurred while I was attending a healthcare quality improvement conference in San Francisco. I had been asked to give a presentation on the work I had been doing with the dementia services in Swindon. (See chapter 6, “Breaking Down the Walls of Silence.”) This was a three-day event with examples of good practice from all over the world. There were also workshops and laboratory sessions, which explored the growing variety of tools and methods for performance improvement. I have attended most of these workshops over the years but my attention was immediately drawn to the final session of the day. This session was a performance of a play called *Charlie, Victor, Romeo*. This play had just completed a very successful run off Broadway. Don Berwick, a well-known American doctor and a leader of quality improvement in healthcare, had seen the play on a recent trip to New York with several medical colleagues. They had been struck by the similarities in the consequence of error in the airline industry, where the play is set, and the consequences of error within the medical profession. *Charlie, Victor, Romeo (CVR)* is a re-enactment of the time immediately before disaster strikes on 5 different air flights. The stories are based on the black box recordings from 5 real events. What is significant in the narrative is the way in which each scenario demonstrates what begins as a simple problem with relationships or communication can result in catastrophe. Don decided to invite the theatre company to perform the play at this conference.

I experienced the same sense of excitement that I experience at the start of any piece of theatre. The lights dim, my senses are awakened and heightened and out of the darkness emerges a scene. The play was intense and emotionally engaging, the performances were outstanding which made the impact of each disaster even more appalling. There was thunderous applause from the audience as the lights went up at the end and a sense of relief that it was over and we were all safe. Don came onto the

stage and thanked the actors and addressed the conference for the last time. He told us that there were plans to take the theatre on tour across America to other healthcare conferences and gatherings. He thanked us all for coming and wished us a safe journey home – and that was it – I could not believe it. I could not believe such a wasted opportunity. The theatre had engaged its audience completely; we had all made the connections and associations with what we do on a day-to-day basis. There was a tremendous opportunity for participants to now engage in the next step, and that opportunity had been lost. I was hurled into action and ran out of the hall to try to catch the actors to find out who was responsible for organising and funding the rest of their tour. I managed to track them down and had a somewhat rushed discussion with them about the theatre piece. They were a lovely group of actors, but they saw themselves just as actors and had not talked at all about the possibility of them developing a pedagogical role with healthcare professionals. They saw their responsibility simply as delivering the goods and that for them meant making sure they performed well as actors and no more. They did advise me to talk to their main contact who was the senior doctor with the National Patient Safety Foundation of the United States of America. She was also at the conference; in fact she had showed great interest in the presentation that I had given earlier. She was very responsive to our ideas about using the piece of theatre within a more educational and developmental framework. She asked me to consider putting together a proposal that she would be able to use to find funding to enable it to happen. We then went our separate ways, both with a sense of optimism about the potential for working together. Back in the UK we continued to talk about the potential of using theatre in quality improvement environments and the National Patient's Safety Foundation continued to seek enough funding for us to be involved in the American tour. Shaun and I prepared a proposal for working with Charlie Victor Romeo that we

believed would fully develop the use of this piece of theatre as a tool for education and development.

The proposal had four distinct stages to it.

1. Exposure to Charlie Victor Romeo – Theatre performance.
2. Deconstruction of the Theatre stimulus. Identification of Health Care parallels.
3. Reconstructing the parallels within a Health Care Context to storyboard.
4. Presentation of Health care re-enactments.

**Pick yourself up, dust yourself down and start all over again**

The negotiations for the funding of this project lasted for a four month period. (The proposal is attached as Appendix 7.) In the end they were just not prepared to fund us to come to America from the UK to undertake the project, preferring to find the expertise locally. This also failed as there was no-one available with the skills to do it and so the theatre piece continued on its tour. The format was changed a little to enable the audience to talk to the actors after the performance but I felt an enormous opportunity was lost. On reflection I was bitterly disappointed and at the time convinced that it was going to be very difficult or maybe even impossible to get funding to do this kind of work. I knew I had a long way to go before it would be taken seriously as a useful methodology for both organisational and personal development.

At the same time I was continuing with the work in the UK. I was also attending a weekly meeting of action researchers at the University of Bath. I was finding this group very supportive of my work and I was able to use this forum to test out ideas I was developing before putting them in to my practice as part of the development of a care pathway for dementia. (See chapter 6: Breaking down the walls of silence.) I was beginning to explore the use of fictional characters devised from my research findings in the dementia project. From this research I began to create characters that I could use to improve the way I communicate research findings to an audience. It is important to note here that each of these pieces of research was undertaken within a more traditional research framework that included, when appropriate ethics approval, which in each case was successful. The methodology used was often a combination of qualitative and quantitative methods and the data collected was always analysed using appropriate data analysis methods. The characters or theatre were devised from the evidence base created by the research. It is also important to note that permission from those contributing was always sought before devising the theatre and or for contribution to related educational purposes.

Using fictional characters in this way was proving to be a very powerful educational tool for the dementia project both with healthcare professionals and members of the public. Accessing much of the traditional research is a daunting prospect for many people. Ensuring that the characters developed are based on actual research can present the information in a much more humanistic manner. People not only have access to the research findings but can also experience the effect of the condition on a human being. This makes sure that the patient or carer is firmly included at the centre of the research and also at the centre of the research dissemination. The Monday action research group was a very useful forum in which to test out the characters and to gain feedback so

that I could develop them further and enable me to build confidence in using theatre for development in my role within healthcare. I had also been invited to contribute to the Alzheimer's International Conference which was being held in Christchurch, New Zealand. I saw this as an opportunity to use theatre and the characters I had developed from the research in an interactive way with the participants at the conference.

**Preparing for the Alzheimer's International workshop in  
Christchurch**

**New Zealand**



**“Dignified Decline”**

I had already begun to use 2 characters, Mary and Sue, (Transcript of these characters is attached as Appendix 9) as a way of connecting people I was working with the reality of living with or caring for someone with early dementia. The brief we were given for the New Zealand conference

was to do something innovative and participatory that would highlight the difficulties and provide some solutions to the problem of early diagnosis.

What we created used the informal format of a 'chat show' that focused on the patient's journey. Because of the relaxed nature of the presentation we hoped to encourage a greater level of participation than is usually achieved from the audience at this kind of event and thus developing a more inclusional approach. This format was very important because the Alzheimer's conference is unusual in that as it is organised by representatives of service users and carers there is also a significant number of service users and carers as delegates at the conference. We hoped that by creating this kind of structure for our presentation they would find it easier to engage and to feel included and that our session would not be dominated by contributions from the medical profession. We organised the performance space so that it represented a television chat show with a sofa and a coffee table. Shaun who played the chat show host spent a little time 'warming up' the audience and creating an atmosphere within which they felt comfortable. He also used this time to get to know a little bit more about who they were and what the professional / service user / carer mix was. This would enable him to direct the questions and to know which areas would be most appropriate to that specific audience. He then introduced the audience to his guests who included Roger, a consultant in old age psychiatry and Patrick, who is a general practitioner. He also introduced them to me and let them know that I would be playing a number of roles, all based on recent research to reinforce the patient and carer perspective. I would then be taking my place on the sofa to answer any questions that were directed at me or at any of the characters I had presented.

In the second half of the session we played a short video that I had developed for the conference which put some of the issues relating to



dementia in the UK into perspective. The video included interviews with healthcare professionals, service users and carers. This set the framework for the work I had been involved in in the UK and we felt it was a good vehicle to encourage dialogue with the delegates and to encourage them to talk about their experiences of the New Zealand system and identify similarities and differences between the two systems. This would also enable the chat show guests to anticipate where some of the questions may come from.

In section 3 Patrick was asked to describe the process a General Practitioner (GP) should go through when facing a person with early symptoms of dementia. This included the signs and symptoms that should alert them to consider the possibility of early dementia. The audience were then given the opportunity, with a lot of encouragement from Shaun in the role of the chat show host, to ask Patrick about the problems facing a GP and what might lead to him missing the early signs. The audience were then asked to listen to the patient and carer perspective of the issues surrounding early diagnosis and were introduced to the following two characters.

### **Mary and Sue**

*Mary is in her late 60's, she is fit and healthy, looking younger than her age and up until recently has led a full and active life. Mary met and married Ted in her early 20's. Ted died a year ago very suddenly from a heart attack. Mary has tried very hard during the past year to remain independent and not "become a burden to my children". Ted was a civil servant and they had a very comfortable life together. They had 3 children, 2 daughters and a son. Sue the eldest daughter lives very close to Mary and they see a lot of each other. Sue is head of the English Department in a local boy's school. She is married to Charles a very*

*successful and therefore busy criminal lawyer. His work requires him to put in very long hours and he is often away from home. They have 3 daughters of 13, 11 and 6. Olivia the youngest daughter has quite severe asthma and is often unable to attend school. Sue relies heavily on Mary to help her with the children, something that Mary is more than happy to do.*

*John, Mary's middle child and only son is also married. He lives in Surrey with his wife Jan. John is an Estate Agent and 2 years ago he decided to branch out on his own and opened his own agency, which he jointly runs with Jan. They are doing very well but have little time for anything else, including visiting relatives; they do not have any children yet.*

*Elizabeth is Mary's youngest child. Just before Ted died Elizabeth emigrated to New Zealand to help her husband run his families sheep farm. They have a 3-year-old daughter and Elizabeth recently gave birth to twin boys. She misses England and her mother and has tried in vain to persuade Mary to live with them in New Zealand.*

(The full script is attached as Appendix 8).

Mary and Sue were devised from the extensive research undertaken by me as part of a project called 'Breaking Down the Walls of Silence' (see chapter 6). The purpose of this project was to redesign services for people with dementia with the full involvement of those delivering and using the services. The devising process I used to develop the characters was based on the methodology of theatre-in-education and theatre for development. This process involves using a creative process alongside a pedagogical process in order to create fictional characters who tell a story. The characters in the story have to engage the audience in a way that they are able to experience the issues (identified by the research) that affect them and their lives. This process involves the actor, in this case myself, undertaking the research, analysing the research and then engaging in a

creative process that allows a character and a story to develop. This process although a creative process is also a very reflective and objective process as the actor is constantly checking what is being created in order to make sure what is being communicated is what is intended. The devising process can be a very intense time where it is crucial to find the correct balance between fact and fiction. The 2 scenarios devised for this event followed this process of creation and refinement and rehearsal in order to ensure the findings were being communicated.

What Patrick had described was the process, informed by research evidence and best practice guidelines, that patients should expect when visiting their general practitioner. The two pieces of theatre were also able to demonstrate from the research the reality facing many patients. Showing the contradiction in this way acted as a catalyst for the audience to discuss, in a very open and animated way, their experiences both as health care providers and users of the service. I believe that the discussion that followed these 2 scenarios was enhanced by their engagement and recognition of the stories and they were able to identify with the issues that affected the characters telling their stories. The conversation that the delegates had was a very different kind of conversation. What I experienced at this event was a level of engagement and a level of honesty as people, users, carers and health care professionals from all over the world that I had not previously experienced at events of this kind, where we had relied on more traditional ways of disseminating research findings. One of the tools we had developed and validated as part of the pathway process in the UK is the 6 question cognitive impairment test, (6 CIT). (See appendix 14 – Care pathway for Dementia).


Patrick, GP, had invested a lot of his time and energy into helping us to find a simple and quick tool that GP's could use to help them to recognise the early signs and symptoms of dementia. We had recommended this short test as a referral tool for GP's and its uptake had been quite

significant. Patrick then demonstrated, with the help of the character Mary, how to use this test. Members of the audience were also invited to come up and to try out the test themselves. I believe that at this point in the session what we experienced from the delegates was a level of trust that we had not previously experienced. We had been able to develop, because of the way in which the theatre had been able to influence, engage and as a consequence enhance the kind of conversation and relationships that developed.

The session engaged the audience to such an extent that we had to continue over the lunch break and delegates made the decision to miss lunch in order to have a little more time to discuss the issues. The feedback was almost unanimously positive, especially from those within the audience who were either sufferers of dementia or were carers of someone with dementia. The only criticism was that the session should have been given a more prominent place in the agenda of the conference and that there should have been a longer timescale allocated to it by the conference planners.

For me this event was a significant milestone in my drive to use theatre in organisational development. There has been a significant move recently to use patient story in order to improve services. Quite often it is difficult to involve vulnerable people in this way for very obvious reasons. By developing characters and devising scenarios based on the research it is possible to ensure that the voice of the vulnerable person is not excluded. It is also possible for me to combine many different issues within the one simple story line and using my knowledge of the devising process to create a story that the audience will engage with. This particular piece of work enabled me to continue the process of synthesising creativity and complexity within my role with a greater understanding of its importance and much more confidence in myself and my embodied knowledge. This

was another step forward in my learning and development and made a considerable contribution to the way in which I was developing an understanding of how my values are emerging in my practice and how my practice is influenced by my values and in particular my passion for compassion.

 As part of the process of writing this thesis and reflecting on my writing I have been trying to clarify my embodied values and to look at how I live these values in my practice. In order to communicate this and to share with others, in a creative form, my learning, I have created a DVD from some of the video clips I have gathered as part of my research process. (*See also, Chapter 3. Expressing and clarifying my values through the creation of a DVD.*) In the DVD chapter 6 “Breaking down the walls of silence” I have focussed on the importance to me and the work I am engaged in in the development of inclusional and responsive relationships. This chapter opens with a clip of me explaining to Shaun the reasons behind my choice of clips, which is being influenced by the importance I place on my embodied values of inclusional relationship, responsive practice, trust, love and respect for self and for others and the importance of living life creatively. The next clips are of people with dementia and their carers talking to me about their experience of living with dementia and their relationship with their healthcare providers. I am trying to make sure that I am including their voices in my work which is contributing to the development of health service policy and improvement and I believe that this clip communicates the inclusional nature of my engagement with them. I have interspersed with these clips further clips from the characters devised from this research. These characters were devised with a pedagogical intent but their development has also been influenced by my embodied values and in particular, my passion for compassion. In the clip where we see Sue in a visit to her GP I have tried to communicate her love and concern for her mother. She is desperately

hoping that all the fairly small signs and changes she sees in her mother's behaviour are not too serious. Her experience of reassurance from the GP was one that many people I talked to had also experienced. One of the main reasons for creating this character was to communicate just how easily these very important early signs and symptoms of dementia can so easily be missed.

As Mary, Sue's mother deteriorates Sue has to face the difficult decision of finding a suitable nursing home for her. What she expresses is the difficulty that many people I worked with expressed and that is the lack of the very specialist understanding of the need of people with dementia in care homes. My research has also been able to highlight an urgent need for us to develop better education and development for care home staff. In the next clip we hear Audrey, who cares for her husband Ray who has dementia, talking about the difficulties she faces rehabilitating Ray after he spends time in respite care. Respite care is designed to give her some time away from the demands of caring for her husband but her experience is that she has to work twice as hard afterwards.

### **Welsh Assembly – I am because we are**

On my return from New Zealand I was approached by a participant from one of the workshops I had undertaken for the Royal College of Nursing Leadership programme. She was organising a conference in South Wales on Clinical Governance. She wanted to know if I would be able to do a couple of one hour interactive sessions to demonstrate how working creatively can enhance your clinical governance programme. I had, over the year, begun to dislike many of these requests because there is actually very little you can achieve with a large group of people within such a short time frame. We wanted to avoid being labelled as the token alternative entertainment. The sessions have to be planned very carefully and timings

rigidly stuck to which leaves very little opportunity for real responsive practice to happen. I usually found myself agreeing to them however because it was at least an opportunity for me to encourage individuals attending the session to consider trying further work in this way. At the end of the session one of the participants asked if I would contact her the next week so that we could talk further about the possibility of doing some 'creative' work with the chief nurse of Wales. Her name was Tina Donnelly and she was responsible for nurse education and development in Wales. Shaun and I met with her and Rosemary Connelly the chief nurse a couple a weeks later.

At the meeting Rosemary explained that she was preparing for the annual conference for all Welsh nurses which was due to be held in about three month's time. The purpose of the conference was to share good practice and to celebrate some of the excellent achievements from the nurses in Wales. She wanted to know if we would be able to create a piece of theatre that would "challenge, provoke and stimulate the audience." The purpose of this was to encourage the participants to ask meaningful questions of the presenters throughout the day. She also wanted the day to encourage dialogue between the presenters and the delegates rather than the usual conference format of one way, didactic, presentation. She had seen theatre being used at conferences before and agreed with us that its potential was never fully exploited. They had already sent out a call for papers and Rosemary agreed to us having copies of the papers from the presenters as soon as they had made their selection so that we would have an understanding of what the content of the presentations would be. She also agreed to us being involved in the development of the conference as a whole so that what we created would become an integral part of the conference. It was crucial for me that whatever we devised should link to and enhance the whole of the day and not just be an interesting bolt on.

She was happy for us to go away and consider what the content might be and to return to the next planning meeting with some ideas.

I was so pleased with this outcome, this would be my first opportunity to undertake a piece of research and from that research devise a piece of educational theatre for a healthcare audience. Both Rosemary Connolly and Tina Donnelly were confident in their vision to want to exploit the potential of theatre for learning – in itself this was, I believe, a commendable vision but also an exciting opportunity. This would be my first opportunity to develop this in a very high profile environment – it was such an opportunity – I was terrified. What terrified me was that I knew that I would have to undertake this performance alone, I would of course have Shaun to research and devise with but the actual performance would be down to me, it was potentially an exposing situation and I began to doubt my own ability to do it. Where was I going to start? We had been given a very wide brief and it was very important that we didn't let Rosemary down. She was prepared to take a risk to a certain extent as she had not actually experienced any of our work. I was also very aware this would be a major stepping stone forward or backwards in my use of theatre in this kind of arena. I also had no idea what the content of the theatre should be, I was filled with lots of ideas for form but no idea what the content should be. I knew I would have to hold fire until I had undertaken the research in order to ensure that the theatre, in whatever form it became, reflected and responded to the needs of the research in a pedagogical and challenging way.

I was able to spend some time reflecting on the selected abstracts for the conference before this meeting. There was a wide variety and they were divided into 4 sections: -

**Changing Roles**

**Leadership and Innovation**



## **Education**

## **Partnerships**

They all had 1 theme in common and that was the changing identity of the role of the nurse. It was agreed that this would be the starting point for further research and potentially the focus for the piece of theatre. Tina was also keen that there should also be some kind of emphasis on nurse education.

## **Undertaking the research – gathering the evidence**

Shaun and I began the research by talking to several nurses about their role as nurses in the modern NHS. This group included nurses of a wide variety of experience and background. They were also selected from different parts of the health service and included nurses from the acute sector, community sector and from primary care. The main theme from this small pilot group was the continually changing role of the nurse. They expressed the view that it was sometimes very confusing for them; they didn't really know where they would end up and what was really expected from them. We decided to extend this research further and interviewed a total of 50 nurses. These nurses were a representative sample from across the country and from across all disciplines of nursing, and from all levels of seniority from student to Directors of Nursing. We also interviewed people, children, young people and older people again from a cross section of society and from different locations across the Country. When we could and when we had consent we used video to capture the interview. We also interviewed others who were happy to express their views and to talk but did not want to have their interview videoed.

I have also included my findings as a patient because I think it is important to include all my NHS experience throughout this time. I had been on a

waiting list for routine surgery to my leg for a considerable time. Although I knew that my surgery was routine I still approached my stay in hospital with an overwhelming sense of dread. Although I was able to rationalise my fears there was no getting away from the fact that I would have run as far away as possible if I could have lived with the embarrassment of doing so. I was only going in for day surgery after all! I had received a letter telling me to arrive at the day surgery unit at 8am having fasted from the evening before in order to go down to surgery that morning. It had been explained to me that my surgery would take place early in order for me to recover over the day and that if there were no complications I would be able to leave hospital that evening and continue my recovery in the comfort of my own home.

When I arrived on the ward I was asked by the ward clerk to unpack my overnight things and wait for a nurse to 'clerk' me. That was my first problem, I had not been informed that I was staying overnight and had only brought with me things for the day. I had also only made arrangements with my family for a day visit and Shaun was expecting to be able to take me home later on in the evening. Although my operation was scheduled for 9am and as a consequence was instructed to starve myself from the evening before, I actually went to theatre late in the afternoon so I had plenty of time to observe the ward activity. I am very familiar with that day-to-day activity of a busy ward and consider myself to be fairly articulate and confident but it was beyond my capability to get simple information from any of the ward nursing staff. They seemed to be incredibly busy but very little of this activity seemed to include patient care. I was surprised to see basic patient care appearing to come very low on their priorities. There seemed to be a reluctance to respond to patient's requests. An elderly lady called for a long time for help to the toilet and even when she did get the attention she required there was an uncaring attitude from the nurse who then left her sitting on a

commode for longer than she found comfortable and she became more and more distressed as her attempts to gain the attention of one of the nurses failed. Eventually I managed to catch the attention of a student nurse who was quite put out at my insistence that she should attend to the patient. I was also concerned that the other patient sharing my small ward had been given devastating news and was then left alone without care or support from the nursing staff. It was left to me to give this patient the help and advice that was essential to her well being before surgery. On a positive note I was very surprised by a visit from my surgeon to apologise for the delay in getting me to theatre. This was due to several emergencies and also the fact that the hospital was working at 96% capacity, which he said, was impossible to sustain. Having been given an explanation for my delay and an idea of how long I was going to have to wait I was certainly more relaxed.

The following day I was discharged from the ward into what they called the discharge lounge. This was a new idea the hospital was trying out to solve the problem of patients having to wait on the ward for medication from the pharmacy to take home with them. This delay usually means that patients who could be on their way home are tying up beds that new patients coming into hospital could use. I was given some information before going down to the discharge lounge, but not the information I wanted. I asked what medication I was waiting for but no one was able to tell me. I also needed to know if the stitches in my leg were dissolvable or would have to be removed, but no one could actually tell me. I waited in the discharge lounge for 5 hours until my medication arrived only to discover that I had waited all this time for a packet of paracetamol!

Having had time to reflect on my experience as an inpatient in an NHS hospital I would describe my experience as mixed. The quality of the

clinical procedure was high and the staff were obviously competent. There was however a lack of basic care and privacy for the patients on the ward. There also appeared to be no one with overall responsibility or with an over view of what was happening on the ward. I talked at length with other patients who were also waiting in the discharge lounge and their experience was similar to my own. My analysis of this is that we, society, do not reward this kind of care financially and in order to gain reward and recognition nursing has had to push itself further up the professional ladder. There is nothing wrong with developing a higher professional status, but it would appear that this has been at the expense of basic nursing care. It is this basic nursing care that we crave when we are ill, the value of some one to hold your hand, to spend time supporting you and helping you through this kind of crisis is not reflected financially. The people who volunteered their opinions on film also supported this view.

When interviewing people as part of this research we asked them to give us their opinion as to what a nurse was and what a nurse does. People were encouraged to tell us whether there was any difference between what they perceived a nurse's role to be currently and how they would like to see it change.

From this research the video and interview data was analysed and emergent themes were identified. The main theme from the research was 'Identity'. This theme of identity formed the basis of the devising process. We continued to meet with the planning team on a regular basis keeping them informed as to the progress and findings of the research. They were happy for us to devise the theatre based on the research findings and we prepared a document outlining the first stage of the devising process. (Devising document is attached as Appendix 9.)

After the completion of the devising paper which we went over in great detail with the conference planning team, we were able to start the process

of devising the characters and their stories. This is the most creative part of the process but it can also be the most difficult and challenging. As you begin to develop the characters and to tell and understand their stories it is very easy to become very attached to what you have created. It is all too easy at this point to become very possessive about your own creative process and this can become, if you are not careful, a very self-indulgent process. This is where it is important to be able to understand the stories you have been told by people and identify what is important to them about their narrative and then to recodify this into a new story, that very often combines several issues, in a new way that is both pedagogical and believable. The way Shaun and I work together at this point is crucial; we have been able to develop a way of working that allows us to take and to give criticism. This is very important in the devising process because not only do I as an actor have to know what it is I intend to communicate but I also have to be sure that I communicate it in a way that the audience is able to receive the information, it also has to be believable. In order to do this I have to draw on my own emotions and feelings and this can also sometimes be a very painful process. It is at times like this in the devising and rehearsal process that Shaun and I have taken to working in the outside. We are very fortunate in that we live in the middle of the most beautiful Wiltshire countryside. When work is demanding and challenging and we need to find something to stimulate us creatively we take ourselves outside and we walk. Connecting in this way to the elements and to nature seems to enable the creative process in some deep way. Connecting in this way to the outdoor world of nature has also helped me enormously in the writing of this thesis as in some way this re-connecting with the beauty and also the cruelty of nature re-connects me with my own creativity and enables me to live more fully my embodied value of living life creatively. Many of the stories that we heard as part of this research process were very painful and I needed to take and was able to take more time to reflect and to walk throughout the devising process

for this particular piece of theatre. I believe that this enabled me to deal with the challenges of maintaining my ability to be creative whilst sometimes being affected by the content of the research. It also enabled me to deal with the enormous pressure involved in creating a piece of theatre like this to a very tight deadline for what may be a cynical audience.

I also felt that the research findings were very important to share with the conference delegates in some other format. This was important in order to be able to share the data that had contributed to the development of the characters and their stories. We edited the videoed interviews and downloaded them onto a video that could be played in a continuous loop alongside the conference poster presentations. Delegates were able to watch the videoed interviews in an informal manner at various times throughout the day.

Our final role in the day was to host a chat show at the end of the day instead of the usual kind of summing up. We had a variety of guests on the sofa all very senior people from the nursing profession in Wales and also Rosemary, who had organised the conference. Shaun was the chat show presenter and I was there as any one of the characters from the theatre that they wanted to question and also as the researcher able to comment and answer any questions that related to the research process itself.

I believe the level of debate during the chat show did the following:-  
It enabled the delegates to talk about whether the theme of identity had really rung true for them. They discussed how they had found a way of seeing how the changing identity of the characters in the piece of theatre met with their own perceptions of today's modern nurse. They also talked about how they were particularly moved by the comment from one of our


interviewees. This gentleman was selling copies of the big issue in the centre of Bath but he was originally from Manchester and he had made the following comment.

*“The problem is....the way I see the problem is that.....You see when you go into hospital, you’re not at your best are you? Or you wouldn’t be there would you? You can be very worried and anxious, frightened even. What you want there then is someone to sit down beside you and to hold your hand and to give you some time and to reassure you. But you see, we, us in this society we don’t value those kind of skills do we? Do you know what I’m saying? So if we don’t value them we won’t pay for them, do you see? So nurses can’t get a decent wage for doing those things because we don’t value them. So they have to become pen pushers and managers and they have to get degrees and then they get paid more, but when you go into hospital they’re all too busy doing other things, they can’t talk to you or hold your hand or any of that stuff, they’re all busy doing things on computers. Well that’s not what they went in to nursing for is it? They don’t want to be doing those things, but it’s our fault in society, we’ve just got our values the wrong way round.....haven’t we?”*

The nurses in the audience expressed the same concerns that they had seen expressed by the characters in the theatre and many of those recorded on video. They talked about how they were very proud of their achievements over the years as they had become a respected profession. They also said that they were concerned that the core values of nursing were perhaps being overlooked in the desire to achieve 100% graduate entry. Rosemary suggested that they should take time out at this moment. She extended an invitation to any nurse present, at whatever level of seniority to meet with her at a date in the near future where they could look critically at the future role of the professional nurse. I believe that this demonstrates how

without the research into attitudes to the role of the modern nurse and the communicating of this research into a piece of educational theatre the outcome of the conference would have been different and an opportunity would have been lost.

I had also achieved what I had set out to achieve. The day had been incredibly demanding of me both as a researcher and as a performer. I had been very anxious at the start of the day wondering if I could sustain the characters throughout this very demanding piece of theatre. I was greatly reassured that the feedback from the delegates showed that they had not only found the performance realistic and engaging but that the content reflected their own concerns and raised issues in a way that enabled them to reflect on them and discuss them in an open and honest way. For me this was another huge leap forward both in my own confidence in my embodied knowledge but also in the response from both the organisers of the conference and the delegates.

 In DVD chapter 3 “I am because we are” I have interwoven clips from the interviews with clips from the characters in the game show. In this context I feel I am able to demonstrate the importance I place on working in an inclusional and responsive way. I am doing this by including the voices of those contributing to the research and also by the construction of a theatre form that allows the audience to participate in the theatre itself.





The initial response from the audience to the character June was laughter as they recognised her from their own experience. The laughter of recognition is very important as it allows me as an actor playing the character to engage with them and fully express my empathy with the character I am portraying. June's voice represents the voice of many nurses who expressed their frustration at not being able to do what they felt intuitively they wanted to do. They expressed their frustration at being locked into a system that only seemed to value outcome in the form of waiting times, delays, waiting lists, discharges. People we talked to about their experience as patients talked about the need to be cared for while in hospital. They needed to be supported and their expectation was that that was the nurse's role, but their experience was that the nurses were usually too busy to tend to their needs. What this event was able to do was to create an environment where, stimulated by the characters and the research, nurses could engage in a relationship where the issues that were raised could be discussed and challenged.

I believe that in this context my practice has been both inclusional in the sense that I have been aware of and embraced the boundaries that prevent us from being inclusional. I have also been responsive in a pedagogical sense in that I have found a creative process that allows me to develop empathic relationships with the people I am working with in a research

context. I can then give voice to their experience in a way that engages the audience / participants in a dialectical process where we all seek to live our embodied values fully in our co-practice. I believe that my practice is driven by my ontological commitment to a passion for compassion and that this is being clarified and communicated throughout this piece of theatre.

The complete script for this piece of theatre is attached as Appendix 10.

### **Summer school for clinical leaders Brighton July 2002 & York 2002**

The request for a contribution to the modernisation agency summer school had been made earlier in the year giving me plenty of time to think about the content. The summer schools were organised by Kate Harmond who was then the clinical director of the N.H.S. Modernisation Agency. The summer schools were organised to develop the leadership qualities of NHS. leaders and were open to any of the professional groups. Kate was determined that these summer schools would really extend the leadership skills of those attending. Kate is also a great believer in enjoying difficult challenges and creating an environment where people are stimulated but also reminds them that they have a responsibility to engage in the process – *“There is no time or space at these events for arm folders.”* (Kate Harmond, clinical director modernisation agency, summer-school, Brighton 2002).

What Kate had asked us to prepare was a half-day session to be undertaken at the beginning of this three day event and would include all of the delegates and set the scene for the whole event. Setting the scene meant putting into context their role as leaders within a modernised NHS and understanding the current climate within which they were employed. I decided to use this as an opportunity to develop my skills further and to

combine the roles of facilitator and actor in a way that I had not had the opportunity or the courage to do before. I wasn't sure whether the delegates would accept me in the dual role. Very much in the way in which Augusto Boal uses forum theatre, I wanted to be able to step in and out of role and also to allow the audience to comment and/or contribute to the drama. I wanted them to be able to use my skills in a much more improvisatory way than I had before. They were also a very large group, much larger than the number we were used to working with and I wasn't sure how well we would be able to engage them. I was concerned that we may only engage them at a very superficial level. The playing of the games would also be an issue, how on earth could we work with over 100 individuals it was going to be absolutely chaotic.

The session was held in the ballroom, which was a very large and impersonal space. We had asked for the room to be set out with the tables and chairs around the outside of the room in a cabaret style. This had the immediate result of unnerving the participants as they were wondering what we were planning to do in the large empty space that this had created in the middle of the room. To overcome this initial anxiety we planned a whole group, high energy exercise, we began with what we call the clapping game. We had never played this with so many people but despite this it still had the same impact. I ask people to make two straight lines facing each other down the middle of the room. With so many people the straight lines were more of a huddle than a line. The process of self organisation begins at this point as people try to make sense of what they are doing. The two groups immediately have separate identities and very quickly establish a team dynamic. The first group clap out a very simple and recognisable rhythm and the second group clap out the same rhythm but with one extra beat added on to the end. Eventually both groups end up at the point where they start, as one group goes back one step each time. This exercise is not only invaluable as a warm up exercise and ice-

breaker but has many other uses. The teams immediately become competitive with the team with the easier task always feeling like the winners and the other team feeling at a great disadvantage. It is very unusual for them to successfully complete the challenge on the first go. What happens then is a very useful introduction into self organisation, leadership and different leadership styles. Usually one or more leaders will emerge as the teams begin to self organise and develop relationships with each other within their team. They very quickly see who is good at doing the task and these individuals are usually encouraged to lead. They also begin to make the connections between the way they are playing the game and the way they behave in a changing environment. It illustrates, in practice, the way in which uncertainty changes people's behaviour, how very easy it is to become repetitive and how we instinctively want to cling on to what is familiar – even when we know we are stopping the process of transformation and improvement. The use of humour in this exercise is also crucial allowing people to laugh at their own mistakes. In this particular workshop one very senior leader was able to laugh at his absolute commitment to bashing out and sticking to his version of the rhythm even though he knew it was completely wrong. ***“I just couldn't help myself – I knew I was doing it wrong but I thought if I look as if I know what I am doing and do it with enthusiasm then perhaps no-one else will notice.”*** (Taken from my reflective journal.)

The debriefing of this exercise took us into a level of debate with this group of participants that in my experience had taken much longer to achieve when I have used more traditional methods of facilitation. It also allowed us to move quickly into a conversation about life in organisations. It was important for us to encourage the participants to begin to reflect on the kind of organisation and system they were working within if they were to develop an appropriate leadership style. This section is very much geared towards exploring organisational theory but I wanted them to

consider the effect on the person within the system, be that a healthcare professional or a patient, how that person relates to others particularly across boundaries both professional and organisational.

In the last exercise of the session they were asked to work with the other people at their table. The task they were given was to talk to each other about their work place and to each come up with an example of something they disliked about the system they worked within and we then shared those examples with each other. I then introduced them to June the character I had devised for the nursing identity project and June told her story. The participants then had the opportunity to talk to June, to ask her questions and to suggest to her ways in which she may be able to change the environment she worked in. The participants found June's story both very powerful and moving and many of the nurses in the room were able to identify with her and with the issues she was dealing with. I then asked them to repeat the first part of the exercise and to talk to each other about their place of work and to put together a second list identifying issues they were having to deal with and we then shared this list. The difference between the two lists was remarkable. What was remarkable was the way in which June had moved them to talk more honestly and openly about what issues really did affect them, what their fears and insecurities were and what really needed to happen in order to improve them. The first list on the other hand was much more superficial and jargon based but very much in line with what is usually produced at facilitated sessions like this. The second list talked more about relationships and the impact on the person. One senior leader made the comment:

***“You really could use these two lists to demonstrate what is expected from us and what really matters to us – it’s a classic.”*** (Taken from my reflective journal.)

What was important for me in this workshop was that I could work with a large group of people in the same kind of depth as I was able to achieve with a much smaller group. Also that the group would accept me moving from a facilitatory role to actor without confusion. This also meant I was now able to draw on a variety of characters developed from research and when appropriate in a much more improvisatory way. Working in this improvisatory way enables me to be much more flexible and respond “in the moment” to the needs of the participants. It also encourages them to engage more fully in the later exercises of the workshop where they use improvisation and re-enactment. They see me take a “risk” by becoming a different character. They also see me prepare, as an actor, in order to believably represent someone else and someone else’s story. The effect of this is one of demystification and shows theatre for what it is and how useful it can be and that it is not an elitist art form but one that they can access and use in their own work. I was also beginning to find that being able to improvise in this way, to dip in and out of the role of facilitator and draw on one of the narratives of a host of characters that we had devised from research, was allowing me to live my embodied values more fully in my practice. I am able to clarify my values by showing, through the words of other characters, the impact on an individual when their values have been violated in their practice.

### **The Launch of the National Service Framework for Older People**

I have reached a point in my development as facilitator where I am now able to use theatre-in-education as a tool for disseminating research as well as using methodologies drawn from the theatre with healthcare teams. So far the theatre had been used with no more than 100 delegates but this was an opportunity to work with at least 300 delegates at the launch of the National Service Framework for Older People.

National Service Frameworks had been introduced by the current Labour government as part of its commitment to improve the quality of health care. The purpose of the National Service Frameworks was to put into a plan for service delivery the available appraised evidence for particular parts of the service. National Service Frameworks had already been produced for cancer, coronary heart disease, stroke and mental health. The National Service Framework for Older People also had a small section on dementia so it was particularly relevant to the work I had been engaged in. Shaun and I were approached by Kate Harmond and Nicki McNaney who were leading the development of services for older people and invited us to join the planning group for the event and to be main contributors. The day was also an opportunity for individuals involved in service delivery for older people to come together and to begin to network at both a regional and national level.

Shaun and I were asked by the planning team to develop a half day programme to start the conference off. They also wanted us to round the conference up with a chat show and to offer a breakfast session on the second day where delegates could explore further the use of creativity. I was also leading a dementia workshop on the afternoon of the second day. It was agreed that our first session should both stimulate and challenge the audience and would also have an element of participation. It was also made clear to us that this part of the day would be attended by politicians and that the 'Elderly Tsar' would be participating in the session. There was a sense that they wanted us to be stimulating but not too controversial. The piece of theatre 'I am because we are' that we had researched and devised for the Welsh Assembly had taught me that audiences of this nature were happy for the content to be controversial if they were confident that the theatre had been developed from research and it was important for me that the research evidence should be available to the audience if they wished to have access to it. With this in mind I

approached the project as I would any piece of action research. The purpose of the action research was two-fold in that I would not only be seeking ways to improve my practice as an actor/facilitator but as a consequence would be driving forward the process of improvement for the care of older people.

Together Shaun and I prepared a brief for the other members of the steering group.

The initial brief was agreed by the steering group and we were then asked to prepare and submit an interim progress report, (attached as Appendix 11.)

### **The Devising Process**

The video footage and the stories we had gathered from the research were very powerful and we didn't want to lose the potential of their impact on the audience. It was also important that the very bold and sometimes very brave statements that some of the healthcare professionals we had interviewed had made were also captured for the delegates. We decided to edit the video using the themes identified by the research and to then underpin this evidence with the use of a real person who was experiencing these issues.

### **Identified Themes from the data collected**

Getting Old and Positive Attitude

Ageism and Equity

Resources

Access to services



Leadership

Relationships.

Specialist services.

Systems Failure and Whole Systems Design

Perception of Health and Social services care.

As we entered into the devising process we both immersed ourselves fully in the research, in the form of narrative that we had gathered. Once again this became an all consuming activity and we were often very moved by the stories that individuals shared with us. The older people especially moved us with some of their stories. On the whole they were incredibly uncomplaining and yet when you listened to their stories some of them had suffered tremendously from an ageist society. The younger people we talked to were generally much more willing to confront issues like ageism and also seemed to have much higher expectations from society in general. The theatre slowly began to take shape; we were incredibly busy at this time and were having to take any opportunity to test out ideas, scenarios and improvisation. I can remember on one occasion causing havoc in a hotel lobby in Bucharest because I had had an idea and needed to try it out before it was lost in the activity of the day. We were both excited by both the form and the content of what we were creating. We were asked to present what we had devised to the conference planning team before they finalised the go ahead for the performance.

**Presentation to conference planning team – am I being censored?**

**‘Judgement Day’**

*Modernising Older People’s Services*

*5<sup>th</sup> & 6<sup>th</sup> November 2002*

*Judgement Day is a piece of theatre that has been specially commissioned for the NSF Conference for Older People. Judgement day is a fictitious story, based on the evidence from extensive research with a broad range of service users, and some service providers of the NHS and the community as a whole. Much of this evidence has been condensed into an interactive Theatre piece in order to celebrate good practice, raise some of the issues for you and ‘set the scene’ at the conference. Judgement Day centres on the unfortunate ‘death’ of Joan Simkins who at the age of 73 has committed suicide. We meet Joan as she first enters the ‘after-life’ where she is asked to explain to ‘the advocate’ why she has decided to end her life and the course of events that has led her to take this action. She cannot progress in the ‘after-life’ until a satisfactory explanation is given.*

*As Joan recounts her last few years we see a feisty and articulate character that is exceptionally lonely, frightened and disillusioned with the society in which she lives. Joan however refuses to be a ‘victim’! She offers commentary on her experiences and provides evidence to support her case. ‘The Advocate’, offers counter argument and commentary while at the same time asks the audience to consider all the pertinent points.*

*A Judgement is made – Joan’s next step will be in their hands!*

We were asked to present the draft script to an invited audience made up of conference planners and individuals who were providing services for

older people, both from health and social care. The performance went very well considering that I had only finished writing it the night before and it was the first time that Shaun and I had run the whole thing together with the video inserts and Shaun's commentary. We were also very pleased with the theatre and its potential and were somewhat taken aback by the strength of feeling from the audience. They were concerned about two specific issues the first was the title "Judgement Day", they felt it had religious connotations and was therefore politically incorrect. I had never really seen it that way before and my intentions had never been to have any religious undertones. As far as I was concerned judgement day referred to the fact that it was set in a court room and the delegates were able to decide on the future of the character. They could decide to let her live and therefore redesign the services she had been using so that her outcome was different or they could agree that there was nothing that they could do and as a consequence she would die. After lengthy and heated debate the team insisted that we change the title from "judgement day" to "decision day."

Their second concern was that the character had committed suicide and they felt that as this was an official launch of the NSF they should not start the conference off with one of their service users committing suicide. Shaun and I had also had lengthy debate about this issue but finally agreed that the decision to have her take her own life was justified. The character that I had developed for the theatre was very feisty and articulate. I had made the decision not to develop a character who would be perceived as a victim from the start but to have an individual who knew what she wanted and her final decision to end her life was for her an expression of that freedom. There was also the potential by having this person in an 'out of body' or 'near death' experience that I would be able to play her more believably rather than having to rely on me trying to play a person who was much older than myself. The team, with only two exceptions, were

unanimous in their agreement that the suicide had to go. It was interesting that the two people who disagreed were not service providers, one of them was PA to Kate Harmond and the other was from the conference office. They both argued that removing the suicide from the theatre would take away the dramatic impact of the theatre and therefore lessening its potential as a tool for change. I was very much in agreement with this latter opinion but unfortunately we were overruled.

I was devastated by this outcome and also very angry at the power that the group had displayed. Shaun was as always very pragmatic and pointed out that they were our customers and we had to try to create something that would satisfy both their fears and our research. We had only one week to now turn this around and were asked to return the following week with a new script that included all their requested changes. For me the week was frantic and I was finding myself in a constant contradiction of what I wanted to communicate and in what way and what would be acceptable and as a consequence, I felt, diluted. I did however manage to create a new character who told another story, a different story, but one which I hoped would have as much impact on the audience. It was with great anxiety following a sleepless night that we turned up for our “judgement day”. Thankfully this time they were happy with the whole piece and only required clarification with some technical details.

The piece of theatre and the character Joan who tells her story in the theatre piece were devised from the extensive research undertaken for this project. Many different individuals had contributed to the research and had told their stories to us in a very open and honest way. Some of the participants in the research, older people, healthcare professionals and members of the general public had also agreed to tell their stories on film and had given permission for us their interviews on film as well as to contributing to the creation of the story. What I was now beginning to consider was how I could make this process, that of undertaking research,

analysing the research, devising the theatre, to become a more explicit part of the re-design process. I had been dissatisfied by the approach to the modernisation of health care services nationally. This approach was very much a process of rolling out training in tools and techniques developed for process improvement but had paid little or no attention to the context within which it was being delivered. What we were considering for the first time was the possibility of using the theatre and the video together within an explicit framework of improving services. In this way the delegates at the conference would have access to the research evidence, would have seen how this impacts on a human being living this experience and then have the opportunity to focus on their own services and ask themselves the question, “How can I improve my practice.”


A full and final script which includes the activity delegates were asked to participate in is attached as Appendix 11.

### **Outcome of ‘Decision Day’**

The original purpose of this piece of research and the use of theatre was to begin the process of service improvement for older people. The rationale for the use of theatre was to communicate the research findings in a way that would place the service user at the centre of the redesign process. The impact of the theatre was enormous and delegates left the session with the beginnings of an outline of redesign for their particular service. This work is continuing across the country as services are engaged in implementing the National Service Framework for Older People. This process of improvement will be ongoing for many years and it is difficult to measure the impact of the theatre over such a lengthy period. I am however satisfied that using theatre in this way encouraged the participants to reconsider the services they provide in a much more patient focussed way. It was also evident that the theatre had enabled the delegates to take a creative leap in the kind of solutions to issues within their own services.

Dr Ian Philp, the elderly Tsar in his summing up of the day also made this point: ***“I was amazed at the creativity displayed by the people on my table following the theatre piece as they engaged in a process of problem solving. I was also amazed at how this seemed to happen much quicker than I have experienced before.”***(Taken from my reflective journal.)

This event also made a significant input into the recognition of the use of theatre and creativity as an accepted educational tool within areas such as the National Health Service. More importantly for me it was recognition of the importance of engaging people in an inclusional process of transformation rather than imposing an improvement process.

 DVD Chapter 4: “Decision Day” (length of chapter 33 mins. 45 secs.)

This chapter opens with me and Shaun walking in the beautiful countryside that surrounds our home. We are talking about the difference between this piece of work and the previous chapter “I am because we are”. My concern here is whether with such a large audience we can still include an element of participation in the theatre. We eventually agree that despite the difficulty we want to ensure that the audience is able to participate. This clip shows how important to me are my embodied values of inclusionality and responsive practice. Showing how I respond to the people telling me their stories by the creation of the character Joan I believe I am communicating love and respect for self and for others and I am clarifying the meaning of living the value of a passion for compassion in my practice. I do this by trying to enter into a relationship with the participants of the research that is based on trust, love and empathy and a desire to communicate their voices, voices which are so often stifled within society as a whole by our negative response to the elderly. In the first clip of Joan I have tried to communicate her understanding of her own ageing body and her determination to make the best of her

situation. I was so often humbled by the elderly participants of the research by their determination to continue very often despite their relationship with healthcare providers rather than as it should be, being supported by them.

In the second clip of Joan I have tried to communicate through her voice how vulnerable older people can often be and again how very often the systems we put in place to help can often fail them. Comments from the older participants like “I mustn’t grumble” and “There’s nothing down for you – nothing – is there?” reinforce these facts. When interviewing the older participants they would very often open the conversation with support for the health service, however as their stories unfolded there were many occasions when they had actually been treated poorly. They talk about the pain they suffer in a way that communicated that they expected to have to put up with a certain amount of pain. The GP in this clip also reinforces this fact that very often healthcare providers expect older people to put up with more discomfort just because they are old. I found this difficult to accept and believe that this is because it violates my embodied value of love and respect for self and for others. It also, I believe, reinforces my ontological commitment to having a passion for compassion. In clip three I have tried to communicate this through Joan by her desire to return home but also to have the support she needs in order to live her life in the place she wants to be rather than to have to give up her independence and live in a nursing home.

Having the opportunity to be involved in a project such as ‘Decision Day’ has had a significant impact on my learning and development as a facilitator of healthcare improvement by enabling me to continue to develop a methodology that synthesises my engagement and growing understanding of complexity theory with my embodied knowledge and experience as a devising actor. Undertaking this within a framework of action research has enabled me to reflect and focus on my learning, my

embodied values and how they underpin and influence my practice. This has helped me to understand my practice and to encourage me to ask myself how I can improve my practice. By doing this I have been able to demonstrate to a wide audience how this synthesis of complexity and creativity can be a useful and productive way of improving healthcare services.

### **Electronic Booking**

In the NHS Plan a commitment was made to introduce explicit patient choice across the NHS. It promised that by 2005 all patients and their GPs will be able to book appointments at both a time and a place that is convenient to the patient. In many cases it was hoped that this booking of patients would be able to be undertaken electronically. This work has been very successful and a conference was organised to celebrate this success. I was approached by the electronic booking team, following the success of the Older Peoples conference, with a request to produce a piece of theatre for this event.

*Dear Marion*

*> I have been passed on your contact details, we are due to be running a National launch of electronic bookings for the NHS on 21st November. I am aware you have worked with the MA before and would like to explore some options for your involvement. This may be around facilitation of the day or developing some theatre style sessions to get the messages across.*

*It is due to be a high profile event with John Hutton as the key note speaker. Would be very grateful if you could contact me. It may be best if that was in the form of telephone conversation my mobile number is..... I look forward to hearing from you.*

*I know this is rather short notice so would be grateful to speak*



*as soon as possible.*

*Kind Regards*

*Debbie El-Sayed*

**National Programme Manager**

**Electronic Booking Programme**

**My response**

As can be seen by the paper that accompanied this email (Appendix 12) asking for my contribution this was a very high profile event. What was most significant for me was that this invitation came as a result of a recognition of the important part theatre for development can play within the overall NHS modernisation agenda. My contribution was now being requested at both a strategic and policy level giving me an opportunity to influence both strategy and policy.

This was a different task to that of the older peoples' conference and what they seemed to want was more of a celebration of their achievements. We responded to their request with a draft structure in order to fully include them in the process. (See Appendix 12).

**E mail Responses to our draft structure**

*Debbie,*

*Option 2 seems to fully justify our decision to ask the Naidoos - creativity is their business and its really good.*

*I agree that trying to get something on secondary care - perhaps a consultant having to deal with the letter from the young fogey, so he can*

*comment on the good and bad of the 2 processes - but I lack the originality to see how this becomes as humorous as the other scenes - perhaps on the golf course? 2 consultants arguing? If the patient experience is sufficiently shown in the 2 GP scenes the 2 patients in the waiting room could be deleted - or could it become a recurring parallel scene (Pete & Dud spring to mind here) to frame the 3 main scenes.*

*Happy to discuss further.*

*Hugh*

*Debbie -*

*I like this, but would just have to be careful that the 'arrogant' doctor isn't too much of a caricature. Does he have to be arrogant? Could he just be someone who doesn't like using modern technology, as I think this may be the issue for some people.*

*Also, in this scenario they are all men. Need more women - perhaps a woman for the young doctor who doesn't like modern technology, and maybe three people, a married couple and a single man, discussing their appointments in the old boy scenario.*

*Hope this is helpful.*

*Sue*

The comments from the conference team were incredibly helpful not only because of what they were saying but also in terms of who it was that was saying it. The E booking programme had initially met with some resistance from the medical staff and it was important to be able to gauge how they would respond to the humour. We were able to use these comments and suggestions to improve the final theatre piece. The slot we were given was also problematic in that we had hoped to introduce the theatre throughout the day but were given the first session of the day only.

There was also the issue of the actors, the work we had undertaken to date had involved myself and Shaun working very closely together but with me taking on all of the acting and improvisation. As this piece of theatre involved a number of different characters who were interacting I was going to have to have another 2 actors working with me. I began the process of contacting Theatre-in-education companies to find another two actors who had experience of devising. This became an enormous task and it soon became apparent how difficult it was going to be to find someone with the right skills. An old friend who was a student of Rose Bruford College at the same time as myself and Shaun is now Director of one of the few remaining TIE companies. He was very helpful and put us in touch with another old Bruford student who now spends most of his time writing but Ian thought he may be persuaded to return to acting for this project. David was our only success and Shaun reluctantly agreed to be the third actor. I was a little anxious about the devising/writing process as it was quite a long time since I had worked with a larger group. My fears were soon put behind me as the devising process began. We found that we could work very well together and soon began to try out ideas on the floor. The first 2 scenes were relatively easy as they involved only 2 actors the third team member was able to comment on the scene as it evolved enabling us to ensure that we were communicating what we intended. The third scenario was little more difficult as it involved all three of us in the action.

We were asked to perform the whole piece the night before the conference to the conference team so that they could vet it before it went out. I was a little concerned that the night before would leave us very little time to make any changes if they were not happy and memories of 'Judgement day' came flooding back. To try to ensure this did not happen on this occasion

I made sure that the team had access to the script as it was produced. They were very happy with the piece and there were very few amendments to be made over night.

### **Response to the theatre**

The feedback from the conference team and from the delegates was very positive and as a consequence the team decided to reproduce the day. This was organised for later on in the same week at another venue. Although the feedback given indicated that it was well received by both the team and the conference delegates I felt a little disappointed that what we had produced although informative was a little more superficial than I would have liked it to be. This event had been organised as a celebration of what the E booking team had achieved. On reflection I felt that although the team had asked for a specific piece of theatre and had to a certain extent defined the content, they had also made it clear that they wanted it to be entertaining. Looking back at my correspondence throughout the devising process I had identified that caricature and cartoon like characters would be the best vehicle within which to communicate the amount of information that they wanted us to communicate. The theatre we devised was technically up to the job so I was unsure as to where my sense of disappointment was coming from. Further reflection and questioning of the process enabled me to understand that my frustration was very much centred around the fact that I was unable to engage with the audience other than through the medium of theatre itself. In this instance there had been and would never be an opportunity to engage in conversation with the audience about how they would use the stimulus of the theatre to inform their practice. I had to accept that on this occasion that was not part of the process. I was able to identify that I needed this to be part of the process and that in this case the need was very much mine and not necessarily the need of the audience. I believe that this sense of dissatisfaction relates

directly to my values of inclusional and responsive practice and that in this case I was unable to include the participants in the process as much as I wanted to. This left me with a sense of failure despite the knowledge that the event itself was perceived to be very successful and we had indeed fulfilled our brief. Again I have been able to include this further understanding of my knowledge as a practitioner and what my practice involves to continue to ask myself how I can improve my practice.

### **Tripoli Medical Centre – Tripoli – Libya**

The devising of the E booking programme was further complicated by my four week visit to the Tripoli Medical Centre. I was approached by Jackie Ardley from the National Institute for Mental Health in England (NIMHE) as she thought I may be available to go on her behalf. She had been approached by a Company who provide support and development to overseas hospitals who want to improve their services. They had approached Jackie as they wanted a senior nurse to accompany their core team. They needed someone who could very quickly develop relationships with the people working in the hospital in order to fully understand their needs. My initial reaction was to say no thank you, I am not interested. On reflection this initial response was borne purely out of ignorance and fear. This fear was very firmly rooted in my knowledge of Tripoli and Libya, knowledge I had to acknowledge came from the media. I agreed with Jackie that I would at least meet up with the organisers before declining their invitation.

The following is an extract from my journal.

***“Why am I so anxious about taking up this offer? Primarily I am concerned about whether I am up to the job. They want someone to review the operational side of the hospital paying particular attention to nursing practice. I would then be required to write a development***

*strategy identifying improvements to be made and put together an education and development plan outlining how this would be achieved. We will be in Tripoli for a four week period with a further two weeks on our return to finalise the report. This is an enormous task and I would find it difficult to achieve here in the UK within a health sector I was familiar with and a culture I was part of. My second concern is about spending time in Libya. I know very little about the country but at a gut level I feel anxious. There is also the beating of war drums from the Bush administration and perhaps at this moment in time where I need to be is at home with my husband and children.”*

I agreed to meet with Simon and Mike, who were organising the work and they reassured me about my safety in Tripoli and I was persuaded to go. They had been invited by Colonel Gadaffi to undertake a review of Tripoli Medical Centre which was their flag ship hospital, but it wasn't working as well as they had expected and local confidence was very low. This resulted in a large part of their health budget being spent on sending people for treatment to places like Malta and Tunisia and they wanted to try to improve the hospital and so reduce the amount of spending on overseas health provision.

Mike and myself stayed in Tripoli for the duration of the project, Simon was with us for the first 2 weeks and Dr Duncan Empey joined us for the last few days and to help myself and Mike with the final presentation to the Hospital Board and the Prime Minister. In the middle two weeks we were joined by a UK Architect and Quantity Surveyor as the proposed changes also included a major overhaul to the fabric of the building.

On reflection I was almost completely overwhelmed by this experience, it has had a profound impact on me and how I live my life now and I am very pleased I had first of all the opportunity to go and secondly the

courage in myself and my ability to undertake such an enormous task. The conditions in the hospital were pretty poor as a result of years of sanctions. I watched a cardiac surgeon carry out open heart surgery on a young man without any blood supplies to help him. I spent time on the maternity unit where it was not unusual to find 3 women sharing a bed. I spent an arduous 48 hours on the paediatric intensive care unit and tried to comfort children who died because of a lack of basic medication, suffering death in tremendous pain because of no available pain relief. Yet throughout this I was treated as a welcome friend by the doctors and nurses who dedicated themselves to trying to provide a service. My report outlined a new strategy for nurse education in association with Tripoli University and a new structure for nursing within the hospital. This work has only just started and I was approached to see if I would be interested in taking on the role of Director of Nurse Education. Although I was honoured and also very tempted I felt that I had to decline this offer. I believe that this role should be taken on by someone from this culture and I know that they will find a suitable leader. I do hope that my relationship with the hospital and the wonderful people I had the privilege to work alongside here will be a long one.

### **HELP – Health and Education for Life**

My worries about the direction we were moving in disappeared when the most recent request for our input was made. Shaun and I were asked to suggest ways that we might use theatre to work with young people in order to raise awareness of mental health issues. This request has resulted in the HELP initiative. HELP stands for health and education for life and is a three year action research programme which uses the creative arts in exactly this way.

Phase one and two of this project is now completed and phase three is underway and there are plans for it to be extended to three additional sites. Each site will be participating in the project for a three year period. For me this demonstrates a very real acceptance of the work that I have been undertaking in order to include theatre-in-education and theatre for development in main stream education and development of health care professionals. For more information about the HELP project please see Appendix 13 HELP phase one report. You can also view some of the art work, poetry and stories contributed by the children in Liverpool on the HELP website.

[www.helpuk.org](http://www.helpuk.org)

In this chapter I have reflected on the development of myself as a practitioner of healthcare improvement. The process of studying my own practice as a way of improving my practice has meant that I believe I now have a better understanding of what my practice is. I have also been able to clarify the meaning of my values and in particular my passion for compassion and communicate through this narrative alongside my visual narrative how they are sustained by living them in my practice. On many occasions I have had to confront myself as a living contradiction and as a consequence I have challenged myself to take more responsibility to know and understand my embodied knowledge and how my embodied knowledge as a theatre practitioner can enhance my practice as a facilitator. This has not been a simple and straightforward process rather it has been one filled with self-doubt and insecurity. Throughout the period of this inquiry I have tried to identify a way to overcome these fears and learn to rely more on my intuition and embodied knowledge. In this way I have been able to trust in the relationships that I develop with the people I work with. These relationships have become pedagogical relationships where I can practice in a much more responsive way. This enables us all to take risks, to challenge our practices and patterns of behaviour in a hope that our co-created future will be a better one.