The Work of the Applied Theatre Artist as Simulated Patient in Open Disclosure Scenarios

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Abstract

The artist employed as a simulated patient fulfils a complex and demanding role. Simulated patients are required to create authentic characters, assist in the facilitation of successful educational outcomes and contribute to providing a supportive environment in which healthcare providers are able to safely practice their skills. Despite the growing research related to the use of simulated patients in medical education, there is little exploration from the artist's perspective. This thesis addresses this gap by exploring the experiences of three artists working as simulated patients in the specific context of simulated Open Disclosure scenarios. Using a qualitative research approach employing narrative inquiry and autoethnography, this study explores the responsibilities and practice requirements for the artist as simulated patient and aims to understand how the artist manages these responsibilities to create quality outcomes for healthcare providers. A thematic analysis of participants’ narratives pertaining to their work as simulated patients in the Open Disclosure context was used to explore several research questions.

The study findings reveal that the artist as simulated patient takes on three responsibilities: acting, facilitating and maintaining a safe environment. Each of these responsibilities has several associated practice requirements, challenges and tensions. The findings also suggest that as they work, the artist has four internal voices in their head and that these voices are associated with the three responsibilities. These are: the actor’s voice and the character’s voice (acting); the facilitator’s voice (facilitating); and the ethicist’s voice (maintaining a safe environment). Further, the study reveals that the artist’s critically aware self filters this inner dialogue to make decisions in the moment-to-moment action. These decisions allow the artist, as simulated patient, to respond within the interactions in a way that can best serve the various needs of the individual healthcare providers.

It is hoped that the findings in this research study will contribute the training of artists as simulated patients in order to provide more effective support in the education of healthcare providers.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Jessica Veurman
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# Table of Contents

Abstract ................................................................................................................................. i

Statement of Originality ....................................................................................................... ii

Acknowledgments ................................................................................................................ vi

Chapter 1: Introduction ....................................................................................................... 1
  Terminology ......................................................................................................................... 3
  Rationale .............................................................................................................................. 3
  Open Disclosure .................................................................................................................. 4
  Simulated Open Disclosure - The Process ....................................................................... 4
  Researcher’s Background .................................................................................................... 6
  Structure of Thesis .............................................................................................................. 7

Chapter 2: Literature Review .............................................................................................. 8
  The artist as simulated patient – overview of existing literature ....................................... 8
  Acting ................................................................................................................................ 11
    Authenticity ...................................................................................................................... 11
    Building and conserving the illusion .............................................................................. 12
    Spontaneity and improvisation .................................................................................... 13
    Awareness of audience .................................................................................................. 14
  Facilitating ......................................................................................................................... 15
    Intentionality ................................................................................................................... 15
    Giving feedback ............................................................................................................. 16
    Individuality .................................................................................................................... 17
    Resilience ....................................................................................................................... 17
  Maintaining a safe environment ....................................................................................... 18
    Safety: Safe practice ....................................................................................................... 18
    Distancing ....................................................................................................................... 20
    Professional integrity ..................................................................................................... 20
    Empathy .......................................................................................................................... 21
  Managing the multiple responsibilities .......................................................................... 21
  Conclusion .......................................................................................................................... 24

Chapter 3: Methodology ..................................................................................................... 25
  Research Design ................................................................................................................ 25
    Autoethnography and Narrative Inquiry ......................................................................... 26
    Participants ..................................................................................................................... 28
    Method ............................................................................................................................. 29
    Field Texts to be collected ............................................................................................ 30
    Method of Collection ..................................................................................................... 30
    Analysis ............................................................................................................................ 34
  Application ........................................................................................................................ 36
  Ethics .................................................................................................................................. 37

Chapter 4: Phase One Analysis .......................................................................................... 39
  Jason’s Stories .................................................................................................................... 39
    Jason: Summary of emerging themes ........................................................................... 41
  Cate’s Stories ..................................................................................................................... 43
    Cate: Summary of Emerging Themes ............................................................................ 45
  Jessica’s stories ................................................................................................................. 47
    Jessica: Summary of Emerging Themes ....................................................................... 50
  Discussion of emerging themes across the memory stories ........................................... 52
  Acting .................................................................................................................................. 52
    Authenticity .................................................................................................................... 52
    Building and conserving the illusion ............................................................................ 53
Spontaneity and improvisation .................................................. 53
Facilitating ........................................................................... 54
   Intentionality .................................................................. 54
   Awareness of HCP’s individual needs .................................. 54
Maintaining a safe environment ................................................. 55
   Safety: Safe practice ....................................................... 55
   Distancing ....................................................................... 56
Managing the multiple responsibilities and self ......................... 56
Conclusion ............................................................................ 58

Chapter 5: Phase Two and Three Analysis ................................. 60
Acting .................................................................................. 60
   Authenticity ..................................................................... 61
   Building and conserving the illusion .................................... 63
   Spontaneity and Improvisation .......................................... 64
   Awareness of HCP’s interaction ........................................ 65
Facilitating ........................................................................... 67
   Intentionality .................................................................. 67
   Giving Feedback .............................................................. 68
   Offering Clues .................................................................. 69
   Awareness of HCP’s educational needs ............................... 70
Maintaining a safe environment ............................................... 71
   Safety: Safe practice ....................................................... 71
   Artist’s Safety: Distancing ................................................ 73
   Awareness of HCP’s safety ................................................ 74
Inner Dialogue – the Competing Voices and the Filter of the Critically Aware Self.. 76
   The Critically Aware Self .................................................. 80
Conclusion ............................................................................ 83

Chapter 6: Research Findings and Conclusions .......................... 85
   Summary of findings ....................................................... 85
   Applications and Implications .......................................... 90
   Recommendations for further research ............................... 90
   Conclusion ....................................................................... 91

References ............................................................................ 92

APPENDICES ....................................................................... 99
Appendix A: Information Sheet for Participants .......................... 99
Appendix B: Questions for semi-structured interview ................. 102
Appendix C: Sample of a memory story and thematic analysis (Cate) ........................................................................ 103
Appendix D: Sample of IPA analysis semi-structured interview (Jason) .......................................................... 105
Appendix E: Themes from semi-structured interviews ............... 110
Appendix F: Extract of focus group discussion transcript ............ 111
Appendix G: Final table of themes from semi-structured interviews and focus group .................................................. 114
Figures and Tables

Figure 1. Research Design ..................................................................................................................33
Figure 2. The Responsibilities of the Artist to do Good Work .........................................................59
Figure 3. The Applied Theatre Artist as Simulated Patient ..........................................................88

Table 1. Field Texts Collected ..........................................................................................................30
Table 2. Artist’s Responsibilities, Practice Requirements, Challenges and Tensions

.......................................................................................................................................................86
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Chapter 1: Introduction

I am an actor and an educator. I am also an applied theatre artist. Applied theatre practice is used to affect individual and or social change and relies on aesthetic engagement for its power and effectiveness (Nicholson, 2005). Its educational applications include Prison Theatre, Community-based Theatre, Theatre for Development and Theatre for Health Education (Prendergast & Saxton, 2009). One of my many jobs as an applied theatre artist is to work in Health Education as a simulated patient, an individual who has been trained to take on, in a detailed and authentic way, the specific conditions, attitudes and or issues of a real patient and or family member (Plaksin et al., 2016; Wallace, 1997). The simulated patient (SP) is a realistic character who interacts in a fictional scenario with a healthcare provider (HCP) to assist in the facilitation of HCPs’ learning (Pascucci, Weinstock, O’Connor, Fancy & Meyer, 2014; Russell, Etherington & Hawthorne, 2012; Sutton, 2011). Simulated patients are important to medical education as they allow healthcare providers to practice real communication and clinical skills without jeopardizing the health and welfare of real patients (Gaba, 2004; Plaksin et al., 2016; Ziv, Wolpe, Small & Glick, 2003). They are also valued because the simulated patient is able to provide feedback, crucial to the HCPs learning (Pascucci et al., 2014).

The artist in a simulated Open Disclosure scenario takes on the character of a patient or family member receiving bad news, usually when a patient’s well-being has been affected following an adverse event. Whilst a range of persons might play a simulated patient (from lay persons to trained actors), it is suggested that in ‘high stakes’ scenarios such as simulated Open Disclosure scenarios, trained actors are often better able to cope with the demands of the scenario because they have the skills to create engaging realistic characters and to support the learning environment (Pascucci et al., 2014). The artist working as a simulated patient is not only required to create an authentic character but also to assist in the facilitation of successful educational outcomes and to contribute to providing an ethically sound environment where healthcare providers can safely practice their skills (Keltner, Grant & McLernon, 2011; Pascucci, et al., 2014; Sutton, 2011; Taylor, 2011). Taylor, (2011) suggests that the artist as simulated patient is able to do this because they are working in both the fiction and reality, being ‘real’ but at the same time ‘not real’. In other words the artist works in a state of metaxis (Boal, 1995) and is able to exist in the fictional world of a character while simultaneously operating in the real world to consciously observe and control their involvement and that of the healthcare professional in the fiction. The artist’s ability to do this gives the work both “authenticity and ethical viability” (Taylor, 2011, p. 137).
In this study, it is proposed that the artist as simulated patient, operating in this dual world takes on multiple responsibilities often simultaneously, such as, acting, facilitating and maintaining a safe and supportive environment. It follows then that significant cognitive demands are placed on the actor as simulated patient (Newlin-Canzone, Scerbo, Gliva-McConvey & Wallace, 2013). These ideas are of interest in this research and give rise to several research questions. These questions aim to understand how the artist, employed to be a simulated patient, within simulated Open Disclosure scenarios manages the multiple demands inherent within their work as simulated patients. These questions are:

1. What are the responsibilities of the applied theatre artist in simulated Open Disclosure scenarios?
2. What are the challenges, tensions and constraints faced by applied theatre artists in high stakes simulated Open Disclosure scenarios?
3. How does the applied theatre artist as simulated patient integrate and reconcile their various and often competing responsibilities to produce high quality learning outcomes for healthcare providers?

To address these questions this qualitative research study explores the work of the simulated patient in Open Disclosure scenarios from the artists’ perspective. To date, investigation of how SPs interact in these encounters has received little attention (Murtagh, 2014) and indeed very little has been written about the role of the SP from the artist’s perspective (Sutton, 2011). Plaksin et al. (2016) suggest simulated patients’ experiences have been largely neglected in the literature including how the individual artist deals with their experiences (McNaughton, Tiberius & Hodges, 1999). In order to address this gap this research employs a narrative research approach combining autoethnography and narrative inquiry to explore the stories and experiences of three professional artists, who along with other work, engage as simulated patients. I am one of these artists.

The process of narrative research requires not just the telling of experience but also the analysis of these experiences (Ellis, Adams & Bochner, 2011). In this thesis, a paradigmatic analysis of narratives (Polkinghorne, 1995) is used to provide knowledge and understanding of the artist’s process. The research intends to realise how artists might contribute more effectively in the education of healthcare providers and support the training of artists who engage in this work.

The literature review supports the research by providing a better understanding of the work of simulated patients from the artist’s perspective. Particular focus is placed on understanding areas of professional practice specific to the artist in the simulated Open
Disclosure context to create both an affective and effective simulated patient.

**Terminology**
In this study, the term applied theatre artist or artist is used to signify the individual working as a simulated patient. Schön (1987) suggests that the term artist refers to “practitioners adept at handling situations of uncertainty, uniqueness, and conflict” (p.16). Whilst actors are often employed as simulated patients and much of the literature uses the term actor to refer to the person playing a simulated patient, most authors agree that the simulated patient is required to do more than acting alone (Pascucci et al., 2014). Therefore, the term artist is used in this study to differentiate the work of the simulated patient from the work of the actor.

**Rationale**
There is a growing demand for skilled and trained simulated patients, as they are considered integral to medical education and training (Bradley 2006; Ker et al., 2005). The use of simulated patients to improve the communication skills and clinical practice of healthcare providers has grown particularly in the past thirty years and is now a widely accepted and indeed valued practice (Jacobsen, Råheim & Rassmussen, 2010; Plaksin et al., 2016). Simulated patients are being used in response to a growing need for more effective communication skills in the health profession (Adamo, 2003; Plaksin et al., 2016; Schlegel, Woermann, Shaha, Rethans & van der Vleuten, 2012). This has largely been in response to patients expressing their dissatisfaction with HCP’s poor communication skills (Abbot, Attenborough, Cushing, Hanrahan & Korszun, 2009) and because real patients are becoming less willing to take part in the training of medical professionals (Ker et al., 2005).

Howard Barrows, now considered the “father of this innovation in medical education”, was in the early 1960’s scoffed at for using actors as simulated patients (Wallace 1997, p. 6). Barrows (1968) was concerned that if medical training was to be patient-centred then students needed to be taught how to relate to patients, and develop their ‘bedside manner’. He sought alternatives to using real patients to protect them from potential harm; however, he soon came to realise the value of using the interactive and experiential nature of SPs as a teaching and evaluation tool for a range of communication and clinical competency-based skills (Barrows & Abrahamson, 1964). Simulated patients are now used widely in medical education to “replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion” (Gaba, 2004, p. i2).
Open Disclosure
Simulated patients are used in a range of contexts and this flexibility assists in meeting various educational outcomes (Adamo, 2003; Plaksin et al., 2016). A particular application of the simulated scenario has been chosen for this research; this application will be referred to as the *simulated Open Disclosure* scenario.

Real Open Disclosures are important to patient health; however, they are difficult interactions to manage. Open Disclosure interactions are designed to inform the patient and or family members when a patient's wellbeing has been affected following an adverse event. An adverse event is an incident that results in unnecessary harm to a patient (O'Connor, Coats, Yardley & Wu, 2010). The Open Disclosure scenario can be either a *Clinician Disclosure* - usually the initial, informal explanation and apology to the patient by a clinician, or a *Formal Open Disclosure* - a formal structured team meeting designed to inform and assist the patient, usually in more serious events (Queensland Government, Department of Health, 2013). Research demonstrates that “increased openness and honesty following adverse events can improve provider-patient relationships”, however there is “a gap between ideal disclosure practice and reality” (O’Connor et al., 2010, p. 371).

The *simulated Open Disclosure* scenario then, allows healthcare providers to practice effective communication skills to help improve their relationship with a patient and in turn help to provide better healthcare for the patient (O’Connor et al., 2010). These simulated scenarios help to improve the skills of healthcare providers by using an experiential based learning approach, which “converts understanding, knowledge and attitudes into behaviour and action” (Kurtz, Silverman & Draper, 2005, p. 6). It also offers opportunity for the HCP to reflect on their skill development to enhance learning (Cleland, Abe & Rethans, 2009).

The *simulated Open Disclosure* scenario has been selected for this research study as it is considered a ‘high stakes’ scenario (sometimes involving fictional life and death situations) and thus provides a more intense and challenging experience for the artist (Pascucci et al., 2014). It is proposed that these scenarios will provide more acute responses from the research participants and therefore make for more robust discussions about the work of the artist as simulated patient.

**Simulated Open Disclosure - The Process**
The simulated Open Disclosure workshop is led by a trained facilitator/educator who has expertise in clinical practice, allowing them to provide guidance and feedback to a group of HCPs (Ker et al., 2005). These facilitators encourage “active participation, exploration, reflection and the individual construction of meaning” (Churchouse & Rudd, 2008, p. 118).
In simulated Open Disclosure workshop there are typically three sets of personnel involved:

1. A trained facilitator clinician;
2. A range of healthcare providers, (in this research context usually four to eight); and,
3. An artist playing the simulated patient.

The artist playing the simulated patient will be given a brief (1-2 pages) that provides information about the character and the situation (adverse event) to be enacted. The artist is given this several days before to allow for preparation. A conversation with a clinical facilitator is provided to allow the actor to ask questions, to clarify points and also for the facilitator to address any specific conditions or considerations for the session. For example, a range of HCPs from various specialist backgrounds might be in one session, therefore the actor will need to be flexible with the character portrayal as they will often be asked to play the scenario differently for each HCP, to maintain relevance for the individual learners (Puscucci et al., 2014).

A session typically starts with the healthcare providers (approximately four to eight) and a facilitator clinician seated facing the artist who waits in neutral state between self and simulated patient. Usually one or two healthcare providers are invited to join the actor in the ‘performative’ space (Jacobsen et al., 2006). The conventions of the scenario require that artist then becomes the simulated patient. Alternatively, the artist as the simulated patient may be asked to wait outside as if in a hospital waiting room and be invited in to the space by the HCPs, as part of the simulated scenario. The artist as simulated patient then interacts with the HCP who responds, not in character, but as himself or herself as healthcare provider (McNaughton et al., 2008). Together the actor and the HCP engage in the fiction. Nestel and Bearman (2014) suggest, “A well-prepared simulated patient (SP) has the ability to draw learners into a scenario quickly, achieving deep engagement” (p. 1). These scenarios are often based on real cases to add to the authenticity (Kurtz et al., 2005) therefore the artist must ensure they play the given character and situation authentically (Lane & Rollnick, 2007), and offer honest/truthful emotional responses as a believable character (Keltner et al., 2011).

It is important to note here that while one HCP is participating in the fiction, the others are watching (Jacobsen et al., 2006). The remaining healthcare providers and the facilitator clinician observe this interaction, in similar way to how a theatre audience might observe a performance. However, the nature of the simulated interaction allows the clinical facilitator, or the HCP involved in the interaction, to stop the action at any time. Doing this allows the group to reflect and gather learning and or to determine alternate actions in an attempt to change the resulting action (Jacobsen et al., 2010; Loth et al., 2015; Sutton, 2011). Stopping
and critically reflecting on the interaction in this way is crucial to the HCPs’ learning (Kurtz et al., 2005). During this ‘time out’, when the action is stopped to allow for discussion, the actor must remain neutral and not allow the discussion to affect their behaviour (Jacobsen et al., 2006). At these times, the simulated patient is often called on to answer questions to assist with educational discussions. The artist as simulated patient must be able to provide reflection ‘in action’ as the character (Jacobsen et al., 2010) and when appropriate they must be able to give feedback ‘on action’ out of character (Kurtz et al., 2005). This dramatic interplay between actor and ‘audience’ is crucial to the artistic and educational outcomes of the SP scenario. Indeed, the notion of audience interaction is also a fundamental tenet of participatory applied theatre work and is a concept attributed mostly to the work of Augusto Boal (Prendergast & Saxton, 2009).

Further to this, the artist must be adaptable, allowing the scenarios to not only be stopped and started but to be able to repeat the scenario several times to allow the HCPs to practice and revise skills (Kurtz et al., 2005). The simulated Open Disclosure scenario can be repeated up to eight times, in order to give all HCPs an opportunity to participate. To allow for a HCP’s individual needs, the clinical facilitator as director may ask the actor to change the attitudes and or emotions of the SP (the basic character scenario doesn’t change), giving each healthcare provider a more purposeful interaction (Kurtz et al., 2005). These variations of character are left for the actor to create (sometimes with only a moment’s notice), therefore the actor’s skills and particularly their ability to improvise with authenticity while remaining focussed on the educational outcomes are key (Russell et al., 2012). There is reliance here on the artist’s stamina and commitment to the task in order to contribute to scenarios in a way that offers “ethical and relational training” (Pascucci et al., 2014, p. 120). The actor must be able to stop, start, reflect, repeat, and change, yet consistently maintain authenticity in the scenario and assist in creating a safe, relevant and learner centred environment.

**Researcher’s Background**

As a qualitative researcher, I recognise that my life experiences and my need to make sense of these have shaped who I am. Denzin and Lincoln (2005) suggest that qualitative researchers “study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meaning people bring to them” (p. 3).

It is my work as both actor, educator and applied theatre artist that has led me to question and think more deeply about my job as a simulated patient and I hope that through this research I might be able to contribute to the understandings and practice of this work. I have worked as a simulated patient on and off for over fifteen years. Recently this work has
become more regular. I find the work enormously challenging and satisfying. The simulated Open Disclosure scenarios are not easy interactions and place high demands on all persons involved. I am interested in understanding how other artists view their practice and whether they work in similar ways to me.

I am a trained actor and have worked in both television/film and in theatre for over twenty-five years. I am also a trained drama educator and have received several teaching awards and commendations. In addition, I have worked for many years as an applied theatre artist and been involved with teaching, planning, performing and directing on a range of projects.

**Structure of Thesis**
In this chapter I have given an overview of the study indicating my motivation for the research and the research questions. A rationale for the study including considered gaps in the existing research has also been provided. The chapter also gives a brief overview of the specific context and process of simulated Open Disclosure relevant to this study.

Chapter Two provides a review of the literature that informs this study. The literature is focussed on understanding the responsibilities and practice requirements for the artist as simulation patient. This literature provides support for discussions in the later chapters.

In Chapter Three I explain the research design for this study including the rationale for choosing narrative inquiry and autoethnography as the methodology.

Chapter Four provides the findings of this research for phase one of the study. Memory stories from the participants provide a background to the work of the artist as simulated patient. A thematic analysis of these stories provides an initial exploration of the research questions.

Chapter Five extends on the findings from the previous chapter by exploring further stories from the participants in phase two and three of the research. An analysis of these stories from recent work in the field provides more details of the artists’ experience as simulated patients. In both Chapter Four and Five concepts explored in the literature review frame the discussions.

In Chapter Six a summary of this study's research findings is offered in the form of a model. This model is explained and explored. Possible applications and implications for this study are offer along with recommendations for further research in this field. I finish with a conclusion to the chapter and the thesis.
Chapter 2: Literature Review

The process of managing the artistic, educational and ethical demands of the simulated Open Disclosure scenario is a complex one. McNaughton et al. (2008) considers the challenge for the artist and describes it as the artist's ability to "embody a complex set of often contradictory cognitive, psychological and emotional features" (p. 90). The artist playing a simulated patient takes on a range of responsibilities each involving a diverse set of practice requirements.

This review of the literature aims to provide a better understanding of these responsibilities and their interrelated practice requirements, together with a sense of how the artist might integrate and reconcile these as a simulated patient within simulated Open Disclosure scenarios. In doing this I identify the various demands placed on the artist as they work to provide a safe and productive learning environment for healthcare providers. The first section of this review provides a brief overview of the existing literature related specifically to the artist's work in patient simulation scenarios. I discuss what other studies have identified as responsibilities and practice requirements for the artist working in this context. Following this, I offer an exploration of the artist's responsibilities under three headings: 1) Acting 2) Facilitating and 3) Maintaining a safe environment. Here the literature is drawn from a wider range of sources with particular focus on materials related to the practices associated with each responsibility. In the final section of this chapter, I present literature supporting the concept of the actor as simulated patient thinking and responding from their various positions of responsibility, often simultaneously. Bowell and Heap (2005) refer to a similar phenomenon as quadripartite thinking.

The artist as simulated patient – overview of existing literature

Applied theatre artists are employed for their professionalism, their skills at creating and maintaining the creative aspects of simulated patient scenarios and assisting in the educative process (Keltner et al, 2011). The artist must call on their skills to manage a complex situation. These skills are vital due to the improvisational nature of the simulated disclosure scenario and thus as the artist must be able to draw spontaneously on their experience and imagination to build characters, situations and narratives in the moment (Kurtz et al., 2005). Pascucci et al. (2014) suggest that trained actors are most often better able to cope with the demands of 'high stakes' scenarios such as simulated Open Disclosure scenarios because they have the skills to create engaging authentic characters and to support the learning environment. Smith, Gephardt and Nestel (2015) claim it is imperative the actor creates a character that is as real as the proxy they represent. The actor must be able to emulate how real patients behave, for example patients don’t often question their doctor when they don’t
understand and they give “covert rather than overt clues to their underlying needs” (Kurtz et al., 2005, p. 94). Some argue that a simulated patient cannot effectively match the realism of a true patient, because of the lack of real risk (Taylor, 2011). However others suggest that the actor is able, through skills and techniques to create authentic characters real enough to enable healthcare providers to “call on the depths of their training and deal professionally with the SP” (Keltner et al., 2011, p. 38). To this end it is considered useful for the actor to use acting styles based in truth and honesty of emotion and create characters that are authentic as this has a profound affect on HCPs and engages them truthfully in the interaction (Keltner et al., 2011). Several articles cite the work of Stanislavski and suggest that his techniques are best suited to creating a character for the SP context (Keltner et al., 2011; Smith, et al., 2015).

Simulated patients are expected to be not only an actor but also an educator (Kurtz et al., 1998; Loth et al., 2015; Sutton, 2011). Artists in a simulated Open Disclosure scenario must also be aware of their ‘audience’ who in this context are the healthcare providers. Artists must use their skills to interact with the healthcare providers in a range of ways to meet both the artistic and the educational demands of the scenario (Jacobsen et al., 2006). Loth et al. (2015) describe the need for actors to create complex and believable characters and at the same time be facilitators who are acutely aware of the educational objectives in the scenario. As the artist realistically takes on their role and is honestly immersed in the fiction, they must simultaneously be outside the action observing and evaluating the interaction as a facilitator (Loth et al., 2015). This duality of experience is what Boal (1992) describes as metaxis, the interplay of two worlds, seeing two perspectives of a situation at the same time. Sutton (2011) draws on his own experience as a SP and describes this phenomenon as the actor working as both actor and educator.

The actor/educator combines the performance skills of the actor with the communication, dialectical and evaluative skills of the educator. It is essential that actor/educators are convincing in their depictions of character and situation; it is equally essential that a certain aspect of the actor/educator’s consciousness operates simultaneously as a ‘detached observer’. This divided self enables the actor/educator to manipulate a scenario, offer considered assessment, give feedback and respond to a facilitator’s interventions. (p. 87)

Further to this and in particular to Sutton’s notion of manipulating a scenario, Loth et al. (2015) suggest the “actor is required to make moment-by-moment decisions in order to effectively facilitate student learning” and as such needs to develop a range of skills in areas including performance, facilitation and knowledge (of specific medical conditions). In Open
Disclosure scenarios the interactions are concerned more with the patient's emotional state and as such in this particular simulation context medical conditions, signs and symptoms are usually not of great importance. Therefore, I suggest that the medical knowledge required by the simulated patient in the simulated Open Disclosure context is minimal and as such part of the artist's acting responsibility in terms of their character creation.

Simulated patients are also responsible for contributing to a safe learning environment for the healthcare providers they are working with. Nelles (2011) suggests that the actor's craft is crucial to creating and maintaining a pseudo-fictional world that is seemingly 'real' but at the same time 'not real', giving it “authenticity and ethical viability” (Taylor, 2011, p. 137). Sutton (2011) understands the simulated patient to be “both less and more than a real patient” - less because they are not really suffering as a real patient would but more because they are able to employ skills to affect a HCP’s “willing suspension of disbelief” (p. 87). I will discuss this concept further in the review under the heading building and conserving the illusion. Pascucci et al. (2014) agree that skilled actors “facilitate the suspension of disbelief – a critical step to engage participants [HCPs] fully in the experiential learning” (p. 20). If the healthcare provider does not engage with the scenario and accept the fictional boundaries then authenticity suffers (Russell et al., 2012).

Artists also use their skills and techniques to tap into life experiences and emotions to create authentic characters, while maintaining a distance for self-protection (Taylor, 2011). Several studies caution that actors should be psychologically healthy such that their past experiences not affect their ability to play a character (Keltner et al., 2011; Naftulin & Andrew, 1975). McNaughton et al. (1999) studied the effects on SPs playing emotionally intense roles and offer one artist's thoughts: “I make a conscious effort at creating a definite boundary” (p. 138). Here the artist is suggesting that they intentionally maintain a distance between themselves and the character they are playing, which helps the artist to “promote a natural and psychologically healthy repeatable process” (Keltner et al., 2011, p. 38).

Nonetheless, actors are valued for their ability to create realistic characters and be able to “move in and out of role and maintain a clear distinction between themselves and the role” (McNaughton et al., 1999, p. 140). McNaughton et al. (2008) suggest that actors bring to the work their flexibility and ability to reflect not just on the patient they are portraying, but also on themselves. Nelles (2011) states, “I often call upon my acting training to realize complex roles and more importantly to protect myself” (p. 57).

Interestingly, not all actors enjoy and or indeed are suited to working as simulated patients (Keltner et al., 2011; Plaksin et al., 2016). Several studies indicate that one of the key
reasons that artists do this type of work is that they experience satisfaction from their contribution and also feel of value to others (McNaughton et al., 1995; Plaksin et al., 2016). Studies exploring the experiences of SPs also suggest those who are effective in playing a simulated patient share attributes such as compassion, commitment to the task, empathy for the learners and anxiety to do good work (Bokken Van Dalen & Rethans, 2006; Boerjan, Boone, Anthhierens, van Weel-Baumgarten & Deveugele, 2008; Harvey & Radomski, 2011; Pascucci, 2014; Taylor, 2011; Woodward & Gliva-McConvey, 1995). Nelles (2011) in her autoethnographic study proposes, “compassion is the single most important factor contributing to why this not acting can be so easily called upon” (p.60). What she is suggesting is that the unique context of the SP scenario where the artist is acting yet not acting asks the artist to call upon their compassion to help them portray the simulated patient in order to be respectful to the real patients they represent.

Working as a simulated patient requires the artist to use their acting skills in ways akin yet different to working in theatre or film (Nelles, 2011). The unique context of the patient simulation Open Disclosure scenario asks the artist to draw on their actor training to modify their acting skills, their skills of facilitation and also their ethical sensibilities. Therefore, I have divided the areas of responsibility of professional practice for the artist as simulated patient based on these three broader responsibilities: acting, facilitating and maintaining a safe environment. I will now review literature related to these three broader topics and more specifically address some of the practice requirements required by the artist as simulated patient.

**Acting**
One of the key responsibilities of the artist working in Open Disclosure scenarios is to act; however acting in these scenarios is complex and different to the work of the actor in other contexts. Acting in the OD context requires a set of specific practice requirements including the ability to: work with *authenticity* which relates to the actor’s ability to create and sustain a realistic character and scenario; create effective fictional models of reality by *building and conserving the illusion*; work with *spontaneity and improvisation* and have an *awareness of audience* (HPCs) in order to interact appropriately with them.

**Authenticity**
In the early 1900s Constantin Stanislavski introduced a system of acting to provide actors with ways of training their minds and bodies to create authentic characters - characters based in truth (Stanislavski, 1937/1986). Other theatre practitioners such as Bertolt Brecht, Eugenio Barba and Augusto Boal have since sought to develop Stanislavski’s ideas or indeed
to seek alternatives to his methods. Their work along with Stanislavski's has provided a range of theories and methods of acting, which have influenced much of our contemporary practice (Hodge, 2010).

The notion of truth and authenticity for the character is central to Stanislavski's method of acting training. Stanislavski aimed to affect audiences emotionally by creating characters based in truth; “only such art can completely absorb the spectator”, enriching "his inner life, and leaving impressions which will not fade in time" (Stanislavski, 1937/1986, p. 16). He was opposed to actors mimicking or representing characters, describing this as imitation, mechanical, over-acting or forced acting (Stanislavski, 1937/1986). Instead he called for the actor to be creative; one who is immersed “in the living experience of human beings” (Stanislavski, 1937/1986, p. 16). The successful creation of such a character in Stanislavski’s system of acting asks the actor to develop their “sense of self”. By working on the self and training the mind and body the actor becomes someone who is skilled, robust and emotionally connected and this self then becomes the “soil from which the role can grow” (Carnike 2010, p. 8). Barba (1995) too discusses this notion of self and its relevance to the performer and suggests that a key aspect of the actor's craft is that they are an "individual". He explains this as "the performers personality, his/her sensitivity, artistic intelligence, social persona; those characteristics which render the individual performer unique and uncopiable" (p. 10). Chaikin (1972) too states, “when we as actors are performing, we as persons are also present and the performance is a testimony of ourselves” (p. 5). Barba (1995) goes further to suggest that the performer “begins with the inherent gifts of his/her personality” then use “points of departure” which is the performers technique or “craft” (p. 13). Barba is suggesting here that the trained actor will draw on their own experiences and then be guided by technique and craft to create the character.

**Building and conserving the illusion**
The simulated Open Disclosure scenario is a simulation of real life ‘dialogue’ between a patient and their healthcare provider and as such participants “suspend disbelief and speak and act much as they do in their real jobs” (Gaba, 2004, p.i2). Importantly the experiential learning process may be more clearly realised when the HCP is absorbed in the fiction as if it were a real clinical encounter because it connects more meaningfully with their real work (Smith et al., 2014). It is necessary then for the HCPs to willingly suspend their disbelief, however there are associated concepts to be considered here. In improvised work there is a step required before participants are able to suspend their disbelief. That is to build and conserve the illusion, to create the fictional world in which the participants agree to engage. O’Neill (1995) believes this “temporary acceptance of an illusion” is central to all forms of theatre and drama (p. 45). The artist works to create the illusion by using their skills of
improvisation and the creation of authentic characters and scenarios, supporting the HCPs to suspend their disbelief and practice their real skills in life-like situations. Interestingly in the OD context the SP is engaged in an entirely fictional situation, while the HCPs are playing themselves. As such the actor must build and conserve the illusion to help the HCPs believe in the fictional scenario. Dorothy Heathcote calls this ‘building belief’, and explains that for some the fictional context is “not easy to jump into, but is crucial to the success of the drama” (Wagner, 1979, p. 67). Heathcote champions the idea that experiences in fictional contexts enable participants to learn about themselves in the real world (Wagner, 1979). Heathcote suggests, that this is possible because participants engage in a fictional world and are free to explore moments based in human experience that they may normally not get the opportunity to do, yet they are simultaneously protected by the fiction (Wagner, 1979). Oatley (2009) argues that people think of fiction as being untrue, however he believes this is wrong, noting instead that fiction is not false but is “about possible selves, in possible worlds” (p. 1). To engage in these fictional, other worlds then Heathcote proposes that everyone involved must “try to accept ‘the one Big Lie’” (Wagner, 1979, p. 67).

Studies of children at play suggest that the acceptance of fiction happens best when all participants engage to build and conserve the illusion through unspoken “implicit strategies” (Dunn, 2009 p. 68). Giffin (1984) calls this the “illusion conservation rule” and suggests that this allows participants to “experience collaboratively a transformed definition of reality” (as cited in Dunn, 2009, p. 68). This implicit acceptance of the fiction means that all participants are helping to not only build, but also to conserve the illusion of the fiction which suggests a more cohesive and binding experience for the participants than the process of ‘willing suspension of disbelief’.

The acceptance of the fiction is important so that the drama work does not fall apart (Wagner, 1979) and also serves to protect the participants from the real world. Pendergast and Saxton (2013), also consider it necessary to build and conserve the illusion to provide a fictional and therefore safe space for all involved. This notion will be discussed further in maintaining a safe environment.

**Spontaneity and improvisation**

The dramatic form of the SP scenario relies heavily on the artist’s ability to improvise. For the artist then it is essential to understand that spontaneity is key to successful improvisation (Spolin, 1983; Johnston, 2006; Johnstone, 1981). Spolin (1983) argues that we learn from experience. In order to do that she suggests we need to be involved in the experience at three levels: intellectual, physical and intuitive. She also argues that of these three, “the intuitive [is] the most vital to the learning situation” (Spolin, 1983, p. 3). Intuition
allows one to respond with immediacy “bearing gifts in the moment of spontaneity…spontaneity is the moment of personal freedom when we are face with a reality and see it, explore it and act accordingly” (p 4). Johnstone (1981) cautions that the improviser must not suppress their spontaneous impulses and censor imagination to play it safe, responses should be obvious and real according to the given circumstances of the scene. He also warns against trying to anticipate problems and prepare solutions in advance, as it’s very likely the solutions will be wrong; nor he suggests, is it prudent to try to make up original responses in order to impress, as these are usually less interesting and don’t lead the improvisation in a truthful direction (Johnstone, 1981). Johnstone (1981) claims that our “imagination is our true self” and thus suggests that when improvising it is important not to censor responses as this stifles creativity and imagination, one should be unafraid to dig deep and face their demons (p. 105). Johnston (2006) agrees, suggesting that if properly handled, improvisation has “the capacity to show us to ourselves” (p. 6).

Johnston (2006) goes further to suggest that, “improvisation requires a degree of consciousness which involves the performer being ‘at one remove’ from real life – yet crucially attached to it. It involves both detachment and engagement, a balancing act that is hard to get right” (p. 8). For improvisation to work effectively it relies on structures and conventions. This allows for freedom of creativity and also for the protection/safety for the improvisers (Johnston, 2006). Skilled improvisers train and practice to ‘get it right’. Other factors that assist the improviser in remaining spontaneous is the awareness and use of status, space, offering and accepting offers (Johnstone, 1981; Pendergast & Saxton, 2013). Importantly for improvisation to work, the improvisers must be awake, listening, watching and paying attention, not forcing the outcome but allowing responses to be spontaneous (Johnston, 2006).

Improvisation according to Johnston (2006) tends to be used for four different reasons: to increase self-knowledge; to learn how to better communicate; to understand and reconcile conflict; and to entertain. It is important then for the improviser to know their ‘audience’ and the intended purpose of the improvisation.

**Awareness of audience**

An actor is able to engage with and affect their audiences in different ways. How they engage and how they hope to affect the audience is determined by the style of the performance. Stanislavski (1937/1986) wanted audiences to feel, to be emotionally moved by what they saw and to believe what they were watching was real. Brecht on the other hand aimed not to lull his audiences into emotion but to move them into action, arguing for a “theatre that is both instructive and entertaining…turned from a home of illusions to a home of experiences”
(Brecht, 1968b, p. 103). This distinction of acting styles affect’s the actor’s awareness of and connection with an audience. Boal (1995) suggests that whilst the Stanislavskian actor tries to consciously be unaware of the audiences’ presence, the Brechtian actor is consciously trying to affect the audience. However, Boal urges that the Brechtian audience essentially still remain mute.

Boal (1979) sought to make the audience participants in the action rather than be just observers of action. In this way audience members become what he refers to as a “spect-actors” – they are no longer just observers of the interaction but possible instruments of change. Boal (1995) suggests this concept has great impact because for the spect-actors the dramatic action serves as an “imaginary mirror” on humanity and thus allows for self-observation, self-reflection that in turn leads to self-knowledge (p. 13). Nicholson, (2005) describes this as the ‘spect-actor’ being able to not only look at the fictional world but also act in it, using it in a way as a rehearsal for life.

Jacobsen et al. (2006) studied the effects of audience (HCPs) interaction in the simulated patient scenario in relation to the notion of the 4th wall (a theatrical concept to denote an invisible wall separating the audience from the actors) and suggest the audience members (HCPs) interact much like Boal intends (Jacobsen et al, 2006). The study reveals how the 4th wall is used in three different ways to affect the learning environment and educational outcomes and concluded that a better understanding and management of this phenomenon might lead to more effective educational outcomes (Jacobsen et al., 2006). Whilst this study focussed on the various interactions the observers or ‘audience’ can have with a simulated patient there was only a short discussion in relation to the direct interaction the simulated patient has with the HCP within the simulated scenario. This is of particular interest in this study.

**Facilitating**

As suggested earlier, a key responsibility of the artist, as simulated patient, is not only to act, but also to educate (Kurtz et al., 1998; Loth et al., 2015; Sutton, 2011). Therefore, the applied theatre artist in this context requires an understanding of and the ability to apply skills and techniques in facilitation. Prendergast and Saxton (2013) suggest that, “facilitation in applied drama is connected to effective pedagogy in drama/theatre education” (p. xiii). Educators and philosophers, John Dewey (1997/1938) and Paulo Freire (2000) have had a significant impact on the development of drama and educational practice both using experience and reflection to convert knowledge into action. Freire (2000) devoted his life to empowering people and believed in setting educational activity in the lived experience of the participants. He conceived the idea of the *dialogical method* of teaching, which involves
respect; it is not about one person acting on another, but rather people working with each other.

The following section then will outline some key literature relating to facilitation. Much of the discussion for this section has been drawn from literature specific to facilitation skills attributed to artists within applied theatre practice with a focus on the practice requirements relevant to the simulated patient context. The review will specifically focus on the practice requirements of intentionality, giving feedback, individuality, resilience and awareness of HCP's educational needs.

### Intentionality

Across the range of contexts within the field of applied theatre practice, the most common feature is its “intentionality” (Nicholson, 2005 p. 3). Projects are designed to affect discourse, understanding and change with “the overall intention that it will be of benefit to the participants” (Prendergast & Saxton, 2013 p. 3). Facilitation and the act of facilitating in applied theatre is essentially grounded in drama education strategies and delivered by those who possess both artistic and pedagogical skills (Prendergast & Saxton, 2013). Preston (2016) suggests that effective facilitation in applied theatre means being critically aware, understanding the purpose of the work and having a willingness to sit within the functional and ethical parameters of the work, to “understand the politics of the work in its cultural context and to engage with the competing, perhaps contradictory forces operating, while being constantly aware of how pedagogical decisions made may renegotiate these realities” (p. 6). Prendergast and Saxton (2009) also suggest that effective facilitation “requires skills of diplomacy because this kind of work is fraught with difficulties around what is left in and what is left out” (p. 18). Further to this Preston (2016) has argued that effective facilitation is process oriented and participant-centred and relies on the negotiation of all those involved; its aim is to “make easier what is being experienced as difficult” (p. 1). Good facilitation then is about intentionality; knowing why the work is being done, how it can be done safely and effectively, with a clear understanding of those involved and the ability to work in partnership with others who often have skills and knowledge in other areas.

### Giving feedback

The next practice requirement within the artist’s responsibility as facilitator in this research context is the ability to give feedback that is constructive and valuable to the HCP. The simulated Open Disclosure scenario is designed to improve the HCP’s communication skills during difficult conversations, therefore the feedback given by the artist relates mostly to how the patient was affected emotionally during the interaction rather than how the HCP
dealt with the patient’s clinical issue. When the artist’s feedback focuses on the HCP’s communication skills and their ability to empathise and build a relationship it is, “more compelling and meaningful to the learners [HCPs]” (Pascucci et al., 2014, p. 124). Prendergast and Saxton (2013) believe that effective facilitation relies on reflection and suggest it is useful to consider Schön’s (1983) concepts of reflection-in-action and reflection-on-action. Reflecting-in-action has to do with moment-to-moment decision-making and will be discussed further in the section, Managing the multiple responsibilities. Reflecting-on-action is about making meaning from the experience through questions and discussions, making the implicit learning explicit. It is possible that this reflection can be richer than the experience as “reflection can enrich perception in very meaningful ways [and] a skilled facilitator will draw participants’ attention to key moments...when a shift or change occurred...when a palpable risk was taken” (Prendergast and Saxton 2013, p. 7-8). This is particularly useful in the simulated OD context because the HCPs are able to get feedback from the ‘patient’, which they would not normally be able to get in the real world.

**Individuality**

Individuality is a further practice requirement of facilitation. Preston (2016) sees the facilitator as an individual who brings his or her own unique personality to the work and suggests that:

> To develop a deeper notion of skilled facilitation we need to consider the values and intentions influencing practitioners who take on this role. We need to acknowledge the facilitator’s persona that evolves in that moment, how they perform and how they negotiate relationships with participants. (p. 3)

Preston argues here that effective facilitation is not just about the competent delivery of techniques, but rather the values and intentions of the individual facilitator. Within this lies the individual’s experience and motivation for the work. An effective facilitator needs to be able to exploit opportunities as they occur, and this requires personal creativity, flexibility and ingenuity (O’Neill, 1989/2006). Booth (2011) states, “what finally counts most is the person in the room...the way she thinks, listens, responds, notices, formulates questions, reflects, dresses, plays, contributes to the community, radiates energy and so on” (p. 21).

**Resilience**

Resilience is the facilitator’s key to survival and it is born from an awareness of the challenges of difficult situations (Preston, 2016). Working with real people in real contexts is unpredictable; therefore, the facilitator must be prepared for things to take an unexpected
turn. The facilitator needs to be resilient and comfortable in new situations, and she/he should demonstrate the ability to improvise in the moment and respond to and “tolerate lots of change” (Prendergast & Saxton, 2013. p. 5). Unsatisfactory and messy situations sometimes require the facilitator to make difficult decisions and a “form of courage brought about by critical resilience is crucial” (Preston, 2016, p. 60).

**Awareness of HCP’s individual needs**

Applied Theatre has its roots in theatre practice and education and its intention is to affect personal or social change (Nicholson, 2005). Prendergast and Saxton (2009) suggest an effective facilitator requires social and empathic intelligence, and whilst they “hold the aesthetic knowledge” they must recognise that participants “hold the knowledge of the subject matter” (p. 18). At the heart of Applied Theatre practice then are the participants who engage in the dramatic world. For the facilitator then it is crucial to understand the participant group and their individual needs as learners. It is important to ensure the work is in their best interests and that the participant group see the learning as valuable and relevant (Prendergast & Saxton, 2013). The work must be appropriately challenging to raise questions and encourage self-reflection to ensure there is learning. An effective facilitator has the desire to help others help themselves and for this to happen it is crucial that the facilitator “de-centre” and allow the work and the learning to come from the participants rather than themselves (Prendergast & Saxton, 2013).

**Maintaining a safe environment**

In this section I address the responsibility of maintain a safe and supportive environment in order to provide protection for all those involved in the OD scenarios. Working safely is integral to applied theatre practice, which uses the dramatic context to provide an aesthetic distance, which allows participants to explore difficult or sensitive issues. The concept of aesthetic distance was introduced in the practice requirement of *building and conserving the illusion* as part of the acting responsibility and will be discussed further here. I will be addressing three specific practice requirements for the artist, these are: safety: safe practice, distancing, professional integrity and empathy.

**Safety: Safe practice**

Being involved in a simulation of an Open Disclosure scenario means HCPs are able to work on real issues in a fictional context. Thus, the HCPs are protected by the fiction and able to explore problems and issues to provide real opportunities for learning by ‘making mistakes’ (Churchouse & Rudd, 2008). The key here is that HCPs feel safe to practice their skills without risk of real-world complications (Churchouse & Rudd, 2008). Indeed “safety is the
cornerstone of simulation practice [and] safety is a principal motivation for using simulation” (Lewis et al., 2017, p. 3). This concept of protection through fiction is a fundamental tenet of applied theatre practice and is crucial in offering a ‘safe’ environment in which the learners can make mistakes without judgement (Nicholson, 2005). Further to this, Prendergast and Saxton (2013) suggest that, “paradoxically it is working in safe spaces and in safe ways that helps us to look at the risky issues” (p. 3).

What makes the SP scenario effective is that the artist, who is unknown to the healthcare provider takes on an authentic character; the healthcare provider then interacts with the SP as they would a patient in the real world, “acting as him or herself in the role of a clinician” (McNaughton, Ravitz, Wadell & Hodges, 2008). Thus, what is important to note here is that the ensuing improvised action is “not a completely fictitious dialogue” (Jacobsen et al., 2010, p. 5). The HCPs are in fact playing themselves albeit in a fictional scenario. This needs to be taken into consideration then as the HCP’s safety is somewhat compromised because they are not in fact taking on a role and therefore do not have the added protection of the role (Prendergast & Saxton 2013). As HCPs are often working in front of their peers, there is an added level of danger, including the risk of them feeling vulnerable or perhaps of being judged.

In addition, within Open Disclosure simulation the emotions can be high due to the intensity of the scenario and the authenticity with which it is played. This then raises further safety issues for the HCP including protecting them from emotion. Gavin Bolton's (1984) work in this area centres on the emotional response participants have when working in drama and its impact on the experience. He suggests that:

The emotional response in a game, play and in drama is a response to an abstraction, to a “bracketing off” from the living, and it can be just as intense – possibly even more intense for knowing it’s a second order experience, one can ‘release’ one’s grieving, for example, in a way one would not do in the actual event. (p. 106)

Bolton is suggesting here that in a fictional context this ‘second order experience’ allows the participant to experience intense emotional responses yet remain protected by the fiction, because they know that it is not ‘real’. However, as suggested earlier, whilst the HCPs understand the scenario is not real, they are effectively playing themselves and therefore missing the protection of role. Understanding this allows the artist to manage emotionally complex scenarios and provide protection for him or herself and in conjunction with the
clinical facilitator help protect the HCPs. These types of risks are important to understand and manage to ensure a safe and supportive work environment is maintained.

**Distancing**

Artists are also responsible to provide a safe environment for themselves. Distancing is normally a skill attributed to the actor (Boal, 1995). However, I discuss it here not as a practice requirement within the responsibility of the actor, but within the artist’s responsibility of maintaining a safe environment. What is clear in the literature around the responsibility of acting is that the actor’s practice requirement of authenticity and character creation is linked to the self. Stanislavski (1937/1986) suggests the notion of self is integral to creating a character, as actors must draw on personal experience, memories and emotions to assist them in creating and sustaining a realistic character. It is also noted that the actor is a real person and is differentiated from the fictional character, which is created for a particular purpose; Barba (1995) offers: “a character is always a specific individual who speaks with a specific intention about something specific to a specific listener” (p. 124). In the patient simulation scenario this concept is crucial as the artist takes on a character designed specifically for the HCP as listener.

Boal (1995) uses the terms ‘person’ and ‘personnages’ to delineate between self and character respectively, however he suggests there is danger in this relationship. To manage this ‘danger’ Boal (1995) suggests the actor’s craft, allows for a safe protective distance such that the character does not overwhelm the person. Boal (1995) goes further to suggest that depending on the character played, the need for ‘protection’ can be considered greater or smaller depending on style or genre and suggests that:

> Whether greater or smaller, this distance always exists. On stage, an actor, though entirely immersed in his deepest emotions, is completely aware of his actions. However moved he may be, he always maintains a total control over himself. (p. 23-24)

What Boal (1995) suggests here is fundamental to the patient simulation context. While the artist is inextricably attached to the character through the self, his/her responsibility is to protect his/herself by remaining at a controlled distance from the character at all times.

**Professional integrity**

Professional integrity refers to ethical conduct and behaviour. The INACSL Standards Committee (2016) suggests that in the patient simulation context this requires a personal set
of principles involving attributes such as “confidentiality, compassion, honesty, commitment, collaboration, mutual respect and engagement in the learning process” (p. S30). The simulation experience can place everyone in a vulnerable position, so an equal power balance and professional boundaries must be maintained to ensure learning outcomes are not compromised and do not “affect a career, self-esteem, create a sense of distrust in professional relationships, loss of a safe learning environment and alteration of group dynamics (INACSL Standards Committee, 2016, p. S31). SPs are crucial to the creation of a safe environment where HCPs feel secure in knowing their participation is valued (Pascucci et al., 2014).

**Empathy**

Nicholson (2005) suggests that applied theatre “is undertaken by those who want to touch the lives of others” (p. 166). She argues this at length in her book *Applied Drama - The Gift of Theatre* (p. 155-167) and introduces the notion that an artist working in applied theatre gives the gift of self, citing “empathy and imaginative identification with the lives of others, [as examples of a gift designed to] “affect or benefit others in some way” (p. 164). Nicholson uses the metaphor of the gift as a way of “acknowledging the positive attributes of empathy, generosity and care for others that characterizes much good practice” (p. 160). However, she cautions that the concept of giving of ones’ self might create an ethical dilemma between the gift-giver and receiver if the motives for giving are blurred; will the ‘gift’ be “accepted as a generous exercise of care ...or regarded as an unwelcomed intrusion” (Nicholson, 2005, p. 5). Working in applied theatre involves working with people so it is imperative to consider what is involved in realising safe and ethical working relationships with all involved.

**Managing the multiple responsibilities**

The responsibilities of acting, facilitating and maintaining a safe environment have been discussed above by providing an overview of the key practice requirements for each responsibility. However, one of the ideas I have proposed in this research study is that the artist must often manage these responsibilities simultaneously. Newlin-Canzone et al., (2013) recognise that often SPs performing several tasks at once such as improvising dialogue, observing the HCP and retaining these observations for feedback purposes, and argue that in this instance the SP’s attentions are divided. They concluded that there should be training to assist SPs with their cognitive workload. It seems then that managing the various responsibilities is a required skill for the artist as simulated patient. Here I discuss how the artist might do this and offer the notion of self as being integral to this.
The actor's awareness of self in action is recognised by western theorists including Bertolt Brecht (Zhao, 2000). Brecht was influenced by the Eastern performance methods and used this idea of the "distancing effect" in his actor training (Zhao, 2000). Observation and understanding of the outside world are crucial to the Brechtian actor's training (Thompson, 2010). Brecht’s theatre was politically motivated, and his actors were required to have a political and social conscience. The actor’s job then according to Peter Brook (1968/1976), is not to revel in the glory of theatre, but to be conscious of their ability to affect change in their community. Brecht demanded that his actors detach themselves from the characters they played (Brecht 1968a), arguing that the audience must be aware at all times that they are watching actors telling or ‘demonstrating’ the stories of their characters.

Further to the notion of actor and self, Zhao (2000) explains how Gao Xingjian talks of three parties; self, actor and character and uses the term "triplication" to describe this concept. He suggests that the actor "benefits from the triplicate relations" and that there are three players at work, the actor, the character and the 'neutral' self (p. 50). Zhao (2000) translates Gao's theory (originally written in Chinese) and describes the process for the actor:

This can be a process that lasts only for a moment. But if we stretch the moment, the actor can shake free from his own person, and gain space for physical or mental manoeuvring in order to become submerged into the character. The personality put aside is then able to examine the character he plays, and to calmly readjust to and ponder on the acting, thus moving into a mental position. (p. 51)

This concept describes how the actor can be in character yet simultaneously work as actor and self to make considered and effective decisions in order to move the action forward.

Bowell and Heap (2005) outline a similar concept in their discussion around the teacher-artist working in the dramatic form of process drama. Here they reveal a theory of quadripartite thinking where the successful teacher-artist operates with “four heads at once”: the head of the playwright, the head of the director, the head of the actor and the head of the teacher (Bowell & Heap, 2005, p. 64). This quadripartite thinking allows the teacher-artist “to make creative and educative decisions with confidence in the present moment of the dramatic action” (Bowell & Heap, 2005, p. 68). These decisions might only be very small ones but may have a lasting impact on the success of the drama work as these minute particulars “are capable of shifting the dramatic action along a ‘spectrum of circumstance’, thus profoundly affecting the quality and direction of the learning outcomes offered by the experience” (Bowell & Heap, 2005, p. 68). This idea connects closely to Schön’s notion of
reflecting-in-action. Schön (1984) suggests it’s about being deeply aware of the moment-to-moment action and sensing if it requires redirection to better serve the needs of the group. He describes it as a “stretch of time within which it is still possible to make a difference to the outcome of the action” (p. 30). Dunn and Stinson (2011) also discuss the concept of quadripartite thinking in relation to teacher artistry and suggest, “getting the balance right is not easy” (p. 628). According to these authors, working in this way requires the ability to engage with four different perspectives or roles “interchangeably and often concurrently” and be able to manipulate these to be responsive to the learners’ needs (Dunn & Stinson, 2011, p.268).

Further to this Bowell and Heap (2005) maintain that the notion of self is melded inextricably with each of ‘the four heads’ and suggest, “in order for the teacher to work in the quadripartite manner we have suggested she needs a critical awareness of herself as she operates in each function” (p. 65).

Jacobsen et al. (2010) also suggest that there are multiple positions at play, arguing that a simulated patient might enact three positions in action. This concept is revealed, by linking the actor’s process of the “in situ building of the SP’s character” to Bakhtin’s theory of utterance (p. 1). Their study investigates how the nature of the improvised dialogue in the interaction shapes the SP’s responses and hence the building of the character and reveals ways an SP might respond in action:

We found three different directions for the simulated patient’s utterance concerning the dialogue’s addressivity: (1) the direct utterance from the student to the SP which brings about an immediate response; (2) the utterance which the SP addresses back to herself as inner speech; and (3) the fully unpredictable utterance from the student that the SP might use to expose ‘the unexpected’ as part of the fictional personality, both verbally and physically/non-verbally. (p.9)

Jacobsen et al. (2010) describe how the artist, in role as a simulated patient creates dialogical responses in action and provide a link to the notion of the conscious self. It is thus proposed that: 1) the immediate/spontaneous response is character/actor driven; 2) the inner response provides a meta-view of the interaction and is facilitator driven; and, 3) an unexpected response used to ‘expose’ is driven by the self. The example given by Jacobsen et al. (2010) to describe this third response is of an artist playing a SP who had to adjust their character when the student (HCP) changed the patient’s background history. In this case the SP was surprised but continued because “she was determined not to break with the simulation” (p. 6). This indicates the actor’s willingness to reach out to the student (HCP)
and make the interaction work for them both. It also indicates the artist’s sense of self in terms of ‘doing what is right’ and in that way demonstrates integrity and ethical decision-making.

**Conclusion**

The artist’s job as a simulated patient in the Open Disclosure scenario is complex. In this literature review I have covered a range of practice requirements the applied theatre artist might bring to meet their responsibilities in acting, facilitating and managing a safe and supportive environment to produce high quality learning outcomes for providers of healthcare. Those discussed in this review include: *authenticity, building and conserving the illusion, spontaneity and improvisation, awareness of audience, intentionality, giving feedback, individuality, resilience, awareness of HCP's educational needs, safety: safe practice, distancing, professional integrity and empathy* and finally I addressed the skill of *managing the multiple responsibilities*. 
Chapter 3: Methodology

The purpose of this research is to gain a deeper understanding of SP scenarios from the artist’s perspective. Autoethnography and narrative inquiry have been employed as methodologies to explore and analyse the stories of three professional actors, including myself, who work as simulated patients. This study aims to understand how the individual employed as an artist within simulated Open Disclosure scenarios manages the multiple artistic and educational demands inherent within their work as simulated patients. It asks:

1. What are the responsibilities of the applied theatre artist in simulated Open Disclosure scenarios?
2. What are the challenges, tensions and constraints faced by applied theatre artists in high stakes simulated Open Disclosure scenarios?
3. How does the applied theatre artist as simulated patient integrate and reconcile their various and often competing responsibilities to produce high quality learning outcomes for healthcare providers?

It is the intent of this research to provide insights that will assist applied theatre artists in understanding and improving their practice as simulated patients which in turn may help healthcare providers deliver better patient-centred care.

This chapter begins by outlining the research design, explaining my decisions to use narrative enquiry and autoethnography as methodologies. I will then offer a brief description of the participants in the study, followed by details of how the data (stories) were collected, the methods of collection and how the story data was analysed to provide research findings. I will also provide a framework of application to demonstrate how I maintained rigor and appropriateness in my research.

Research Design
The theoretical paradigm is the framework that Guba calls the “basic set of beliefs that guides the action” for the researcher (as cited in Denzin & Lincoln, 2008, p. 31). These beliefs include the researcher’s epistemological, ontological and methodological premises. This research is constructivist in that knowledge and truth are not considered absolute, rather the research is founded in the principle that our understandings of the world are co-constructed and shaped by context (Denzin & Lincoln, 2008); meaning is made through shared understandings, and as such, my research participants’ understandings will be integral to my research findings (beyond simply ‘data’). To this end I have explored my research questions using a qualitative research design. Denzin and Lincoln (2008) describe
research design as “a flexible set of guidelines that connect theoretical paradigms first to strategies of inquiry and second to methods for collecting empirical materials” (p. 33). Thus, the researcher must choose a strategy of inquiry or methodology and research methods that uphold the values and beliefs of the researcher and the tenets of the research.

Autoethnography and Narrative Inquiry

As an applied theatre artist, actor and an educator I recognise the value of stories as a way of making sense of the world. Crossing time, culture and race, story is central to our lives. Huber, Caine, Huber and Steeves (2013) suggest, “human beings have and continue to draw on stories as a way to share, and to understand, who we are, who we have been and who we are becoming... [stories] are at the heart of how we make meaning of our experiences of the world” (p. 214).

This research study applies research methodologies that recognise the value of sharing stories along with the analysis and interpretation of these stories to make meaning (Polkinghorne, 1995). Dwyer and emerald (2017) suggest that qualitative approaches to research that draw upon "stories" are numerous, encompassing ethnography, autoethnography, narrative inquiry, life history research, phenomenology, and others. These approaches to narrative research describe lives, "collect and tell stories of them, and write narratives of experience" (Connelly & Clandinin, 1990, p. 2). My research makes "meaning of experience" (Clandinin & Connelly, 2000, p. 8) for the artist in simulated patient scenarios. I have positioned myself in the midst of the research using autoethnography to explore my own stories and narrative inquiry to explore the stories of my participants.

The notion of story is central to narrative inquiry and while autoethnography has its roots in ethnography, emerald and Carpenter (2017) suggest it is a “comfortable companion” for narrative inquiry as it is “intimately concerned with 'story'” (p. 28). Further to this, both autoethnography and narrative inquiry are linked by other key tenets. Both are concerned with the sharing of individual experience and recognise that by sharing our experiences we can learn more about others and ourselves (Chang, 2008; Clandinin & Connelly, 2000). It is the researcher's presence and investment in the research and the collaboration between the researcher and the participants that promotes meaning making (Chang 2008; Clandinin, 2006).

Both methodologies aim to engage the reader in personal stories of experience (Clandinin, 2006; Ellis, Adams & Bochner, 2011). Personal stories are then framed within larger cultural stories to “provide additional perspectives and contextual information” asking the researcher to dig deep into the stories and to examine the social/cultural/political
circumstances that inform the experience (Chang, 2008, p. 103). Ellis, Adams and Bochner (2011) claim that it is necessary for autoethnographers to “systematically analyze personal experience in order to understand cultural experience” (p. 273). Clandinin and Rosiek (2007) agree and suggest that while individual experience is the starting point for narrative inquiry it is also “an exploration of the social, cultural and institutional narratives within which individual's experiences are constituted, shaped, expressed and enacted” (p. 42). So, while narrative inquiry and autoethnography have drawn criticism and are sometimes “treated with suspicion” (Squires, Andrews & Tamboukou, 2008, p. 66) or have even been considered by individuals like Ellis (2009) as “naval-gazing, self-absorbed” narcissism, (p. 371) these readings of the research approach misunderstand its purpose, as narrative research can achieve a “connection between the story and the wider cultural point that shifts a story from just interesting, to research” (emerald and Carpenter, 2017, p. 27).

Narrative research has become increasingly popular over the past few decades (Squire et al., 2008). Caine, Estefan and Clandinin (2013) refer to this rise in popularity as a “narrative revolution” (p. 574). More specific to this research study, Clandinin, Cave and Berendonk (2017) suggest that narrative inquiry has a very promising future in research practice in medical education. However, scholars caution that with an increase in popularity has come some uncertainty; the researcher must be clear about their approach to narrative research to avoid confusion for the reader (Clandinin et al., 2017; Lopez & Willis, 2004; Polkinghorne, 1995; Squire et al, 2008). To this end then, in this research study both autoethnography and narrative inquiry will be approached with a phenomenological perspective, as emerald and Carpenter (2017) suggest “phenomenological approaches adopt a constructivist/interpretivist epistemology, to glimpse into the lived experience of individuals, which brings with it a respect for the participants’ perception of reality; a belief that reality is multiple and situational” (p. 5). emerald and Carpenter’s description supports constructivist tenets and my research concerns for participant inclusion.

In considering the analysis of these stories I refer to Polkinghorne (1995) who makes distinctions in narrative research approaches using Bruner’s theory of paradigmatic and narrative cognition, suggesting one employs paradigmatic reasoning to move from stories to common elements, calling this analysis of narratives. The second approach uses narrative reasoning and moves from elements to stories and thus is called narrative analysis. In my stories and the stories of my participants, I have attempted to find common elements and moments of understanding in our experiences. Thus, my research design has employed a paradigmatic analysis of narratives to reveal common themes generated through careful analysis of all the collected stories, my own and those of my participants. Polkinghorne (1995) also reasons that there are two types of paradigmatic research, one that applies
previous theories to the data to seek concepts deductively and the other to work to derive concepts inductively from the data. Whilst I proposed a theory, that the artist as simulated patient manages several responsibilities simultaneously, I was also interested to find out if this concept revealed itself in the research or if indeed there were new ideas, theories or concepts not yet considered. With this in mind I worked both deductively and inductively.

Nonetheless, I favoured the latter approach allowing the concepts and themes to emerge from the range of field texts (Polkinghorne, 1995). Bruner (2002) reminds us that, "telling stories is an astonishing thing. We are a species whose main purpose is to tell each other about the expected and the surprises that upset the expected, and we do that through the stories we tell" (p. 8). Ellis (2004) refers to “treating stories as data and using analysis to arrive at themes that illuminate the content and hold within or across stories” (p. 196).

Participants
As this study is focused on the experiences of artists in simulated patient scenarios my participants include two professional actors and applied theatre artists, Jason and Cate (pseudonyms have been used) who, like me, work in this context. Together we have made meaning of our experiences (Clandinin & Connelly, 2000). Analysing the experiences of my colleagues, alongside my own, has allowed for a broader scope of research evidence and enabled more credible findings. Below is a brief summary of Jason and Cate’s experience as actors and as applied theatre artists.

Jason completed a Theatre degree in 2013 and became a member of an ensemble with Backbone arts and Arts Link as part of a school’s touring program. Jason has also worked as an actor for several years with a Brisbane based independent theatre company and is currently working as Teacher Artist on a highly successful project within a Brisbane high school. He has also performed in and directed a range of short films. Jason has had some previous experience with patient simulation work but has only recently started working with the Open Disclosure scenarios. He talks briefly about his initial experience in this context and his pleasure at using his skills as an actor to help healthcare providers improve their communication skills in patient-centred care.

I think the work is really great. I’m so grateful to be able to see doctors coming out of the room saying, “Oh, that was amazing!” They didn’t know what to expect but after having worked with the actors, they learnt some new skills, not forgetting their training and medical skill, but to learn to just be there for the patient.

Cate graduated with a theatre degree at a major University in Australia in mid 1990s. Since then she has worked in theatre and film and television. She first worked as a simulated
patient in Open Disclosure work around 2006. Cate now works regularly as a simulated patient not always with Open Disclosure scenarios – but the work is always about improving healthcare providers’ communication skills. Cate suggests that it is the healthcare providers’ learning that is at the heart of the work and so as an actor in this context the characters and scenarios she creates are integral to this. She says:

This work makes you feel like you can use your acting skills in a way that you put far less focus on yourself. I find I have a different mindset when I’m going to work as a simulated patient because it’s not about what I can do, or MY performance. When I go and do simulated patient work I’ll be given imaginary patient scenarios and I’ll translate that into character traits that will help the role-play. I am sensitive that this is a learning environment for them, I take it very seriously, and am aware this is an artificial and unusual type of learning and practice. I don’t think I could do this work without acting skills and training I have had over the years. Plus, I have enough experience in life to be able to make things real.

Both Jason and Cate show an awareness of the artistic and educational context of the simulated Open Disclosure scenario.

**Method**

This study has been guided by a narrative research approach. Clandinin (2006) describes narrative research as having a number of steps and suggests that, “research puzzles are framed, research fields and participants selected, as field texts are collected, written and composed, and as research texts are written and negotiated...with their participants” (p. 47). Chang (2008) however describes the autoethnographer’s research process as “data collection, data analysis/interpretation and report writing” (p. 49). So, whilst narrative research and autoethnography share the processes of storytelling as described above it seems there are some differences in the research process including the involvement of participants and the terminology used to describe the research texts. Chang (2008) and Polkinghorne (1995) both use the term ‘data’ to describe collected research materials, however the term ‘data’ is historically linked to scientific study and thus the positivist paradigms (emerald and Carpenter, 2017). In keeping with the constructivist approach, I refer to Clandinin and Connelly (2000) who use the term ‘field texts’, to describe the stories of participants that are collected in the field and are “created, neither found nor discovered, by participants and researchers in order to represent aspects of field experience” (p. 92). Therefore, within this thesis I will be using the term ‘field texts’ to describe the stories and materials to be collected. Field texts are the evidence upon which research claims are made (Clandinin & Connelly, 2000).
Field Texts to be collected
Across the three phases of the research thirteen field texts were collected and analysed. Field texts were collected in three ways. In Phase One stories of participants’ past experiences were collected, while in Phase Two semi-structured interviews conducted immediately after an OD workshop were recorded and transcribed. Finally, in Phase Three, I recorded and transcribed a focus group discussion. Each phase of the research was designed to build on the previous, with ongoing analysis of the field texts providing structure and purpose to the research. This aspect will be discussed further under Analysis. The table below offers an overview of the field texts that were collected.

Table 1
Field Texts Collected.

<table>
<thead>
<tr>
<th>Field Texts</th>
<th>Participant 1 Memory Stories Critical Incidents</th>
<th>Participant 2 Memory Stories Critical Incidents</th>
<th>Researcher’s Memory Stories Critical Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2,3</td>
<td>Three stories based on strong memories from past experiences in simulated patient Open Disclosure scenarios.</td>
<td>Three stories based on strong memories from past experiences in patient simulation Open Disclosure scenarios.</td>
<td>Three stories based on strong memories from past experiences in patient simulation Open Disclosure scenarios.</td>
</tr>
<tr>
<td>4,5,6</td>
<td>Participant 1 Story (Semi-Structured Interview)</td>
<td>Participant 2 Story (Semi-Structured Interview)</td>
<td>Researcher’s Story (Semi-Structured Interview)</td>
</tr>
<tr>
<td>7,8,9</td>
<td>Story immediately following a simulated patient Open Disclosure scenario</td>
<td>Story immediately following a simulated patient Open Disclosure scenario</td>
<td>Story immediately following a simulated patient Open Disclosure scenario</td>
</tr>
<tr>
<td>10</td>
<td>Focus Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Sharing of Thematic Analysis, co-construction of meaning making.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Method of Collection
In Phase One, the field texts collected were stories of past experiences as a simulated patient in the Open Disclosure context; I have called these, memory stories. All three participants including myself shared three memory stories each. Chang (2008) suggests, that while there is danger in the reliability of memory, “the past gives context to the present self and memory opens a door to the richness of the past” (p. 71). These memory stories are accounts of specific moments in the work where there was a shift in thinking or some kind of new realisation. Tripp, (1994) calls these critical incidents and suggests that the incidents themselves may have been routine or mundane, but their impact has been ‘critical’. Ellis,
Adams and Bochner (2011) call these “epiphanies” and suggest that these epiphanies reveal ways a person could negotiate ‘intense situations’ and that the effects of these linger in recollections, memories and feelings (p. 275).

Participants were asked to share stories of moments that have caused them to reflect on their work in the simulated OD context. It was suggested that these might be moments that didn’t work or moments that offered a surprise (an unexpected response), they may have been quite profound or at the time seemed insignificant but have somehow had an impact over time. Participants were originally given the opportunity to write their three stories, however all participants, including myself opted to record their stories, arguing that they felt it would be much easier to vocalise their stories rather than write them. I was present during the recording of the participant’s stories and acted as a guide to make the process easier for them, however I had no input into the stories. I then transcribed the stories verbatim, attempting as much as possible to remain true to their meaning and intention, omitting simple things only, for example, vocal stumbles and repetition of ideas. The three stories from each participant were then re-storied as a new narrative, an interim text (Clandinin & Connelly, 2000). In order to remain true to the participants’ voices I kept their three stories together and preserved the sequence of each story. These re-storied interim texts were given to participants for member checking both as an ethical consideration and to elicit any further details and or thoughts (Dwyer and emerald, 2017).

In Phase Two, three field texts were collected using semi-structured interviews held immediately following a simulated patient session. These offered stories of current experience and practice, adding a new and present perspective to the memory stories collected in Phase One. The semi-structured interview format, with open-ended questions offers better opportunities for participants to tell unsolicited stories “reconstructing their experiences according to their own sense of what’s important” (Seidman 2006, p. 88). In order not to prompt storied answers, Seidman (2006) reminds us that it is useful to invite participants to tell stories and “reconstruct rather than to remember” and to ask the “what happened?” rather than “do you remember?” questions (p. 91). Polkinghorne (1995) agrees, suggesting “if the interviewer will not suppress the interviewee’s responses by limiting the answers to what is relevant to a narrowly specified question, a storied answer will be provided. The interviewer can solicit stories by simply asking the interviewee to tell how something happened” (p. 13). Smith and Osborn (2003) also suggest that the semi-structured interview allows the investigator to probe further if important and interesting comments arise. All participants then were engaged in a semi-structured interview and were guided through their storytelling (Dwyer & emerald, 2017). I was the interviewer for the sessions with my participants, while one of my supervisors conducted an interview with
me. Each participant was asked to reconstruct what happened during the session and then invited to respond to set of open-ended questions designed to delve further into the experience. Following this, participants were asked to comment on concepts and ideas derived from the thematic analysis of their memory stories in Phase One. A list of these questions is available in the appendices (see Appendix B). All stories were recorded and transcribed and transcripts were provided to the participants for member checking. This process is discussed in more detail in the ethics section.

Finally, in Phase Three of the research, to offer reflexivity and deepen understanding further experiences where shared and expanded upon in a focus group. A focus group invites participants to interact and offer new insights, and to provide “rich detailed perspectives” on material the researcher has presented (Asbury, 1995 p. 415). Discussions were focussed around common experiences drawn from recent OD workshops and on the analysis of the stories from Phase One and Phase Two. To support this process, a list of emerging themes was shared with the group. I facilitated this discussion and contributed to it as a participant. Clandinin (2006) reminds us, “narrative inquirers cannot bracket themselves out of the inquiry but rather need to find ways to inquire into participants’ experiences, their own experiences as well as the co-constructed experiences developed through the relational inquiry process” (p. 47). I was aware that my personal research agenda may influence this discussion, so I made every effort to explore my findings with my participants rather than probing them for answers (Seidman, 2006, p. 86) so that together we were able to co-construct meaning. This focus group discussion was recorded and transcribed.

Using the nine memory stories, the three semi-structured interviews and the focus group discussion, I drew together my research findings. As I set about contextualizing the work theoretically, my main point of interest was to create a model to help explain the complex nature of the work of the applied theatre artist, as simulated patient, in simulated Open Disclosure scenarios.

The figure below offers a diagrammatic view of the research design.
Research Questions
We draw upon our own experiences, which orient us to the inquiry (Caine, Estefan & Clandinin, 2013, p. 576).

Phase 1
Field Text collection & Analysis

Phase 2
Field Text collection & Analysis

Phase 3
Field Text collection & Analysis

Figure 1. Research Design
Analysis
The process of narrative research requires the telling of experience and the analysis of these experiences (Ellis et al., 2011). As detailed earlier, my overall research design uses the concept of paradigmatic analysis of narratives (Polkinghorne, 1995). I have used a primarily inductive approach to identify particular experiences (mine and my participants as actor's in simulated patient scenarios) that group together to form common themes around the actor’s experiences in simulated Open Disclosure scenarios.

In allowing the themes to emerge from the range of field texts, different analytical approaches have been used. The memory stories in from Phase One have been interpreted using a "straightforward" thematic analysis (Riessman, 2008, p. 53), which resulted in a summary of the themes as they emerged from the stories with a final discussion linking the common themes to have emerged across all nine stories to the literature. The semi-structured interviews in Phase Two and focus group discussion in Phase Three were analysed using interpretive phenomenological analysis (IPA) to examine how the participants made sense of their experiences (Smith et al., 2009). This resulted in a categorisation of emerging themes (Smith & Osbourne, 2003). These themes were then translated into a narrative account, which includes extracts from the field texts and links to the extant literature. What is common across the two methods is that the analysis was largely inductive, allowing themes to emerge from the stories however as the field texts were analysed there was a sense that each on informed in some way the analysis of the next. Also, the final selection of themes discussed where chosen with reference to the existing literature and to assist in exploring the research questions.

Across all three phases of the analysis, a different coloured font represents each participant or storytellers voice (Chan, 2017). Participant 1, Jason is in blue, participant 2, Cate in green and myself as participant 3 in orange font. This approach serves to easily identify and preserve each participant's voice across the ongoing analysis. Care was also taken to distinguish between my two voices, as researcher in black and participant in orange (Smith & Osborn, 2003).

In Phase One, a thematic analysis was applied to interpret the interim texts created from field texts 1-9 (memory stories). Riessman (2008) asserts that with thematic analysis, “content is the exclusive focus” (p. 53) and argues that the analysis must focus on the told rather than the “aspects of the telling” (Riessman, 2008, p. 54). With this in mind I analysed the stories one by one to identify themes within each story. Themes were first listed as they appeared in the story then sorted by grouping similar themes together. A sample of this can be found in the appendices (see Appendix C, sample of Cates memory story 2 and analysis).
Each of the participant’s three stories was analysed in this way and a summary of the analysis written up. The memory stories and accompanying analysis are presented in Chapter Four in the order the stories were told and analysed. Finally, common themes to have emerged across the nine stories were identified and these were discussed in relation to the extant literature. By using a thematic analysis in Phase One, key ideas and concepts relating to the research questions were discovered. Using the approach, this first phase of exploration provided some direction for the ongoing research and assisted with the development of discussion points for the semi-structured interviews analysed in Phase Two.

In Phase Two field texts 10-12 were created from semi-structured interviews. These interviews conducted with each one of the three participants (including myself) immediately following a simulated Open Disclosure workshop. These were recorded and transcribed and then analysed using interpretive phenomenological analysis (IPA). IPA aims to explore in detail the meaning particular experiences hold for participants (Smith & Osborn, 2003) However the researcher plays an active role in this process as the “end result is always an account of how the analyst thinks the participant is thinking (Smith, Flowers & Larkin, 2009, p. 80). Smith and Osborn (2003) describe this concept as a “double hermeneutic... the participants are trying to make sense of their world [and] the researcher is trying to make sense of the participants trying to make sense of their world” (p. 51). In order then to remain true to each participant and their experiences I analysed each transcript story by story. This involved reading each of the field texts in detail, to find points of interest and identify any emerging themes. Smith, Flowers and Larkin (2009) describe this as “active engagement with the data [to discover] ways by which the participant, talks about understands and thinks about their experience” (p. 82-83). The analysis process involved reading the first interview a number of times and noting what was interesting or significant whilst also identifying themes as they emerged. These themes were then listed in the order they appeared in the text. The next stage involved a more theoretical ordering as I tried to make sense of the emerging themes, identifying patterns of those that seemed to connect with aspects of the research questions and what I interpreted to be the more interesting and important aspects of each participant’s story. These were then clustered together under what Smith, Fowler and Larkin (2009) describe as “super-ordinate themes” (p.96). An IPA analysis of Jason’s semi-structure interview is available in the appendices (see Appendix D).

The initial list of themes created in Jason’s analysis was then considered during the analysis of the further transcripts. Smith and Osbourne (2003) suggest this is useful as it assists in finding responses to support the extant themes, however they also caution that researchers need to acknowledge new themes as they emerge and “respect convergences and divergences in the data – recognizing ways in which accounts from the participants are
similar but also different” (p. 73). A new list of emerging themes was created with the analysis of each new transcript and as each new theme emerged it was added to the list in a different colour to represent the particular participant’s voice. Themes were then selected and organised in relation to the research questions. Smith and Osbourne (2003) suggest that in constructing the final table of superordinate themes, “the themes are not selected purely on the basis of their prevalence within the data” (p. 76). As I saw patterns develop between emergent themes the list was reconfigured until a final list with super-ordinate themes was created (see Appendix E). This table was discussed in the focus group.

In Phase Three all three participants gathered for a focus group discussion, which was recorded and transcribed. An extract of this transcript is available in the appendices (see Appendix F). This focus group was conducted some months after the interviews to allow for the analysis of those transcripts to be included in the focus group discussion. This final field text was also analysed using IPA and the emerging themes were used to support discussions from phase one and two and to provide a deeper, shared understanding of the applied theatre artists’ experiences. A final table was created categorising all themes to have emerged from the four field texts analysed across phase two and three (see Appendix G).

A discussion of themes to emerge from the Phase Two and Phase Three analysis and supported by the extant literature is presented in Chapter Five.

**Application**

In order to maintain rigor and appropriateness in my research, I turn to Tracy (2010) who suggests, “quality qualitative methodological research is marked by (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence” (p. 839). Using these criteria, I suggest my research topic is worthy as there is growing interest in the use of SPs and very little literature to date that describes the artist’s experience in terms of their contribution to the educative process. Rich rigor was demonstrated in the collection and analysis of the field texts. Sincerity was shown in recognition that as the researcher I used self-reflexivity to mitigate bias. Applying two methodologies and combining field texts from two other participants is evidence of credibility. The research provides resonance by contributing to theoretical understandings and provides transferable findings to improve the artist’s craft and thus the educational outcomes of SP scenarios. Ethical procedures used are pursuant to the Griffith University Code for the Responsible Conduct of Research. Finally, the research study demonstrates meaningful coherence through the careful and thoughtful use of appropriate methods and by connecting the literature, findings and interpretations with each other (Tracy 2010).
Ethics

The sensitive nature of the simulated patient learning environment has meant that no observation or recording permission was requested. This decision was made to ensure a safe and supportive learning environment for all involved: artists, facilitator clinicians and healthcare providers. However, while there is no direct recording of the scenarios, important ethical concerns remain in all research and autoethnography and narrative research have particular ethical considerations, including concern for the other parties involved, such as the healthcare providers and facilitator. As Ellis (2009) cautions, when you tell your own story you tell others by implication, your "stories are entangled in theirs" (p. 375). I have therefore ensured that my stories and those of my participants take into consideration the facilitator and healthcare providers, who in this context place themselves in a vulnerable position in front of their colleagues.

Ethical consideration was also given to my relationship with my participants. By including the two participants’ stories, the research offers a broader perspective and therefore demonstrates more credibility. However, Clandinin and Murphy (2009) warn that as the research facilitator I must be careful not to influence the participants’ responses and that as the writer of their stories I must remain true to their meaning and intention. Their experiences and stories are inextricably linked to who they are as people and this has been acknowledged and valued in the analysis and presentation of their stories (Bamburg, 2012). With this in mind, participants were given copies of the scripted interviews and interim texts, giving them the opportunity to check for accuracy and integrity of the transcripts. This is called ‘member checking” and Dwyer and emerald (2017) suggest that not only is this an ethical consideration but that “this process might elicit more detail and elaboration on the themes, and through this process the researcher might access a deeper, more reflective response” (p.8). One participant asked for some minor changes and these were honoured in the text. Pseudonyms have been used to protect the participants’ identity.

There are also institutional ethical procedures to consider. Ethical clearance was sought from Griffith University before the research was conducted. This was approved with the GU reference number, 2018/081. All procedures and policies are aligned with the Griffith University Code for the Responsible Conduct of Research and the Griffith University Research Ethics Manual was used as a resource. Also, consideration was given to participant recruitment; formal consent was obtained by giving a copy of the informed consent materials to the participants. Participants were informed they might withdraw without penalty at any time.

As a researcher I am also responsible for the management of field texts and research
texts/materials. Such materials were subject to responsible and ethical conduct standards. I was solely responsible for maintaining and updating the materials. Electronic materials were stored on my personal computer, locked with a password. Electronic copies were stored on an external hard drive and any print material has been stored in a locked filing cabinet.
Chapter 4: Phase One Analysis

The research findings for this study will be presented across two chapters. Informed by a narrative research approach, these chapters explore stories shared by the research participants, including myself. In this chapter the Phase One memory stories will be analysed and discussed. Within Chapter Five, the semi-structured interviews and a focus group discussion stories collected in Phase Two and three will be examined.

As noted in the methodology, each participant provided three stories. These were then re-storied to create one interim text for each participant (Clandinin & Connely, 2000). In creating these new texts, adjustments were made to phrasing, such as vocal stumbles or repetitions and only material that was not related to the artist’s experience was omitted. The memory stories were then analysed using thematic analysis. The themes, once identified, proved to be important in providing direction for the ongoing research and assisted with the development of questions for the semi-structured interviews conducted in Phase Two and the ideas and concepts presented in this chapter are further explored in Chapter Five.

**Jason’s Stories**

Whilst Jason has had some experience with being a simulated patient, he has only recently started working with simulated Open Disclosure scenarios. For this reason, his stories all relate to his initial experiences in this context. In his first story he shares moments from a training day for medical faculty members who are learning to be facilitators of simulated Open Disclosure workshops, so there is a slightly different perspective to the work. Stories two and three come from his first experiences as a simulated patient in the Open Disclosure context over a two-day workshop. Across the three stories there appears to be a shift in his focus as he becomes more familiar with the various responsibilities and demands placed on the applied theatre artist in the simulated OD scenario.

I didn’t know what to expect and that alone was a crazy thing. On the day, I was just sitting there and then it was just like “ok you're in character”. It’s not like the normal [theatre] process. I knew after doing that I needed to be more flexible in terms of “ok we're doing it now”. I really enjoyed having to adapt in the moment and respond differently when my scene partner changed. If someone’s provoking you rather than being empathetic there is a difference. It’s quite intense stuff but if you’ve done your homework, and you know it [the character and scenario] then the natural empathy that a person has or the pain that they feel when these things happen will come out in the character. Also, it was a really great experience to
hear the doctors going, “Oh wow!” It’s one thing when you get feedback from other performers, saying, “You did a really good job”, but another to get it from the doctors when they say things like “Oh that just felt really real”. Also, the people I was working with were really passionate about what they were doing, they really wanted to make a difference for the doctors and not make it a terrifying experience for them; everyone knew what we wanted to achieve, knew the importance of the work and how powerful it can be so dealing with the safety around that was really great.

My second story is about my first day of a two-day workshop. I remember I felt a bit unsure about when to start to get into it [the character and scenario]. The way it was set up was, the doctors were all in a room preparing and I was waiting outside the room. Then the facilitator would come out and go “are you ready?” and you’re kinda like, “arghhh oh! I don’t know!” I think that experience of waiting outside is really tough sometimes because you’re not listening to the group like you would to an audience, as if you’re standing backstage waiting to come on. I remember feeling kinda like, “I don’t know when to start preparing the emotions, you know just start tapping into them a little bit more... so I remember feeling a little bit isolated outside and I’m like “NO! I’m not ready.” Knowing the process a little better could have made the experience a little less nerve racking and less stressful; just so I could have been more focused on performing and being in the moment with them. So, I guess I was feeling a bit freaked out about when to start and when to activate my actor brain and when to go into character and knowing what was the right time and feeling safe around that. But after the first scenario I thought everything is fine, knowing that you can just play from that point on. I remember that the doctors were so great. This one guy was so good that I was finding it really hard to be upset because he was really caring and I remember thinking that this guy is already onto it and well I have to go with the truth. It was interesting hearing this guy afterwards, he felt like he was missing things and I’m like well no not really for me you were just doing the best that you could in a situation like that. Yes, you still have to give a doctor’s diagnosis but [it’s about] knowing the right times to say things.

My third story then comes from the second day of workshop, seeing the difference and the effect that the workshops had on the doctors was so great. Really seeing how powerful that change was for them, and knowing they can take that into the real world really stuck with me. But, I remember thinking, “do I need to need to up the intensity to challenge them further now?” By nature, I tend to be really helpful
so if they are doing the right thing, I’m not going to slap them over the wrist. I want them to feel like they’ve done the right thing. So, a part of me was questioning that, “so now they know that they can deal with it do I take it further or do I then just come across as being an insane person?” I was asking myself these things in the moment. Also, I think it’s interesting that you’re in character and then sometimes the facilitator might jump in, so you have to deal with breaks in the middle of a scene and how you stay in the zone as the person and try and block out what your hearing? I think too, having to do the same thing over and over again [was difficult]. I really just had to feel and just wait for things to happen, you can’t plan too much because then you feel like your repeating. So, it’s just about truth, of finding it in the moment every time and not having to worry about whether it is good enough. As long as you’re listening and doing what you’ve been trained to do then it’s there. Sometimes in a scenario your like “oh that was great to just go RAGGGHHH!” and then in the next one you just sit there and you’re just listening and talking, and you ask yourself, “is that right?” It’s interesting, sometimes it’s just feels like it’s right and other times I feel like I don’t need to go there because this [doctor] just the way they are being, it’s not there. Something I experienced with all three really. Like sometimes the doctor might say something that hurts the character, and I have a choice, I can either go off the rails or I can just sit with it for a while. So that’s one of those moments where you could take the scenario in a new direction. In one of the scenarios I just stood up and walked over to the corner and started breathing heavily and he [the HCP] was like “are you all right” and I was “yeah I just need to breathe”. I think I just wanted to throw them a curve ball because they were doing so well. But it was great because I think it’s that thing where your body sometimes just takes you places and just to trust it. It was cool.

Jason: Summary of emerging themes
Across the three stories Jason tells how he is learning to translate his skills to make the OD scenarios successful both artistically and educationally. It seems important to Jason across the stories to create an authentic experience with a range of comments like, “I have to go with the truth”, “it’s just about truth, of finding it in the moment every time” and he appears in his first story to get great satisfaction from the health care providers sayings things like, “oh, that just felt really real”.

Jason also appears to be coming to terms with understanding and managing aspects of the form. In his first story he expresses some tension around not knowing “what to expect” and it appears that very quickly he sees the OD context as different to other acting work. He talks
about the immediacy attached to the start of the scenario and suggests he needs to be more “flexible”. He also comments on the intensity of the work and indicates that it’s about being prepared as the actor but then being able to “adapt in the moment” and be open to the different interactions and responses. In Jason’s second story it seems there were several practical issues and external factors creating challenges and tensions for him that took away his ability to be properly prepared and, in his words, feel “safe” so he was able to focus on performing and “being in the moment with them [HCPs]”. In his third Jason story talks about some of the challenges that come with the improvised nature of the form and having to manage the stopping, starting and repetition of scenarios, however he does appear to be more comfortable with the form as his focus shifts to more detailed moment-to-moment experiences with the HCPs.

Jason talks about the important and “powerful” nature of the work and the need for “safety” and proper work practices to not make it a “terrifying experience for them [the HCPs]”. In his first story he tells of his experience with a training day for the facilitators and that he was included in discussions around the educational context of the workshops. That he is there to assist in the HCP’s learning seems important to Jason and he seems to want to create an experience for the HCPs that is authentic yet appropriately challenging in a safe, non-threatening environment. There was somewhat of a challenge for Jason in his second story, he explains he was trying to remain upset as the character, but the HCP was "so good I was finding it really hard to be upset". Jason seems in the moment to recognise the HCP has some good communication skills and as the actor he chooses to respond authentically in character. He says, “I remember thinking that this guy is already onto it and well I had to go with the truth”. By doing this he seems to be making choices that are not only truthful for the character but serve the educational outcomes for the individual. What is also interesting here is that at the same time it seems Jason was able to lock information away to then be able to offer important feedback later for the HCPs learning.

Jason appears to contribute to the process, not just as an artist but also as himself. He shows care and concern for the HCPs and a desire to provide a safe and supportive learning environment. He says, in his third story, “By nature, I tend to be really helpful so if they are doing the right thing, I’m not going to slap them over the wrist. I want them to feel like they’ve done the right thing.” Also, in this story Jason seems quite struck by the positive changes he saw in the HPCs’ communication skills, knowing that these skills can be translated into real life however this brought about new challenges for Jason as he asked himself, “Do I need to need to up the intensity to challenge them further now?” It appears there are tensions for him around wanting to appropriately challenge the HCPs to assist with their learning and remaining adaptable to the individual’s needs and that each interaction is
different because the health care providers bring different skills and experience and he is aware of this as he says, “I just wanted to throw them a curve ball because they were doing so well”.

It appears that there is a lot going on for Jason during the scenarios as he thinks about the character’s responses, his own emotions, the HCP’s experience and giving feedback. It seems that on several occasions, particularly in his third story, his comments seem to be more reflexive, using phases like, “Part of me was questioning”, “I was asking myself these things in the moment”. Jason appears to have been having conversations with himself in the moment-to-moment action of the scenario. For example, he says, “The doctor might say something that hurts the character, and I have a choice, I can either go off the rails or I can just sit with it for a while”. It seems he is making decisions in the moment based not only on the authenticity of the character but on which direction to take the scenario, to best facilitate the individual’s learning.

In the telling of these stories, Jason revealed his enthusiasm for the work, appearing to gain both personal and professional satisfaction at being able to use his skills as an artist to help healthcare providers improve their communication skills.

**Cate’s Stories**

Cate has had many years working as a simulated patient and has worked many times in the simulated Open Disclosure context. Her first story tells more generally of her initial experiences in the work as she grappled with the form. Over the years she has found she manages these with more ease. Cate’s second story tells of her concern for one of the doctors during a workshop and how she was personally affected by the incident. Essentially this is a story about the safety and ethical issues for the healthcare provider and artist when the scenario hits too close to home. Cate’s third story tells what happened when a doctor responded unexpectedly during a feedback session and the resulting tensions for both Cate and the HCP.

The first time I ever did this work the role I was playing was a young mum and my child had died, so MASSIVE! I was very nervous about reaching the emotional points, because I knew I needed to get the doctors to practice their communication models with me. I also used to suck at stopping and starting in the beginning...I think I was more worried about myself (my performance) rather than them (the HCPs). I would get very frustrated in my own head and feel like I didn’t do a good job. Plus, it was exhausting the stopping and starting. The other thing that I found hard to manage in the beginning was the time constraints. But
you learn to let go of things like that, that you think you need. It doesn’t matter what ‘I’ need. I feel, that I am there to serve someone else and this is how I’m serving them, with my skills as an actor. I need to very flexible, open, receptive and authentic. That was tricky in the beginning because there was no flow, no journey for the character and I needed to make it as truthful as I could. Essentially, it’s about communication and I can do that. I have grown in the work a lot.

For my second story, I am reminded that the work I do is very powerful. In one session I was playing the character of a woman whose 14-year-old daughter has meningitis. The diagnosis had been missed in the emergency department the night before and now my daughter is in ICU fighting for her life. It’s a really intense scenario so it deserves the truth, and I give them the truth. I was with a doctor and as we were working I was watching them change and I couldn’t understand what I was seeing. I’m thinking, “Am I affecting you that much?” and because I don’t have lines to remember, I’m going in my head, “Oh are you ok?” I started to question what was going on. I could see that they were clearly uncomfortable and I’ve seen uncomfortable but this was just different and I was thinking “Ohhh!” but the little comments in my head were saying things like “Are you OK?”, “Oh! we must be doing really good work”, “I’m really seeing you being affected”, “Where is this going?” Anyway, I thought, “Oh well I’ll just keep going maybe this is just a really intense scene”. I remember that the scenario just seemed to ramp up because of what the doctor was giving me... their response informs what comes out of my mouth. So, I was getting to a very intense emotional place and the next thing they stopped and said, “I can’t do this, I’m so sorry, I can’t do this” and I just felt my heart drop. Obviously, what I had been seeing was a pre-cursor to them losing it. When that happens, it’s a real shock, I didn’t know what to do because the doctor was in pain and I took them to that place - I was one of the people that helped take them to that place again. Sometime later the doctor was encouraged to talk about their story. We were all really emotional, but we had to keep working and...I was thinking, “I don’t want to, I really don’t want to”. But I did. I had never seen anyone break down quite like that before, for some reason with this one, I felt guilty...I’m not sure why. I remember wanting to go up to the doctor and talk about it but not feeling like I actually could. They didn’t make any contact with me, so I gave them space out of respect. This incident really impacted me I think - it probably did change me as it made me take the work even more seriously. I was reminded that the participants are real, and they live these stories every day and they have to go
home at the end of the day to their families and somehow let it go and they talk about that in the room it is really powerful.

Actually, my third story is about another incident that changed me and this time I was reminded that words are really powerful. As simulated patients we are sometimes briefed a little about who we are working with and what we will be doing next to be able to pitch the character and the scenario at the appropriate level for the different participants. I had been asked to take it easy, just to start the process and see how the doctor might communicate. What I remember is that this doctor was really, really forceful in their manner. At the end of the scenario I was asked for feedback, in role. I remember thinking that the doctor was really intense, and I was trying to find the words to explain how I felt and was thinking, “Umm what’s the word that’s coming to mind” and then I said (in role), “I feel like I was ambushed”. Well the doctor’s reaction really threw me - they blew up...and I thought, “Oh no what have I done?” The doctor was having a go at me, but not having a go at me at the same time. I remember my word and her reaction and thinking, “Oh wow!” I was watching my facilitator trying to put it back together, trying to calm the doctor down. Again, I was thinking, “Oh no what have I done, have I done something really bad, did I not take it seriously enough how challenging this doctor might be?” I just said one word and now I am just sitting here, quietly feeling very bad about putting people in this emotional position. I actually wondered if I was going to get into trouble. I felt in trouble but not in trouble, watching someone else trying to put the doctor together. I really felt like I could get in trouble. So, it did change me that day, I am much more careful with the words I choose to use. I try to be sensitive to their feelings but remain honest. I have grown with experience.

Cate: Summary of Emerging Themes
It seems that Cate’s involvement in the work and her own life experiences have helped her find ways to meet some of the demands of being a simulated patient and she suggests in her first story that over the years she has “grown in the work a lot”. However, her second and third stories suggest she is still meeting new challenges.

Cate appears to be very aware of her role in the educational context of the work. In story one, Cate says she understands she is there to help the HCPs practice their communication skills and says, “I feel, that I am there to serve someone else and this is how I’m serving them with my skills as an actor”. She suggests that some of her skills as an actor are to remain
“flexible, open, receptive and authentic”. Cate seems to suggest that improvisation, spontaneity, truth and authenticity are important to the learning context. She also suggests there were challenges for her in the beginning, in particular reaching the emotional points, stopping and starting, working with time constraints and not always having a flow for the journey of the character; these things created frustrations and performance anxiety for her to think she “didn't do a good job”. It seems however that after years of experience many of these are not really challenges for her now. However, there are other challenges. Cate’s second story tells of the “powerful” nature of the work the emotional impact that high stakes scenarios based in truth can have, she says “It's a really intense scenario so it deserves the truth, and I give them the truth”. She comments that she could see the HCP being affected so she “must be doing really good work”. However, in this story it appears the scenario affected the HCP at a very personal level and Cate seems to feel partly to blame, experiencing a sense of responsibility for the very real distress the doctor felt. Cate appears to show genuine care and concern for them as she says, “I felt my heart drop”. This suggests that both the HCP and Cate were personally affected by real emotions that were not part of the fiction but caused by the fiction. Cate, in her second and third stories used words and phrases such as, “guilt”, “shock”, “oh no what have I done?” It seems, particularly with the last comment that there are tensions for Cate as she tries to unpack the interaction, again laying some blame on herself. She also suggests she didn't want to keep working but she did, and she talks about giving space to the health care provider out of respect, demonstrating professional integrity. It appears Cate was affected by these incidents as they have stayed with her. She talks about how this incident impacted upon her, reminding her of the powerful nature of the work and that she has a responsibility to providing a safe and ethical work environment for all involved, including herself.

Cate also appears to place importance on meeting the individual needs of the healthcare professionals. This becomes apparent in her last two stories. For example, in her third story Cate suggests that HCPs have varying skills and abilities, and this is sometimes discussed with the facilitator beforehand. In this story Cate suggests that one of the things she is expected to be able to do is “to pitch the character and the scenario at the appropriate level for the different participants” and thus meet the various needs of a specific individual HCP.

By discussing the importance of managing a scenario and changing it to suit the individual HCP’s needs, it appears that Cate like Jason, has conversations with herself during the interactions and like Jason these conversations appear to help her try to make sense of moments. In her second story it seems that while she was in character she was also aware of the intensity of the scenario and that it was affecting the healthcare provider. This created tensions for Cate as she was questioning herself in the moment and was unsure of whether
the HCP was caught in the emotions of the fiction or if it was something more. She says, “The little comments in my head were saying things like, ‘Are you OK?’” In her third story whilst in character, Cate appears to have had a conversation with herself trying to find the right words for the character to use in the feedback session in order to be helpful to the HCPs learning. She says, “I was trying to find the words to explain how I [as the character] felt.” Setting on the character saying, “I feel like I was ambushed”, led to an unexpected reaction from the HCP. The HCP’s reaction to this caused Cate to place judgments on herself not the character with comments like “Oh no what have I done”, [am I] going to get into trouble”, and “I felt in trouble but not in trouble”. It appears that these conversations in her head help Cate to make sense of the moment-to-moment action for herself and the character. Cate also suggests that this incident changed her practice. It appears that finding the appropriate balance of honest and empathetic feedback for the HCPs is a challenge.

It also seems from her comments, that it is important to Cate to do a “good job” as she has continued to change and develop her practice over the years to meet the various demands of the simulated Open Disclosure scenarios.

**Jessica’s stories**

The first story tells of three particular incidents that happened in one workshop about seven years ago. These stayed with me for a long time and have given me much cause for reflection. In fact, my thinking around these incidents has been a motivating factor for completing this research. My second story is one of self-discovery, both personally, and professionally and this incident has continued to influence my work as an applied theatre artist and actor. My third story, much like Cate’s second story, reveals what happens when the fiction becomes too close to reality for the healthcare provider and the effect this has on both the healthcare provider and the artist as simulated patient.

I remember being quite anxious before the workshop because this was one of my first OD workshops after a three-year break. I was introduced to a few of the doctors/participants, most of them just looked at me and half smiled, you could tell there was tension around the task in front of them. Everyone was a little bit scared, including me. As the facilitator talked about the scenario I just adjusted how I was sitting in the chair and took on a particular attitude for the character to start the scenario. So, anyway this doctor began the interaction with me and I clearly remember the moment – I felt a shift in me as I took on the role more fully and began interacting with the doctor, not as me but this new character. The doctor seemed to recognise this too and what really struck me in that moment was that there seemed to be a shift in the doctor as well, as they engaged in the
fiction with me. At the same time, it felt as if everyone else in the room shifted in their chairs as well. It was like for those moments of the scenario we all believed that this was real; it was a very strong feeling. I remember feeling really good about that and thinking “ok, great start! Everyone is on board with you. You are going to be ok, they get it, and this is going to work”. So that incident made me feel really good and I felt good about my work. However, in this same session I worked with a doctor who had real difficulty connecting with fiction, with my character and situation, which I had never experienced before. They were smiling and joking while they were talking to me and I remember thinking while I was in character, “what do I do here? This person is responding really inappropriately”. I think a part of me was really disappointed and annoyed, feeling that they were not taking this seriously, but part of me also understood that this was possibly a nervous reaction. I was hoping the facilitator might stop the scenario, but they didn’t so I had to make a decision – do I let them get away with this response and try to work through it or do I call them on it? So… I responded as the patient and said something like “so you think this is funny?” I remained very clearly in role as a very unhappy patient. I could sense that the doctor was a little shocked by my response I think they thought I would just play along and laugh too. I remember being really concerned about whether I’d done the right thing. So, I talked to the facilitator about it afterwards and they felt my response was appropriate, so I felt better about myself, and the choice I had made. Then, at the end of the whole session there was this spontaneous applause and I remember thinking, “Oh no! no! You’re not supposed to clap! This isn’t a performance, yes I was acting but it wasn’t a performance”. It’s quite odd really because here they were applauding me, but it made me feel like I’d done something wrong, because they saw this as a performance rather than us working together in the space. It’s interesting I don’t see this work as a performance because I do believe that acting is central to my work in this context.

This leads me to my second story. Very early on in my experiences in Open Disclosure scenarios I had a huge A-hah! moment with my acting. At that time, I had played this particular character about 4 times and I remember I was a bit scared of playing her because there were quite a few things about the character that I had trouble connecting with, and I didn’t want this to affect my credibility as the character. So, I looked for aspects of her backstory that resonated with me and I tried to focus on those things. I found the more I played the character the more I was able to build on these ideas. In one of the sessions, I was improvising with a particular area of the characters life, her relationship with her husband.
This situation was very close to something I’d experienced in my own life and it suddenly became very real for me. I understood it, when it happened. I completely understood what was happening to me and I used it to go to a place that was very real. I knew what I was doing, and I felt very safe/protected and in a way, it was very cathartic for me to go there. I was saying things as the character, but they were really coming from me and the words and emotions were coming from a very deep place of my own. I knew at the time what was happening, and it was quite dark, but I loved it, as an actor I loved that I could use these moments from my life with this character because I knew that these moments were real. Also, as me it was freeing to say these things, because I had never said them before, but they were real for me. I also knew that it wasn’t hurting me or damaging me and that I wasn’t going to a place that was too far. As I said it felt very cathartic. Now, I find that whenever I play this character and I have played this character many times over the years, I use this experience to help me find her truth. I think it is very effective for the character and the scenario. It is also very helpful for me as the actor because I know that I have something really strong to work with each time. This incident has stayed with me and now I strive to find these kinds of moments in all my acting work and I think I am a better actor for it.

For my third story, which happened more recently, I was playing the character of a woman who had just lost her husband to suicide. I again was able to draw on some very personal experiences here, which meant finding the truth for the character and scenario was relatively easy. That I can use my own experiences helps me to find the emotional points time and time again. So, we were in the middle of a scenario and I was getting quite emotional, in character...I could sense that this doctor was getting quite teary and I remember thinking, “are they just connecting with me or, what’s going on, and are they ok?” The doctor continued and was doing some really good work, showing real empathy for my character...I said something (I can’t remember what exactly), but it triggered something in them and I could see that they were empathetic to my character’s situation...So, as the character I thought, “ok that’s it, you get it, you get me.” As the character I felt so connected to that doctor in that moment and I thought ok I’m ready to move on ready to hear what else you have to say to me and I remember thinking “well done that was such good work”, but then they just started crying (I got upset as I talked about this in the recording). I knew then that this was something else, this was something beyond the scenario - there was something very real here for this person. I remember my heart just dropped in
my chest I remember thinking I really want to give them a hug but I didn’t know if it was me Jess that wanted to give them a hug or the character and I remember thinking, “what do I do here, do I hug because that's my impulse but is this coming from Jess or the character?” I didn't hug! I even said this in the debrief session afterwards because I really felt that I wanted to give the doctor a hug, and I wanted them to know that.

Jessica: Summary of Emerging Themes
The three stories are separated by several years and they are quite different in terms of the experiences they share. The idea of doing 'good work' and the anxieties around that are very strong in the first story. Stories two and three are mostly around the notion of safety. In the second story I talk about the connections between my character and my own life and how this affected me in the moment-to-moment action. In that situation I was able to distance myself from the character. Story three tells how a HCP is emotionally affected by the scenario and how this in turn affected me.

In story one I also talk about the tensions around the task at hand and suggest that the notion of anxiety seemed to be shared by the group as I say that, “Everyone was a little bit scared, including me.” Perhaps this anxiety comes from everyone feeling their personal and professional reputation is on the line in these scenarios. It seems that my response to the three particular incidents described in the story is about me judging myself on whether I felt I had done ‘good work’. I say that, “I felt good about my work” because I felt that I had been able to successfully build and conserve the illusion and all the HCPs seemed to accept the fiction. However this feeling was turned upside down when later a HCP was not able to accept the fiction, and this was a challenge I’d not faced before. It suggests that I was both annoyed and disappointed in their response but also aware it might be their own nerves making them react in this way so was unsure of how to respond. Later I asked the facilitator if “I'd done the right thing”. It seems I needed some validation that I had done good work and if not then to understand what the facilitator would have preferred so I could do it better next time. Finally, at the end of the day the HCPs applauded me. Interestingly my response to that was to feel like “I'd done something wrong”. It seems I was quite anxious about the fact they applauded me because I didn’t see this as a performance. Whilst I understand my job is to be an actor in the space, there is also a strong connection to my role in the educational context and it is important to me that it is being acknowledged.

As also identified in Cate’s stories, it appears that when scenarios are authentic and based in truth they can be highly charged interactions and so the safety of the HCP and actor needs to
be considered. In story two it seems that there were some tensions for me as areas of the character's life were linked to my own. Whilst I was initially concerned about the credibility of the character I had created this appeared to change when I found I had quite strong personal connections to the character and I was able to use these to be more authentic. However, during the scenario suddenly things "became very real... the words and emotions were coming from a very deep place of my own". It appears that as the actor I was able to recognise this moment for what it was and as such I was able to distance myself from the character to remain safe in the work. I suggest that this experience has made me a better actor and has helped me in finding the truth in all characters I play. I suggest again in story three that being able to connect to the character personally made finding the truth for the character easier. However, it appears that sometimes the line between fiction and reality can blur a little, as in story three where I suggest there was confusion between the character's response and my own; I was not sure if the emotion was coming from me or the character and this created tensions for me. Also, in story three it seems that the truth of the scenario affected the HCP and their very real emotional response had an effect on me. However, this like Cate's story appears to be more about our care and concern for the HCP's welfare.

What appears to be happening for me, as with Jason and Cate, is that throughout these stories I am having conversations in my head. In my first story there appears to be a conversation in my head around my effectiveness or otherwise as a simulated patient. For example, I say, "I remember...thinking "ok, great start! ...You are going to be ok, they get it, and this is going to work". It also seems at one point I was making judgments about whether the scenario was working, and I was questioning the appropriateness of the responses I was seeing in the HCP in the interaction as I said, "I remember thinking while I was in character, what do I do here? This person is responding really inappropriately...I had to make a decision – 'do I let them get away with this response and try to work through it or do I call them on it?'" In story two my inner dialogue was primarily about protecting myself by distancing myself from the character. In story three my inner dialogue seems to be concerned with the HCPs emotional wellbeing. For example, "I remember thinking, "are they just connecting with me or, what's going on, and are they ok?" There were also comments and discussions around the character's feelings in the moment, "As the character I thought, 'ok that's it, you get it, you get me'", and my interpretations of how I felt the HCP was managing the communication skills within the scenario, "I remember thinking 'well done that was such good work'". It seems that these conversations helped me make sense of moments and or make decisions in the moment-to-moment action.
Discussion of emerging themes across the memory stories

Across the nine memory stories presented, there appear to be several common themes that relate to the work of the actor as simulated patient in Open Disclosure scenarios. These are:

1. The importance of creating authentic characters and scenarios.
2. Identifying the challenges that limit the ability to build and conserve the illusion.
3. The need be flexible and to respond truthfully in the moment.
4. Understanding the purpose of the work is to serve the educational outcomes.
5. Being aware of the individual health care provider’s educational needs.
6. Being aware of the effects of emotionally intense scenarios.
7. The need to distance one’s self from the character.
8. Showing care and concern for the healthcare providers.
10. The desire to do good work.

Several of these themes are closely related to the artist’s responsibilities and practice requirements as simulated patient that were outlined within the literature review. For example, the first three appear to sit within the responsibility of acting, the fourth and fifth themes into facilitating and six, seven and eight fall under the responsibility of maintaining a safe environment. These themes along with nine and ten will now be discussed in relation to the extant literature outlined in Chapter Two. These discussions then take the first step towards addressing the three research questions.

**Acting**

It was proposed within the literature review that for the simulated patient the responsibility of acting includes the following practice requirements: *authenticity, building and conserving the illusion, spontaneity and improvisation* and *awareness of audience*. All of these practice requirements emerged within the memory stories, except *awareness of audience*. These will be discussed here with links to the extant literature.

**Authenticity**

One of the stronger themes to emerge from the nine stories was, the ability to create authentic characters and scenarios to create a realistic experience for the HCPs. Indeed, Jason expresses his joy at hearing the HCPs say, “Oh that just felt really real”. I also talk with enthusiasm about drawing the HCPs into the fiction such that “for those moments of the scenario we all believed that this was real”. Smith et al. (2014) discuss the need for SPs to create authentic characters and scenarios and in doing so they are constructing an effective learning environment for health care providers as it connects clearly and meaningfully with their real work. All three participants discuss their responsibility to make the characters and
scenarios as real as possible, with Cate for example talking about using her skills as an actor "to make it as truthful" as she can.

In the stories, the participants also discuss how they create realistic characters by understanding the character brief given and finding aspects of the character that resonate with their own experiences. Jason talks about reading and analysing the character/scenario brief, and about "doing your homework". These methods of creating a realistic character draw on the acting theories developed by Stanislavski (1937/1986) as discussed in the literature review.

However, there are tensions and challenges in creating authentic characters. I discuss in my second story that initially I struggled to find personal connections with my character and her situation and this led to feelings of anxiety around being able to make the character credible. Also across both Cate's and my stories tensions and challenges associated with safety when creating real scenarios with emotional intensity are revealed, together with how these may have an effect on both the HCPs and artist. These are discussed further in a later section focused on maintaining a safe environment.

Building and conserving the illusion
The stories also revealed material relating to the second theme around the challenges that limit the ability to build and conserve the illusion. This theme suggests that it is important for the artist to be able to engage the HCPs in the fiction as if it is a real clinical encounter. In this way the experience connects more clearly to real life and enables a more meaningful level of experiential learning (Smith et al, 2014). In my first story I discuss the joy of being able to engage the HCPs in the fiction. Conversely tensions were raised for me when “I worked with a doctor who had real difficulty connecting with fiction” and I questioned my ability to conserve the illusion appropriately. Jason also cites external organisational issues as challenges to being able to prepare himself. Not really knowing how and when to start the scenarios made it difficult to successfully build the illusion for himself and thus engage the HCPs. He suggests that his lack of experience was perhaps also a factor in this, “Knowing the process a little better could have made the experience a little less nerve racking and less stressful”.

Spontaneity and improvisation
The need to be flexible and to respond truthfully in the moment was another theme to emerge from the stories. Jason discusses the need to be able to improvise to "adapt in the moment" and respond truthfully as the scenario shifts and changes. Cate also talks about
needing to be “flexible, open, receptive and authentic”. Smith et al. (2014) support this by suggesting the actor, as simulated patient, needs to engage with the principles of improvisation as whilst it works on moment-to-moment to action improvisation has a strong structural base. Professional actors are trained for flexibility and spontaneity and are thus able adapt to last minute changes and modulate emotions (Pascucci et al., 2014). Jason in his third story discussed the challenges that come with having to manage the stopping and starting and repetition of scenarios. Cate suggests that in the beginning reaching the emotional points, stopping and starting, working with time constraints and not always having a flow for the journey of the character was a challenge and tested her improvisation skills but she has found that over the years as she has become more familiar with the form this has become much easier.

**Facilitating**
In the literature under the responsibility of facilitating, I briefly unpacked the practice requirements of intentionality, giving feedback, individuality, resilience and awareness of HCP’s individual needs. In this section I will talk specifically about themes that emerged from the stories around intentionality and awareness of HCP’s educational needs. Whilst giving feedback, individuality and resilience and did not emerge strongly in the thematic analysis Cate does discuss some of the challenges of giving feedback and I refer to the concepts of individuality and resilience in a later discussion around the notion of self.

**Intentionality.**
A strong theme to emerge across the participants’ stories was, understanding that the purpose of the work is to serve educational outcomes for the healthcare providers. The participants acknowledge that as simulated patients they are not just acting, they are also helping to facilitate learning. Jason comments on how satisfying it was to see the HCPs skills improve over the course of the workshops and knowing that he can help the HCP’s develop their skills, so they can “take that into the real world”, had a powerful impact on Jason. Cate too suggests that in this context “It doesn’t matter what I need. I feel that I’m there to serve someone else” and she is glad to be able to do that with her skills. Lewis et al. (2017) support this notion and suggest artists are “part of an educational team, focused on fulfilling the learning objectives of a simulation activity in services to learners” (p. 3).

**Awareness of HCP’s individual needs**
A theme to emerge in several of the stories is being aware of the individual HCP’s educational needs and being able adjust the characters and scenarios to appropriately meet their skill level. Lewis et al. (2017), suggest that SPs need to be trained to “respond with
more authenticity and flexibility to the needs of the individual learners” (p. 3). Cate suggests in her third story that she needs to be “able to pitch the character and scenario at the appropriate level for the different participants”, and in Jason’s second story he questions himself during the scenario wondering if the character should be harder, more challenging to more effectively assist in the HCP’s learning. It appears that accommodating the individual HCP’s needs is practice requirement for the artist but also one of the challenges the artist faces.

Maintaining a safe environment
The literature discusses the following practice requirements in relation to the responsibility of maintaining a safe environment: safety: safe practice, distancing, professional integrity and empathy. While professional integrity and empathy, were evident in the stories neither emerged as a theme, however they will be both be referred to later in a discussion on self.

Safety: Safe practice
Open Disclosure simulations come with risks and the safety of both actor and HCP can be compromised. Lewis et al., (2107) suggest that safety is central to simulations and they “must be conducted in a manner that minimizes the risk to all stakeholders” (p. 3). Often OD scenarios are based on real cases and can deal with life and death situations. This is evidenced in one of my stories where “I was playing the character of a woman who had lost her husband to suicide” and one of Cate’s stories where she reveals, “I was playing a young mum and my child has just died”. It seems several stories revealed tensions around the emotional impact the scenarios can have on the health care providers and the tensions and challenges for the actor when this happens and thus the theme, being aware of the effects of emotional intense scenarios emerged. Cate tells in her second story that she felt “guilty” and she “didn’t know what to do because the doctor was in pain and I took them to that place – I was one of the people that helped take them to that place”. Cate seems to suggest in her story that she, along with the facilitator, allowed the scenario to go on too long which resulted in the HCP becoming very emotional. Cate was concerned that she had in some way contributed to the deterioration of a safe learning environment, which caused the HCP to become distressed.

As evidenced above there also appears to be a sense of responsibility and guilt attached to the work when a HCP is personally affected. Feeling care and concern for the health care providers was another theme to emerge from the stories. For example, Cate says that she was “feeling very bad about putting people in this emotional position”. Cate and I both commented in our stories, “I felt my heart drop”, “I remember my heart just dropped”. These
examples show that there was a level of anxiety for Cate and I as we felt we had perhaps misjudged the HCP’s emotional state and pushed them too far. There are also safety issues to consider around the HCP’s working in front of their peers and thus feeling perhaps fearful of being judged in some way. Jason discussed the nature of the work and the need for proper work practices to make it a safe and not “terrifying experience for them [the HCPs]”.

**Distancing**
The ability to distance one’s self from the character was another theme to emerge from the stories. As discussed above there is a challenge for the actor in highly intense and emotional scenarios to maintain a distance from the character for personal safety and self-protection. Boal (1995) suggests that whilst an actor might be “entirely immersed in his deepest emotion, [he] is completely aware of his actions. However moved he may be he always maintains a total control over himself” (p. 23-24). What Boal is suggesting here emerged in my second story; “I knew what I was doing, and I felt very safe/protected.” Here I recognised the need to protect myself from the character's emotions.

**Managing the multiple responsibilities and self**
How the artist might manage their multiple responsibilities, often simultaneously, is of interest in this research. Newlin-Canzone et al., (2013) suggest that SPs do this by dividing their attention or using a “task switching strategy” citing an example of the artist switching “between the tasks of observing the learner and portraying the case” (p. 211). I believe it is more complex than this and propose that the artist as SP uses an inner dialogue that allows them to attend to the various responsibilities. In addressing this I will discuss the theme, inner dialogue: conversations in the head, which emerged as a theme through the analysis of these stories. Across them, there were several occasions where the participants, whilst in character, were in effect talking to their educator-selves, their actor-selves or indeed talking to themselves. I propose that these dialogues or conversations helped the actor make sense of what was happening in the moment and to make decisions to benefit the artistic and educational goals of the simulated OD scenario. This idea relates to the theoretical discussions around quadripartite thinking outlined in the literature which suggest that a teacher-artist might operate with four heads at once, allowing them “to make creative and educative decisions with confidence in the present moment of the dramatic action” (Bowell & Heap, 2005, p. 64).

The participants’ stories suggest that these conversations in the head help the artist manage the various responsibilities. For example, Jason says in his third story, “Sometimes the doctor might say something that hurts the character, just hits a nerve in the character and I
think, “I have a choice whether I can go off the rails or just sit with it for a while”. Jason suggests that the character feels hurt but he has a range of responses available to him and is guided by his responsibilities to make a choice that is best for the healthcare provider and their learning outcomes. Given this situation, he has a conversation with himself where he asks himself if he should challenge or sit? The artist might also have a conversation with his actor self to make decisions by referring to acting choices around authenticity and responding truthfully in the moment, as Jason explains in his third story. "Part of me was questioning – so now they [the HCP] know that they can deal with it [the character/patient] do I take it further or do I then just come across as being this insane person/character”. Here Jason appears to have a conversation with himself. As a facilitator he sees that the HCP can be challenged further. However, he also seems to wonder, as the actor, if he takes the scene to far will the character and scenario loose credibly. Another example comes from one of Cates stories. She says, "The little comments in my head were saying things like "are you OK?", ... “where is this going? Anyway, I thought, “oh well I’ll just keep going maybe this is just a really intense scene". It appears here that Cate is listening to comments in her head around the HCP’s emotional state and thus their safety as well as her facilitator self and her actor self, trying to make decisions around how to move forward in the scenario. As Cate reveals in her story sometimes these conversations don’t always lead to the most effective decisions and this can cause tensions for both the actor and the HCP.

Sutton (2011) talks of a “divided self [which] enables the actor/educator to manipulate a scenario, offer considered assessment, give feedback and respond to a facilitator's interventions” (p. 87). However, I propose that it is more complex than that. The concept of quadripartite thinking offers the notion that the self is melded inextricably with each of ‘the four heads’ and for the teacher to work in the quadripartite manner, “she needs a critical awareness of herself as she operates in each function” (Bowell & Heap, 2005, p. 65). Similar to Bowell and Heap's I propose that the artist as simulated patient manages their responsibilities by listening and responding to an inner dialogue and that the critically aware self is also present in this conversation.

Further to this notion of the self, across the stories there is a strong connection to the individual participant and their experiences in this context, not just as an actor or facilitator, but also as a human being. Preston (2016) reminds us that we bring own unique personality to our work based on our values and intentions. Jason says, in his third story, “By nature, I tend to be really helpful so if they are doing the right thing, I’m not going to slap them over the wrist. I want them to feel like they’ve done the right thing.” The notion of the critically aware self appears to be integral to each of the responsibilities and indeed crucial to the overall process of being a simulated patient. McNaughton et al. (1999) suggest that not all
artists are suited to this type of work and acting skills alone are not enough and that motivation and personality are factors in the success of SP work. With this in mind, I propose that the notion of self in this research context sits around the three responsibilities and that indeed some of the practice requirements discussed in the literature: professional integrity, individuality, resilience, empathy and are associated with self and become instead personal requirements. These are discussed further in the following chapter.

Also, across the memory stories a strong overarching theme was the desire to do good work. I suggest that doing good work in the context of Simulated Open Disclosure scenarios is about the artist finding ways to manage the responsibilities and complexities of the work artistically, educationally and safely in order to produce high quality learning outcomes for healthcare providers.

**Conclusion**

In this chapter several of the artist’s responsibilities and practice requirements as outlined in the literature review were discussed in relation to the participants’ experiences as simulated patients. The participant’s stories supported much of the literature presented in the previous chapter and also revealed several associated challenges and tensions for the artist as simulated patient. The stories also appear to suggest that one of the ways the artist manages their responsibilities is through an inner dialogue, a conversation, they have with themselves while interacting with the HCP in the moment-to-moment action. It seems that these conversations help them to make artistic, educative and ethical decisions in the moment and in this way help to provide quality-learning outcomes for the healthcare providers to do good work. It seems too that the notion of the critically aware self, including personal requirements of professional integrity, individuality, resilience and empathy are inseparably linked to this whole process. A diagram, see Figure 2 on the following page, shows how this might work. These ideas will be explored further in Chapter Five, while a revised version of this model, based on the analysis completed in relation to Phases Two and Three is offered in the final chapter of this thesis, Chapter Six.
Figure 2. The responsibilities of the artist to do good work
Chapter 5: Phase Two and Three Analysis

The previous chapter provided an analysis of three significant memory stories presented by the participants. An analysis of these stories and consideration of the extant literature resulted in the identification of three key responsibilities of the Applied Theatre artist within Open Disclosure scenarios: acting, facilitating and maintaining a safe environment. Various practice requirements and challenges and tensions relating to these responsibilities were also identified and discussed. Further to this, ideas associated with the artist listening to an inner dialogue to help them make decisions in the moment and the notion of the self being linked to this, with the ultimate goal of doing good work were also introduced. The chapter concluded by offering a diagram to represent the relationships between these ideas.

In this chapter I extend upon the ideas presented in Chapter Four by offering an analysis of the participants’ stories within the semi-structured interviews (Phase Two) and a focus group discussion (Phase Three). As detailed in the methodology chapter, each of these was transcribed and then analysed using interpretive phenomenological analysis (IPA). The emerging themes were collated, sorted, categorised and tabled, with five super-ordinate themes revealed (see Appendix G). The themes from Phase One were carefully considered in the creation of this table. This chapter provides an exploration of these themes with a focus on new insights. I extend on the responsibilities and practice requirements for the artist and offer a further explanation of inner dialogue with particular focus on the voices that contribute to them and how they link to the three responsibilities. These have been identified as: the actor’s voice (acting); the character’s voice (acting); the facilitator’s voice (facilitating); and the ethicist’s voice (maintaining a safe environment). Alongside this discussion, I also introduce the notion that the applied theatre artist’s critically aware self filters these four voices to create the simulated patient's responses and actions in the moment to ultimately do good work.

Acting
In the previous chapter, acting was identified as a responsibility for the applied theatre artist. Several practice requirements and the challenges and tensions associated with these were also discussed. Phase Two and Three analysis revealed several themes to extend on these and offer new insights and these sit within the super-ordinate theme, acting within the form of simulated Open Disclosure scenarios. In discussing these themes I address the practice requirements of: authenticity - in particular of creating characters connected to personal experiences and the challenge of working with the facilitator’s direction; building and conserving the illusion; finding the hooks a new term coined by the group to describe ways the artist might engage the HCPs in the fiction; further discussions around the
challenges associated with spontaneity and improvisation; and a new practice requirement, awareness of HCP’s interaction.

**Authenticity**
The theme of authenticity and the ability to create realistic characters and scenarios emerged from the participants’ memory stories and this was discussed in Chapter Four. It emerged again in this phase of the research and it appears once again that authenticity in acting comes directly from skills and techniques used by trained actors, particularly those who subscribe to the more realistic styles of acting developed by practitioners like Stanislavski (1937/1986). Cate was trained in this way and she tells why and how she uses her acting skills in the Open Disclosure space in response to a question about her main job as a simulated patient.

To give the participants the most truthful version of that experience I can. They all know and are so sensitive to the fact that it’s not real. Every time a new person steps into that playing space with me, with the two chairs that we’re given, I think, “I’m going to draw you in, and I’m going to make you feel that this is the real thing, to the BEST of my ability. Most of the time the feedback I get is that’s what I’ve achieved, like, “that was so real, how do you do that?” “you must be exhausted?” “do you do acting for a living?” You know, the beautiful questions that ensue. I’m not a mystical human being; I’m just a person doing my job. I want them to forget that’s it’s a role play, even though they know that it’s a role play and to use what they’ve learnt on me because I’m going to give them the best fake human being they can get, for their learning.

Cate suggests here that one of her priorities is to be authentic and to do this she creates characters and interactions based in her own truth, experiences and emotions. It appears important to Cate that for each new scenario she builds and conserves the illusion of the fiction by drawing the HCPs in and have them believe for those moments that the scenario is real. She also suggests that individual health care providers are different therefore each time she works with a new person she is going to give them a unique and authentic experience that is of value to their learning.

The theme of creating a character though personal connection also emerged from the semi-structured interviews. It appears that for the participants to create characters based in truth they use their own experiences to inform the characters they play. Jason is quite new to this context and he talks about his experience in creating a character for the simulation and suggests he doesn’t approach the work in the same way he would a play. He suggests that to
prepare for the simulation scenario he is not given a script but rather a brief description of the character and situation and so he has learnt that it is up to him to create much of the character.

I think I just learnt about how much of [Darren] is myself. When I recreate something, I put the name of [Darren] over me, so much of it is me...The responses I got from people were like "oh you definitely are like a grieving father, we've seen it". I guess that it's reassuring in some sense to know that. I felt like I learnt that it's not about creating this other person - you are the character.

Here Jason suggests that in this context of the simulated Open Disclosure scenario a good deal of himself is the character. He also suggests here that hearing comments from the HCPs that the simulated patient he created was very realistic is reassuring. Barba (1995) suggests the performer "begins with the inherent gifts of his/her personality" then uses "points of departure" which is the performer's technique or "craft". Here Barba suggest the actor is trained to use personal connections and then distance themselves from it through learnt techniques. In this way, the quest for authenticity creates a fine line between self and the character and in creating characters for the simulation context there is a strong reliance on self. This also has consequences the artist needs to be aware of and manage for self-protection. The notion of self-protection will be discussed further within the practice requirement distancing under the responsibility of maintaining a safe environment.

Another theme to emerge relating to authenticity was the challenge of responding to facilitator direction. The participants commented that while they trust the clinical facilitator and will always try to meet their expectations, sometimes it is difficult to do this and still stay truthful to the moment. Both Cate and Jason commented on this.

She [the facilitator] signalled me to cry. I remember thinking, “Oh you want me to cry in this scene, far out, I don’t know, I can’t just be asked to cry in something like this”. But if my facilitator, who I trust wants me to go there I have to see if I can... So, when I was in this scene I was trying to listen and I’m thinking I need to be sad now, so I was being heavy and sad, but I didn't feel that I could go there truthfully.

He really wanted me to push it hard because a lot of people in this group were high-level practitioners, so he wanted me to go harder than I normally would...I wanted to go to places that he wanted me to, but I also needed to stay true in the moment.
Cate and Jason both suggest that meeting the facilitator’s direction to portray the SP in a certain way is sometimes a challenge if the emotion is not authentic. However, both suggest that it is important to them that they try to meet the facilitator’s expectations. Nelles (2011) agrees that authentic characters are imperative to the success of the patient simulation scenario, however she cautions that this can sometimes be compromised when directions or notes given by the facilitator clinician are not congruent to the authenticity of the patient character or the scenario suggests that at times SPs are asked to “put aside [their] ‘unique’ responses in order to perform as expected” (p. 57).

Building and conserving the illusion
In Chapter Four it was identified that part of the artist’s job is to engage the HCPs in the fiction. HCPs are aware that the scenario is not real so the actor must “employ skills to effect a [HCP’s] willing suspension of disbelief” (Sutton 2011, p. 87). As discussed in the literature the artist does this by successfully building and conserving the illusion of reality. Taylor (2011) suggests that creating this ‘reality’ is not about depicting real life but rather about emotionally engaging the HCP. As in the previous chapter, challenges to building belief also emerged in this phase. One of these challenges was how to start the scenario and in particular how to find something new each time to be able to successfully engage the HCPs. This became a bigger discussion in the focus group.

Jason: I guess the difficult experience I had was deciding on how to enter the room and my choices, because I think that where it’s starts, it really brings a certain energy. So, I think I just sort of challenge myself to decide but if it was too much I would talk to my facilitator about it. So, I had a list of things from the scenario and I would just hone in on that one and if they dealt with it really well then I could move on, keep going. But if they got stuck with it then I might bring up something else. That goes to the idea of the hook.

Jess: So, you were finding hooks through your two pages of the scenario and you found all these bits that you could latch on to - in terms of the scenario details.

Jason: Yeah.

Jess: OK, so hooks for me are also attitudes, they are ways in, that’s a hook for me. Like, I’m going to approach it like this because I’m furious with the doctor.

Jason: Yeah that’s right.
Jason talks here about finding hooks to allow him to start the scene effectively, to create “a certain energy” on which to build the scenario and keep the scenario moving forward. He suggests that he finds these hooks in the written scenario brief. I suggest I do something similar and use the information in the brief and also particular attitudes for the character to help me find ways in and through a scenario. The notion of finding the hooks was not discussed in the literature review, however it is not a new concept in drama in education. For example, O’Toole and Dunn (2002) use the notion of the hook to engage child participants in drama, suggesting it’s about finding something of interest to the group to raise intrigue and questions or issues to be explored. In this context, hooks offer ways into the scenario and to keep the actor and the HCP engaged. These hooks can come from a range of stimuli, and the improvisational nature of the work allows for these to sometimes come from an external source as Jason explains.

By the last scenario I was exhausted what actually happened which was interesting, one of the participants came out of the room while I was in the corridor preparing, saying “I can’t do this” – and I thought “Oh that’s exactly how I feel I can’t do this anymore – I can’t even cope right now”, then that became my mantra. So, I walked in with this thing of, “I can’t do this, I want to be with my son, I want to die, I want to go and be with my son” and it just opened everything up again. It was just about finding that initial switch. It was a cool moment because I’m waiting outside the room and thinking ok I’ve done this array of approaches and I want to try something else.

Jason suggests here that after a day of repeating the scenario and looking for new ways into it he found his inspiration, his hook into the scenario, from a comment from a HCP and his own emotional state. He was able to bring that into the character with specific details of scenario. This provided him with a new way in to the scenario, allowing him to feel confident with a fresh and interesting approach with which to engage and energise himself and the HCPs. His comment that it “opened everything up again” appears to indicate that there were some new discoveries for the HCPs with this version of the character and the scenario.

Spontaneity and Improvisation
The ability to improvise and work spontaneously with the individual HCP within a given scenario is a major part of the actor’s responsibility (Pascucci et al., 2014). In the previous chapter participants expressed the need to be flexible and to be prepared to respond quickly to scenario changes. Participants also commented on the challenges around the stop start nature of the simulated scenario. In Phases Two and Three, several smaller themes emerged around the challenges of improvising in the specific context of the simulated OD scenario.
Participants made several comments again about the stopping and starting of scenarios, the repetition of scenes, finding emotional points and remaining fresh as challenges to the work. Johnston (2006) reminds us that improvisation is hard work and improvisers must be awake, listening, watching and paying attention, not forcing the outcome but allowing responses to be spontaneous.

In relation to these challenges, the following comments were offered:

I think role-playing can be underestimated; it takes a huge toll physically and mentally... As the actor you need to do your job well and you need to make it fresh! We have to listen and engage with what each new participant offers us.

As the day went on and I got more and more exhausted, I relied more and more on things that happened in the moment to keep me fresh...you try to find new ways to explore what it is that you're doing and keep it fresh and also challenge yourself, you are not just giving up because it’s really hard.

Sometimes you do the same scenario eight times and trying to do something a little bit different to keep it fresh and that's very stressful, very taxing... thinking, “Oh will I be able to do it and manage to be convincing and new and fresh?”

It seems that the improvised nature of the work and the particular form of Open Disclosure which requires the repetition of scenarios over the course of several hours, creates challenges for the artists in keeping each one fresh. Plaksin et al. (2016) support this notion suggesting that “fatigue or exhaustion” are common side effects of SP work (p. 18).

Awareness of HCP’s interaction
This is a new practice requirement within the artist’s acting responsibilities, however it aligns to some degree to the discussions in the literature around awareness of audience. The literature outlines different ways in which the artist interacts with the HCPs. Jacobsen et al. (2006) suggest that the ‘audience’ engage in three different ways to affect the learning environment and educational outcomes. They suggest the group of HCPs: 1) observe the interaction like an audience; 2) reflect as a group separate from the interaction altogether and essentially ignore the artist; and 3) interact with the artist in a “hot-seat” situation to ask questions to further learning opportunities. My experience leads me to agree that the actor does indeed interact in these various ways, however this did not emerge as theme within any of the participants’ stories across the three phases of research. However, what did emerge was the participants' awareness of HCP’s interaction in the scenario. Cate acknowledges
this, “I know it’s pretend, but for them it’s not...because they are playing themselves.” It appears that Cate is very aware of the unique nature of her interaction with the HCPs and that this has educational and safety implications for all involved. I believe this awareness of the HCPs is crucial to the success of simulation and this will be further discussed in the responsibilities of both facilitating and maintaining a safe environment. Importantly in the focus group discussion the participants agreed that they do not regard the healthcare providers as audience.

Jess: I think we decided as a group that really, we don’t view the group in any way as an audience.

Jason: Yep.

Cate: Yeah.

Jason: Yeah that’s right they kinda blur out.

Jess: Yeah because when I’m in a scene I’m not even aware that they are there, you (Cate) said that you sometimes use it as part of your scenario.

Cate: Yeah.

Jess: What about you (Jason)? You said something about and awareness of them shifting in their seats in the interview.

Jason: I brought it up after I had people coming in and out of the room while the scenario was going.

Cate: What? The other day? Agghhh

Jason: Oh yeah, so I almost said geeze it’s a busy room in here or something like that, but I didn’t

Cate: Yeah, yeah.

Jason: Because it wouldn’t have helped.

Jess: Because it wouldn’t have helped the scene

Here the participants agree that they are aware of the HCPs observing however they are not integral to the scenario interaction, as an audience would be in the theatre; as such the participants don’t feel themselves to be playing to an audience. There is of course an awareness of the observers in the space, particularly if they are shifting or moving about, and both Cate and Jason suggest they sometimes will use that as part of the scenario but only if it helps the scenario in some way. As suggested above the artist interacts with the HCPs in a variety of ways however the participants in this study do not see them as an audience. For these reasons I have changed the practice requirement awareness of audience (as discussed in the literature review) to awareness of HCP’s interaction.
Facilitating
Understanding the educational context for the healthcare providers was another superordinate theme to emerge from the Phase Two and Three field texts and appears to sit very comfortably within the responsibility of facilitating. Several sub themes to have emerged again complimented much of the discussion from the previous chapter. However, there were new insights including further challenges and tensions that come with the responsibility of facilitating. These included further understanding of intentionality and working as the actor/educator and giving useful and relevant feedback. A new practice requirement introduced here is offering clues. Also discussed is the awareness of HCPs educational needs, with this being necessary in order to appropriately challenge them for their learning.

Intentionality
As outlined in the literature and the previous chapter, the practice requirement of intentionality suggests that the artist needs to be mindful of the educational purpose of the work, knowing why and how the simulated scenarios work and who is involved. This emerged again as a strong theme through the interviews and the focus group. It is the duality of role as actor/educator discussed in literature that sets the educational intentions for the artist as simulated patient apart from straight acting roles.

Whilst the participants seem to understand that they are employed as SPs because of their acting skills, across the four field texts the participants also appeared to be very attuned to their role in the education process and their important contribution to the learning context as both actor and educator (Sutton, 2011; Nestel & Beardman, 2014). Further to this Pascucci et al. (2014) suggest that actors who understand the educational goals of the activity and are able to create “highly realistic simulations with an educational focus” are favoured (p. 121). In the focus group discussion participants spoke with great conviction about their dual responsibilities as actors and educators in the workshop space.

Jess:  At the end of the day even though our skill base and why we are employed is because of our acting skills we bring so much more to it than that...We come here because we want to make a difference.
Jason: Yeah.
Cate: Yeah.
Jason: Yeah that's why we come here.
Cate: That's right. Which is why it's really important.
Jess: But it's so interesting though that we are actors, you know we go into the room as actors and I see myself as an actor but actually I'm really...
Cate: A teacher, yeah you are teaching with your acting skills
The participants appear to be very sure that their role as SP is about teaching and they are acting for the purpose of education. As applied theatre artists they are aware that what they do, as actor/educator is important for creating successful and valuable learning outcomes.

Jess: I think at the end of the day, I believe in the work and both of you have said it, the powerful nature of the work, it's very powerful.

Jason: And then there are the responses from people like, “this is the sharpest learning curve I've had in ten years”. It's the intensity of the experience that makes it an important learning curve for them as doctors.

The participants also appear to recognise that the experiential nature of the work is powerful in the learning context and that quality of the experience they can provide for the HCPs is important to the overall success of the work.

**Giving Feedback**

Giving feedback did not emerge as a strong theme in the Phase One, however Cate did speak of the difficulties she had with a particular HCP responding negatively to her feedback. Pascucci et al. (2014) suggest that feedback needs to be given sensitively; it needs to be honest and address the concerns yet carefully placed to spare the HCPs humiliation. In this phase participants talked about the importance of and challenges to giving useful feedback to assist in the learning process. In the interviews both Cate and I spoke of some of these challenges. In particular, we speak of only been invited to give feedback in character and that this sometimes limits what we feel we would like to say.

I have to stay in character while they are talking and I can’t join in on the conversation, I have to be invited. So sometimes I would like to say things but I don't always get the opportunity to...because sometime I think they [the HCPs] think "oh I've haven't done a good job here", and while it might not have gone the way they intended there is often a lot of good stuff they do and I think it’s important for them to hear that.

I wanted to give feedback but not as the character, but I wasn't sure in that moment if I could and she [the facilitator] wasn’t giving me the right signals, so I just did it as the character, but I try to put a bit of Cate in there as well.

It appears that both Cate and I want to say more in the feedback sessions but feel that we are limited by what we can say in character, in particular around making the HCP feel positive.
about their interaction. Cate suggests that a way around this is to layer the character’s response with your own, and in this way, we respond not as the character but as the simulated patient (this concept is discussed further later in this chapter). This became a much bigger conversation in the focus group discussion and we realised that giving feedback was quite different depending on the facilitator. As part of this conversation Jason explained he had only ever given feedback as himself never as the character until the example he gives here.

Jason: It depends...I had a different facilitator in the room it changed the way I was able to give feedback. On the first day I gave feedback as [Jason] straight away it was like “ok cut scene, ok [Jason] how did they go?” Then the second day I would leave the room and they would chat and then I would come back in the room and give feedback as [Darren] the character. Then they would ask me to leave again and then they would talk about that and then I’d come back in as [Jason], so I had the chance to talk about it different ways.

Since the interviews and focus group discussion we have spoken with the clinical facilitators and have now experimented with a range of ways to give feedback, including time jumps, to give the most valuable and beneficial feedback for the HCP’s learning.

Offering Clues
Participants spoke about the need to offer clues to the HCPs in the moment-to-moment action and as such this emerged as a new theme and a new practice requirement. The artist as simulated patient offers clues similar to ones a real patient might give, giving “covert rather than overt clues to their underlying needs” (Kurtz et al., 2005, p. 94). Picking up on these clues or missing the clues, provides opportunities for the HCPs to reflect and learn, improving their communication skills.

In relation to this practice requirement, the participants offered the following comments.

I would give lots of clues with my language “I am devastated”, “the most important thing to me was...”, “I feel so lonely” and they were not picking up on it.

If they don’t ask me about my husband, I can’t tell them about him, but I give them lots of clues to help them, like “my husband flies out on Saturday and he’s asking me every day, does he need to cancel work?”
I’ll sometimes drop clues. Like I’ll say a line over and over again or I’ll say something to send them in a different direction to get them off their stuck thought.

Here the participants suggest that as the simulated patient they give a range of clues about the character’s situation hoping that the HCP can pick up on these clues. These are clues about specific information they feel the HCPs need to advance the interaction. The artist as simulated patient may also offer clues if the HCP appears to be struggling with a difficult but important issue or perhaps struggling to find the words, in this way they help to guide the scenario. This becomes part of the learning for the HCPs in terms of communication skills and in particular their ability to pick up on verbal and physical cues. In my experience, these moments often become points of discussion during reflection time. The clinical facilitator may even stop the action and direct the HCP to a clue that has been missed and ask them to go back into the scenario to see what happens when they acknowledge it.

**Awareness of HCP’s educational needs**

Further to the discussions in Chapter Four, the participants in this phase of the research again spoke of being aware of the healthcare provider’s educational needs, with the focus being on the needs of the individual HCP in the interaction. It seems that the participants are conscious that each individual HCP brings a different set of skills, experience and expertise to the scenario. Each healthcare provider can have a very different approach (Smith et al., 2104). Therefore, each HCP requires a unique interaction that is meaningful and beneficial to their learning. Being aware of this and being able to pick up on cues from the HCP helps the artist make choices in the moment to appropriately challenge the HCP and provide an experience that is helpful in meeting educational outcomes. Jason tells of his experience with two HCPs and how he recognised their different educational needs.

The very first participant I had today, his voice was quite high, and he sounded very clinical, but he was saying all the right things, so I was kind because I knew that he was trying. [Then later someone] was doing really well, so I just threw in this curve ball that put me outside of my comfort zone but also challenged them. I was aware of doing that too.

Jason appears to be aware that the two HCPs were managing the simulated scenario differently. The first appeared to be struggling a little and so Jason says he was kinder in his responses, whereas in the second interaction he felt he could challenge the HCP further. Jason is able to makes changes in the moment-to-moment action adjusting his responses to suit their individual needs. These adjustments to character and scenario help to make the learning “self directed, experiential, relevant and practical as well as enjoyable and
motivating for the actors and learners alike” (Pascucci et al., 2014). Sometimes the clinical facilitator will discuss variations of the simulated patient with the individual and or group beforehand to give the HCPs opportunities to work with particular patient types.

**Maintaining a safe environment.**
Maintaining a safe and respectful work environment was another super-ordinate theme to emerge. Several sub-themes emerged to support further understanding of the practice requirement of safety, in particular several themes around the challenges to this. As in the previous chapter participants spoke of the high-fidelity nature of the work and that it can affect the HCPs in various ways both personally and professionally. The participants expressed a great deal of concern for the HCPs when it seemed that their safety was compromised. As such, there are ethical and moral considerations here for the artist. I will discuss further the need for safe practice, in particular the need to build a safe, “sacred” space and the potential for power imbalance to exist between the artist and HCPs. The practice requirement of distancing for self-protection will be discussed and a new practice requirement awareness of the HCP’s emotional needs.

**Safety: Safe practice**
In the previous chapter the need for safe practice was discussed. In particular, participants raised concerns about the emotional intensity of the scenarios and the need for both artist and HCP to be protected from these. In this phase of the research the participants spoke across all field texts about the safety aspects of the work including: the safety issues that arise when a scenario mirrors real life experiences for the HCPs; the need to set up a safe space for the HCPs to feel comfortable and being aware of potential power imbalances that might arise.

In the focus group, Cate shared this story of her experience with a group of HCPs from a rural hospital who had difficulties with a scenario that was very close to home for them.

They said, “we’ve had similar incidents like this it’s still very raw for us”. One of the male doctors as he was talking he said I have to be very careful not to cry too because it’s a small hospital we know this town so when something happens we know not only the person it’s happened to we know their families and then it just got into that conversation. It didn’t happen at the end of the scene because the lady couldn’t go on and it was stirring everyone else talking about it, because she couldn’t explain what happened, she didn’t go “let me tell you why I’ve had this experience”, “I don’t think I can do this”, “it’s too hard for me”, she just couldn’t stop crying. So, the facilitator did a lot of talking and she left the room and
everyone else started crying. [So, we said], well we can't work now with this scene it’s too – we are not going to learn anything it's too sad, too emotional.

It appears that the scenario triggered a very emotional response, not just from not just the HCP interacting in the scenario, but from several of those observing because it was similar to real situations they had been involved with. The decision was therefore made by the clinical facilitator and the artist to move on to a different scenario to protect the group. Whilst safe work practice is indeed the primary concern of the clinical facilitator (INACSL Standards Committee, 2016a) the participants in this study believe that as applied theatre artists they also have a responsibility for helping maintain a safe and supportive environment in order to create the best possible learning opportunities.

In the focus group the importance of setting up and managing the space was discussed and Jason offered the notion of a ‘sacred space’ where the clinical facilitator ensures that everyone understands the processes for the simulation.

Jess: You talked about the notion space, of protecting the space.
Jason: Oh yeah, the sacred space
Jess: Yes, you called it the sacred space and you talked about a list of things for the clinical facilitator to help set up and manage the space, like how to manage signals, questions, time, roles etc.
Jason: Yeah, [I noticed with a different facilitator] by end of day two they [HCPs] were talking so much about their learning and what was exciting was, they didn’t have time to say, “oh that was horrible, I just wanted to get out of there”.
Cate: Yeah
Jess: Yes
Jason: They were talking. It was really difficult [the previous day] because I felt like, I know I have to protect myself and I have to make sure I’m safe but at the same time I have to look after their needs...I think it needs to be kept a sacred space for learning.

It appears that Jason’s experience with a different facilitator changed the way the work environment unfolded, and he felt the learning experience for the HCPs was much richer on the second day when the space was more clearly set up with clear rules and expectations and more supportive of the HCPs achieving the expected learning outcomes (INACSL Standards Committee, 2016a). When this was not done as effectively on the first day, it added to his sense of responsibility to care for and protect the HCPs.
Another of the smaller themes to emerge around the notion of safety was the challenge of dealing with actor status. This refers to the relationship between the artist and the HCP and the potential for a possible power imbalance. Sometimes it appears the HCP can view the artist with trepidation and this can create a block for them. Cate and I shared similar views on this.

It often starts out where they (the participants) look at you in a very intriguing but protective manner almost like they are a bit afraid, they don’t know what to make of us, but at the end of the day they talk to us like we are humans again and all these questions come out like, "Are you an actor?"

There was a lady who came up to me and said, "I've never met an actor before" and she said it as if I was something alien. Then it made me realise for her, one of the biggest fears she had about the day was actually working with an actor.

Both Cate and I seem to suggest that there can be some tension for both the actors and the HCPs in terms of their professional relationship. However, Cate’s comments suggest that this is usually resolved by the end of the day and there appears to be great intrigue and interest in the acting profession. The term actor status has not come up in the literature, however there are discussions around the notion of professional integrity and building relationships and how power imbalances can compromise learning outcomes (INACSL Standards Committee, 2016b). The potential for an imbalance of power to exist, between the artist and the health care provider was supported in a study by de la Croix and Skelton (2009). The study suggests that in the simulated interaction the SP is seen to have power because they are part of the educational team and know and understand the process, having a clearer idea than the HCP of what will take place (de la Croix & Skelton, 2009). This is important for the artist to understand so that they can help to reduce the feeling of a power imbalance and thus create a safer, more respectful learning environment. Again, the clinical facilitator can help this by setting up a supportive space.

Artist’s Safety: Distancing
The practice requirement of distancing was addressed in Chapter Four and has again emerged as a theme. There has also been some consideration for this in discussions around authenticity. The artist draws on their own life experiences to develop authentic characters, but with this comes the need for distancing and self-protection. Boal (1995) suggests trained actors are able to find emotional points but remain in control and distance
themselves from it (Boal, 1995). Cate appears to be aware of this and the techniques needed to manage this.

I know it's not real, but I don't want to be fake I want to be real and I draw on all of my experiences and emotions. I know they're probably not as deep as they would be if I wasn't acting, you know what I mean? I know I'm acting because as actors there is always a safe place we go to, to protect ourselves. I have to protect myself.

It seems Cate is very aware of her self in the work and whilst she draws on her own experiences and emotions to create the character, she is able to distance herself from these. She knows as the actor that while the emotions she feels are deep and they appear real, they are not real, for as Bolton (1984) explains, they are second order experiences.

Jason talks too about the notion of finding emotion for the character that is real requires the actor to tap into their own experience. This he explains can be a challenge for him particular when he is asked to be angry. He explains that he is not naturally an angry person; therefore, he has to find something within himself, which can be confronting.

I really worked on trying to let myself be angry and say, “it's ok to be angry”, obviously not hurt anybody, but know it's ok to be mad. I as the character [Darren], have the right to be angry. I was up against the wall, because I was thinking I need to be angry but I don't' want to hurt [the HCPs] feelings - actual people's feelings, and I'm like yes but this is the scenario and you are an actor and the character is angry not you and you have the right to be angry, your son has just died and it's ok for you to be mad and it doesn't mean that you're a bad person if you show anger.

What appears to be happening for Jason here is that he has to remind himself that it is the through the skills of the actor the character is showing anger not him. By understanding this he can distance himself and his personal dilemma of feeling he is upsetting the HCPs from the anger the character displays.

Awareness of HCP’s safety
This is a new practice requirement and emerged via the theme of the need to be aware of individual HCP’s emotional needs. In this section I focus on the safety issues for the individual HCPs and the artist’s sense of responsibility and their concern and respect for the HCPs who are at times placed in vulnerable positions. Both Jason and Cate suggest that each
new interaction with a HCP requires the artist to cater for the individual’s needs and provide a unique and safe experience for them.

There is definitely an element of knowing when to push it up and knowing when to bring it in. Just sensing it. I don’t want to crush them... I think for the participants, it’s something I’m really aware of and that’s one of the reasons I didn’t want to go too far into anger. These people are volunteering their time to come and learn and if they get so terrified in a training session they might not want to come back. They need little wins to get to that point when then you can go "ok let’s just try it with some curve balls", so they have this thing, where they can deal with stuff so then the facilitator can say "ok let’s take it to the next level and it’s not a judgment on their ability, it’s just about going, "well you guys have got that let’s see what else you can take". So, I’m very aware when I can see someone who is on the edge or vulnerable.

I’m not here to harm, I’m here to help them (the participants) learn. You’ve got to have a quality about you that can be receptive to the fear of working with someone who is not an actor and being able to pick up on their cues, like a participant’s cue of, “I’m really scared right now”. Even though I may have been told to go to a ten it will be a different ten to another participant because you have to consider what this person is capable of dealing with and I am really mindful of that, because I’m not about ruining anyone’s self-esteem, it’s about building them up.

Both Jason and Cate suggest the need to encourage the HCPs and that putting them into a situation that is too challenging for them is not helpful. This appears to be a bit of a balancing act and Jason suggests the artist does this by sense. Cate talks of a quality that allows the artist to be receptive to the HCP’s feelings and being able to pick up on their cues. So again, the artist is adjusting their performance to suit the needs of the individual HCP. These might be modifications on emotion or intensity to change the degree of difficulty for the HCP. In this way the artist works to appropriately challenge the HCP to be of most benefit to their learning (Pascucci et al., 2004). Both also comment on the fact they are aware that the participants are not protected by role and that they are playing themselves and this adds to their vulnerability. Jason and Cate suggest they aim to create a scenario that is going to be helpful and not harmful. It seems both are aware of the HCP’s state of vulnerability and that each HCP is very different.
Inner Dialogue – the Competing Voices and the Filter of the Critically Aware Self

In Chapter Four I proposed that the artist uses an inner dialogue to manage the responsibilities of being a simulated patient and that the critically aware self was integral to this. In this section I extend upon these discussions and propose that there are four voices contributing to this dialogue and that they emerge from the three responsibilities. These four voices are: the actor’s voice (acting); the character’s voice (acting); the facilitator’s voice (facilitating); and the ethicist’s voice (maintaining a safe environment). Based on consideration of the field texts across the three phases of this research, it now seems to me that these voices negotiate with one another as each one responds to the individual HCP’s educational, emotional, personal and professional needs. Further to this I also propose that the artist filters these voices through the critically aware self and that this process enables the artist to make decisions in the moment in order to respond as the simulated patient. In this way the artist is able to continually adjust the action and create a unique and positive learning experience that will lead to quality learning outcomes for each HCP.

To help explain this process, a story from each of the participants is offered below, and importantly, within them I make a distinction between the voice of the character and the voice of the simulated patient. In particular I argue that the character is the fictional patient who has a unique voice inside the artist’s head, whereas the simulated patient’s voice is the result of the inner dialogue and is the voice that actually speaks in the interaction with the HCP.

Example One

In this first example, Jason talks about several inner voices offering advice and helping him make decisions in the moment:

I can’t think. So, I’ll say in character – “I’m so sorry just give me a minute” and then I just breath and I let myself think and then I’ll talk, and I’ll say something and yes, the actor brain is there. So, I’m thinking ok they’re doing really well here, and it’s been pretty cruisey so far, so I think how can I do a small shift in my sensibility and will they respond in an appropriate way?

Here it seems that Jason’s character is feeling emotional, creating challenges for the actor to think. This in turn means that the simulated patient is unable to be effective. Jason, the applied theatre artist recognises this, so he gives himself a moment by speaking as the character through the simulated patient and requests some time. He is then able to engage his actor voice to help make a decision about the simulated patient’s next moments. As the facilitator then, Jason determines that the HCP is doing well and so he wants to challenge them further. With this in mind Jason the artist listens to the facilitator’s voice and adjusts
the simulated patient’s response and thus scenario. He then aims to assess the HCP’s response to this to see if further adjustments should be made.

**Example Two**

This example offers a different set of circumstances to understand how the inner dialogue occurs in the artist’s head. Here Cate tells the story of a HCP who was playing with the bed sheets while talking to her and she found this annoying, resulting in an inner dialogue between the various voices in her head about how to respond to this.

*Example Two*

*Cate:* One guy when he was standing up beside my bed, HE WAS FIXING MY SHEETS! And all I could feel was my sheets being tugged and I’m like, “I’m sure you’re going to stop that soon” so I thought, “you’re really nervous”, here’s me going “what do I do, what do I do, he is really nervous”. I was on the verge of saying, “can you please stop that”, in a nice way, but he stopped. He did go on for a good 30 seconds and I’m like “just leave the bloody bed alone” it was so wrong in so many ways.

*Jess:* And so they are the moments that I’m really interested in. So, for you, there you are Cate as the character lying in the bed having this conversation with this doctor, but who is annoyed with this? Is the character or is it Cate?

*Cate:* It’s both. Well it’s more the character, but I Cate am the character, I bring so much of me.

*Jess:* But when you’re thinking, “ok he’s nervous” is that Cate?

*Cate:* That’s Cate. Definitely Cate

*Jess:* So, Cate’s telling the character, chill out he’s nervous let him pull on the sheets but after a while Cate goes all right that’s enough?

*Jason:* Yeah. You’ve got permission now

*Cate:* You’re right, you’re right.

*Jason:* Yeah, it’s like you register it and then you run it through the facts of what your character has been given and then you go, would she or he respond in what way?

*Jess:* You find a way for the character to do it in a natural way

*Cate:* Absolutely and this is another skill that actors who do this work need I feel, don’t you?

It seems here that Cate, the applied theatre artist, and as such her sense of self, is ever present in this interaction and actively filtering the conversations in her head. Here we see that both Cate and the character are annoyed about the bed sheets. However, her facilitator
voice is telling her that the HCP is nervous. As artist she filters these competing voices and ultimately attends to the facilitator voice, with the result being that the simulated patient makes a decision not to respond to these annoying actions.

Jason supports this interpretation when he suggests that in this situation it is the artist who runs "through the facts" to decide how the simulated patient might respond, with the facts including consideration of the HCP's emotional state and their abilities. In response to his comments I suggest that the artist must find a way for the simulated patient to respond naturally or truthfully. Newlin-Canzone et al. (2013) would appear to agree as they suggest that the artist is multi-skilling, doing a unique and demanding job by performing several roles at once and that there are "attentional demands" placed on the artist in their efforts not only to portray a character, and improvise plausible responses but to also observe the HCP (pp. 207 – 208).

Example Three
I also offered a story in the focus group around the idea of the inner dialogue.

Jess:  I had a moment where I'd poured my heart out, but the doctor didn’t acknowledge it, he just said “and nothing has changed.” I just looked at him and my brain just went white noise, white noise. So as the character I’m going, “what?” “Nothing’s changed?” “I almost died, and I may die because of what’s happened, so how can you say that nothing has changed?” So as the character I’m going “AHHHHH!” Then I remember having a conversation with myself, going “Jess, you have to say something” but as the character I’m speechless, I don’t know what to say. In the end I said, “everything has changed”. It was a conscious decision to say that because I knew he was struggling but I thought “I can’t let this go”, but then I’m thinking “let it go, let it go”, but I’m thinking “I can’t let it go, as the character”. As the character I could not let that moment go and I had to find a way. I thought how am I going to let him know that what he just said was so inappropriate but do it in a way that was going to be helpful.

Cate: Do you also think this was informed from the previous day, because you know he was struggling?

Jess: Yes completely. Definitely yeah and because the facilitator also said don’t be too hard

Jason: I think it also ties into what we were talking about the other day about moderating your performance based on their level of
Jess: ... their individuals needs. The more and more that we talk about this and that I do this work I think that one of the real challenges for us is meeting those individual needs...

Jason: Yeah
Cate: Yeah, yeah

In this story I describe a process of listening to both my character voice and my facilitator voice. Filtering this via my critical self, I feel empathy for the character while also determining that something needed to be said on the characters behalf. However, at the same time, my facilitator voice tells me that the HCP is struggling; also, because I had already worked with them the previous day and had been asked by the clinical facilitator I am aware I should not go too hard. As such, there are now also ethical and safety issues for the HCP to be considered, and hence the ethicist’s voice joins the conversation. In the end I had to make a decision and based on all the voices in my head, my critically aware self filters these to create a response from the simulated patient that would be both truthful to the character and also helpful to the HCP for their learning.

This discussion also reveals a further theme that is about creating versions of truth to cater for the individual needs of the HCP. I note:

It’s got to be truthful. At the end of the day my main job is to have a truthful interaction with the participants, because if it’s not truthful then there’s no real learning that can happen because it’s pretend, it’s false. So that’s what I aim for, is the moment of truth. So for example, in the moment there might be 5 choices that I have that are all truthful responses for that character, then I say to myself “well which one is going to be the most beneficial for you, is it one that will challenge you a bit further because I can see that you are really good at this and so I’m going to challenge you a bit more, or is it that I can see that you are struggling with this and therefore I’ll take this option to allow you to move forward”. But in the first instance it has to be a truthful response.

Here I suggest that by making choices in the moment based on what the voices are saying, the artist is able to modulate the character and find versions that remain truthful to the scenario, so the illusion is maintained, and the HCP can continue to engage and suspend their disbelief. This ability to adjust and redirect is aimed at bringing the HCP to an appropriate level of interaction while keeping the scenario truthful (Pascucci et al., 2014).
When the artist is able to do this, the impact is more powerful for the HCP and the learning can be more clearly connected to real life (Smith et al., 2014). To this end then the artist must consider the HCP’s prior abilities, experience and qualities as factors in their decisions, interactions and performance (Pascucci et al., 2014).

From the examples given above, I suggest these various voices in the head of the artist deliberate, discuss, compromise and make decisions for the simulated patient to respond in a way that remains authentic but importantly meets the required educational outcomes for each individual HCP.

The Critically Aware Self
In Chapter Four I suggested that the artist as the critically aware self draws on the following personal requirements: individuality, resilience, empathy and professional integrity. In this phase of the research I offer a further explanation of these to better understand what the critically aware self in this research study context means. Alongside this I discuss the participants’ desire to do good work. It was also proposed in the previous chapter that doing ‘good work’ is about the artist being able to manage the various responsibilities, challenges and tensions of being a simulated patient to produce high quality learning outcomes for the health care providers and that the notion of self is inextricably linked to this.

**Individuality: motivation and experience**
Each of the participants in this study brings their own unique style to their work as simulated patients. It appears that their individuality is linked to their experience, values, intentions and unique personality (Preston, 2016). The participants shared stories around their personal connection to their work including things like their experience and motivation for doing this type of work. Jason tells of his personal desire to help people.

> I also think that there's the actor, but I think there's a part of me that wants to see people grow. My mum is a counsellor and there's an element of me that wants to help others, strongly. So, when I see someone who might have got it sort of, I think I can give them keys that can help them take it even further.

What Jason seems to suggest here is that he has a personal investment in this work and he is intimately committed to the work. He also appears pleased that he can use his skills to help others help themselves. It seems that for him, who he is, as an individual, influences how he manages himself and his responsibilities as a simulated patient. McNaughton et al. (1999)
suggest then that not all actors are suited to this type of work and acting skills alone are not enough. Motivation and personality are also factors in the success of SP work.

**Resilience**
The work of the artist as SP in Open Disclosure scenarios requires the individual to give of themselves in many ways and this creates both satisfaction and anxiety. What the participants suggest is that much of their anxiety comes from managing sometimes difficult situations and that failure to do this may have a very real impact on others’ lives. Preston (2016) acknowledges that resilience is born out of the wider challenges of working with situations that are difficult, messy and unpredictable. The participants expressed disappointment when they felt they could have done something better. This is not uncommon, as other SPs have reported frustration and dissatisfaction if they feel their performance didn't achieve the learning objectives (Bokken et. al., 2006). Jason and Cate demonstrate resilience to the challenges and the tensions and suggest:

> As an [artist], you challenge yourself, you are not just giving up because it’s really hard.

> I love my work and I’m very grateful for it, I don't run, or call in sick, I do the best I can.

It appears that while Jason and Cate find the work challenging at times, they are prepared to stay with it because they value themselves and value being able to contribute. It seems there is satisfaction that comes from the complexities of the work.

**Empathy**
In the previous chapter empathy was addressed within the responsibility of maintaining a safe environment. Discussions there focused on the artist showing empathy for the HCP when the scenario emotionally affects them. Here however, I also propose that empathy is a personal requirement of the artist as it links to the notion of the critically aware self. In this phase of the research participants again showed care and concern for the HCPs when emotions were affected but they also commented on feeling empathy for the characters they play as they imagine the experiences of another person and respond on their behalf. There were also remarks demonstrating empathy for the healthcare providers and the responsibilities they have in their day-to-day work life.
They (the HCPs) are putting on a face to deal with us, they are going into a scenario just as I am, it’s just that they have got to use this in real life and we don’t.

I know I am and that the others are too, very conscious that you don’t want to them to feel vulnerable or feel like they’ve failed in front of their colleagues, so you are very, very conscious of that. It’s a hugely vulnerable positions that they place themselves in.

Jason suggests that whilst this process can sometimes be harrowing as a simulated patient, it is minimal compared to the experiences HCPs have in their daily working lives and there is an appreciation and understanding of that. I also comment on the fact that the HCPs are putting themselves in a vulnerable position in front of their peers.

Professional integrity

The participants appear to take their work as SPs very seriously and each expressed a desire to do good work. It appears important to them both personally and professionally. It also appears that doing good work goes beyond self-interest and artistic endeavours, what is important to the participants is that they are able to help the HCPs to be better at their jobs so they in turn can help their patients. Pascucci et al. (2014) suggest that while advanced acting techniques are considered important to the work, particularly as the training is focused on interpersonal interaction, communication skills and emotional content the “desire to do work that has a purpose beyond creating art” is also considered essential (p, 122). Jason’s comments in the semi-structured interview support this.

Jason:  I want to do a great job.

Q:  Why?

Jason:  Because it’s what I pride and value in myself and I want others to see that I’ve worked hard and that I’m doing a good job.

Q:  I get the sense ...that it’s very important for you to do good work for the participants as well?

Jason:  Yeah, in a way that helps them learn, because I think that whatever they take from this, it’s going to change, affect people and if they get the maximum that I can give it’s going to change their work and it’s going to have huge, positive ramifications.

Jason talks about doing a “good job” for the benefit of others, in this case the healthcare providers he is working with. It appears that what Jason is suggesting here is that his efforts
and his “good work” can make a difference for the HCPs and their learning and then further to what that might mean for their patients. However, Jason also talks about his personal pride in doing a “good job” and that it is important to him that this is recognised by others. It seems important to him that he feels he is of value. He talks about giving the “maximum” of himself to create change, which he sees as having an impact beyond himself and the immediate work. These sentiments are echoed in my own comments.

Jess: Reputation is a big one. Definitely because I pride myself on doing really good work (gets a little teary), makes me really emotional actually (laughter through the tears), that is so weird. But yeah! It’s about doing good work.

Q: But again, you pride yourself on doing good work because...?

Jess: Because I value it, because I think it’s so important, because I see those doctors put themselves on the line and I want to make sure that I’m the best that I can be for them, because if they are better at what they do; then that transfers to their future patients.

There appears to be a very personal connection to the work revealed here by my emotional response. Like Jason I suggest that doing this work is important to me and that my conduct and professional integrity helps to make a difference to the HCPs learning and beyond. Each of the participants comment on their desire to do good work and suggest that it’s about working to “the BEST of my ability”, being “the best that I can” and giving “as much as I can give” for the benefit of the HCPs and ultimately for their patients. It seems that recognition of their work and being valued by the program organisers is important to the participants and there is great satisfaction in contributing to educational programs of social value (Boerjan et al., 2008; Bokken et al., 2006; McNaughton et al., 1999).

The above discussions around the personal requirements of the artist as simulated patient offer further understanding of the critically aware self. I suggest that the artist’s professional integrity, who they are as individuals, their resilience in working with difficult situations and their empathy for others allows for critical self-reflexive analysis. The critically aware self therefore filters the voices of the inner dialogue to moralise the artists practice (Preston, 2016) and thus create an effective and affective simulated patient.

Conclusion
This phase of the research has extended on the previous chapter and offered new insights. I have argued that by listening to and responding to four different voices and then filtering this inner dialogue through a critically aware self, the artist is able to manage the
responsibilities, challenges and tensions of being a simulated patient. In doing this they are able to create various versions of the truth to cater for the specific needs of the individual healthcare provider. This then leads to good work, which results in improving the HCPs skills so they in turn can provide better health care for their patients. In the following chapter I offer a revised version of the model at the end of Chapter Four to further explain these findings.
Chapter 6: Research Findings and Conclusions

In this final chapter a summary of this study's research findings is offered in the form of a model. This model, which is a revised version of the one offered at the conclusion to Chapter Four is explained and explored. In addition, suggestions about the possible applications of the findings of the study are offered, together with its implications and some recommendations for further research in this field. A conclusion finalises both the chapter and the thesis.

This research study aimed to understand the work of the artist as simulated patient in Open Disclosure scenarios from the artist's perspective, and to extend upon the relatively limited existing research addressing the artist's voice in this practice. In this study, three professional artists shared their experiences as simulated patients. Narrative enquiry and autoethnography approaches were used to privilege the artist voice, with their stories being supported by existing literature to provide a practical and theoretical understanding of simulated patient practice. The study was guided by following three research questions:

1. What are the responsibilities of the applied theatre artist in simulated Open Disclosure scenarios?
2. What are the challenges and tensions faced by applied theatre artists in high stakes simulated Open Disclosure scenarios?
3. How does the applied theatre artist as simulated patient integrate and reconcile their various and often competing responsibilities to produce high quality learning outcomes for healthcare providers?

Summary of findings

In responding to research questions one and two and as evidenced in Chapters Four and Five, three main responsibilities for the artist working as simulated patient in the Open Disclosure scenario were identified. These were: acting, facilitating and maintaining a safe environment. It was found then that each of these responsibilities had their own practice requirements. A range of challenges and tensions related to these were also revealed. Table 2 offers a summary of these responsibilities and practice requirements, together with the challenges and tensions identified and discussed in the previous two chapters.
### Table 2

**Artist's Responsibilities, Practice Requirements, Challenges and Tensions**

<table>
<thead>
<tr>
<th>RESPONSIBILITY</th>
<th>PRACTICE REQUIREMENTS</th>
<th>CHALLENGES AND TENSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTING</strong></td>
<td>Authenticity&lt;br&gt;• Character creation &amp; development&lt;br&gt;• Finding and maintaining truth&lt;br&gt;Building and conserving the illusion&lt;br&gt;• Finding the hooks&lt;br&gt;Spontaneity &amp; Improvisation&lt;br&gt;Awareness of HCP’s interaction</td>
<td>Facilitator direction&lt;br&gt;Engaging the participants (HCPs)&lt;br&gt;Keeping it fresh: Exhaustion; Repetition; Stopping and starting; time</td>
</tr>
<tr>
<td><strong>FACILITATING</strong></td>
<td>Intentionality&lt;br&gt;• Working as Actor / Educator&lt;br&gt;Giving Feedback&lt;br&gt;Offering Clues&lt;br&gt;Awareness of HCP’s educational needs</td>
<td>Facilitator direction; in &amp; out of role&lt;br&gt;Clues not pick up by HCP&lt;br&gt;Appropriately challenging the HCPs</td>
</tr>
<tr>
<td><strong>MAINTAINING A SAFE ENVIRONMENT</strong></td>
<td>Safe practice&lt;br&gt;• Safe/sacred space&lt;br&gt;Artist safety: Distancing&lt;br&gt;Awareness of HCP’s safety</td>
<td>Intensity of scenarios&lt;br&gt;Actor Status&lt;br&gt;Drawn from personal experience&lt;br&gt;Safely challenging the HCPs&lt;br&gt;• HCP’s vulnerability</td>
</tr>
</tbody>
</table>

In addition, and as the first step toward responding to research question three, it was suggested in the previous two chapters that the artist has four internal voices in their head and that these are associated with the three responsibilities. These voices were identified as: the actor’s voice (acting); the character’s voice (acting); the facilitator’s voice (facilitating); and the ethicist’s voice (maintaining a safe environment). These voices were found to combine to create in an inner dialogue, which assists the artist in managing the complexities of the work. Further to this, it was reasoned that the artist’s critically aware self is linked to these dialogues – a notion which suggests that the applied theatre artist brings much of himself or herself to the simulated patient role. This critically aware self is created through a combination of each artist’s professional integrity, individuality, resilience and empathy. It was therefore proposed that the artist’s critically aware self listens to the inner dialogue created by the four voices and filters their responses and reactions through the critically aware self to make decisions for the simulated patient. These decisions guide the artist’s responses in the moment. It was also argued that each healthcare provider requires a unique interaction that is suited to their individual needs and as such the artist draws upon the dialogue between the voices filtered through the self to make adjustments to the work of the simulated patient in to the moment-to-moment action.
Finally, it was also determined that for the participants in this research study it was important to do good work. Each participant expressed that they valued their work as a simulated patient, particularly being able to contribute to the education of healthcare providers who are then more able to help their patients.

On the following page is a model is offered (Figure 3) which attempts to capture the complexity of these ideas and to represent the work of the applied theatre artist as simulated patient in simulated Open Disclosure scenarios. The model includes the responsibilities, practice requirements, challenges and tensions of the artist and reveals how by listening to an inner dialogue and filtering this conversation through their critically aware self, the artist is able to respond appropriately as the simulated patient and thereby do good work. This process is discussed in more detail in the following pages.
Figure 3. The Applied Theatre Artist as Simulated Patient
The Applied Theatre Artist as Simulated Patient model (Figure 3) suggests that the work of the simulated patient begins with the applied theatre artist, the person who will take on the role of the simulated patient. It presents the notion that the artist has three responsibilities, with each of these having their own practice requirements. These multiple responsibilities create tensions and challenges for the artist, creating as series of voices that must be attended to and then filtered through the critically aware self so that the artist as simulated patient can produce good work.

To capture this complexity, the three circles of responsibility are held within a larger circle, indicating that the responsibilities work together mutually. Also sitting within the larger circle and alongside the responsibilities are the words “challenges” and “tensions”, these signify the range of challenges and tensions that might impact the artist’s ability to meet their responsibilities.

The three responsibilities, acting, facilitating and maintaining a safe environment that the artist must take on are represented by three circles of equal size, denoting that they are of equal value and importance. Within each of the three circles are the practice requirements associated with each responsibility. The three circles overlap indicating that the responsibilities and practice requirements share commonalities. For example, the actor’s safety with distancing is a requirement of maintaining a safe environment yet it is the actor’s skill that allow this to happen; spontaneity and improvisation are the responsibility of acting, however being able to practice this allows the artist to give clues to assist in facilitation of educations outcomes. Also, across the three responsibilities there is a shared requirement of awareness of the HCP, although within each responsibility a different awareness is needed.

The arrows emanating from the three circles of responsibility into the critically aware self indicate the various voices that contribute to the artist’s inner dialogue. The acting responsibility generates two voices, the voice of the actor and the voice of the character, the responsibility of facilitating produces the voice of the facilitator, and from maintaining a safe environment comes the voice of the ethicist. The artist listens to these various voices as each one responds to what is happening in the interaction. Allowing these voices to speak means the artist is able to consider a range of perspectives in the moment-to-moment action. Importantly then, the artist’s critically aware self, filters this inner dialogue to create informed responses as the simulated patient.

As each artist is unique, so too are their professional integrity, individuality, resilience and empathy. By acknowledging and listening to the dialogue between the voices, the artist weighs up the contributions, suggestions, emotions and feelings from each of them and
filters these. Filtering the dialogue allows the artist to make a decision on how to respond as the simulated patient and as such, how best to meet the various needs of the individual HCP. Thus, the simulated patient is the embodiment of the various voices and the artist’s critically aware self.

The inner dialogue continues throughout the interaction with the HCP and allows the artist to make adjustments to the simulated patient’s responses; managing the responsibilities, practice requirements, challenges and tensions to create version of the truth in the moment-to-moment action. These versions of the truth are created to provide an engaging interaction that is both challenging and safe for the individual HCP to meet educational outcomes that are meaningful for them and their future patients. Being able to do this leads to the artist feeling they have done good work both personally and professionally.

Applications and Implications
The findings in this research are the result of engaging with artists who work as simulated patients. Exploring the participants’ experiences to understand the work from their perspective offers what is to date a relatively untouched area of study. A large percentage of medical training in the western world relies on the use of simulated patients. It is hoped that this research and in particular the model developed as an outcome of it, provides medical educators and artists with an understanding of the complexities of the artist’s responsibilities in simulation training. Importantly it is hoped this study will be used to support the training of applied theatre artists or as a reflective tool to help them as individuals to help them to come to a better understanding of their work and thus improve their practice. Whilst this study has focused on the work of the artist in the particular context of simulated Open Disclosure scenarios, it is expected that the findings of the research can be applied to other areas of medical training where simulated patients are used. The model may also be useful for medical faculty members involved in simulation patient training to understand the way the artist works to maximise their involvement in the training process.

Recommendations for further research
Further research from the perspective of the artist is recommended; particularly around the concept of the inner dialogue and the role the critically aware self plays in this. A study in which several professional artists working as simulated patients are observed and video recorded would be useful, particularly if these artists were then invited to reflect upon their decision-making processes in response to these videos. These artist’s reflections could then be considered in relation to the model, with improvements being created through this
process. By viewing themselves on the video and then offering comments on their work as a simulated patient greater depth could be added to the discussion, expanding upon the value of this model and further enhancing appreciation of the complexities of this work. In doing this, it would be hoped that the artist could recognise what they are doing in the moment-to-moment action and identify particular points of action, potentially making their implicit actions explicit. Importantly this would give voice to the artists' experiences, capturing their tacit knowledge. It would also be worthwhile to see how the model, proposed in the research findings, might relate to other simulated patient contexts other than Open Disclosure scenarios.

**Conclusion**

I came to this study because I value my work as a simulated patient. I hoped to understand more clearly what it is that I do as an artist in this context and then share my knowledge. However, I was also interested to see if my experiences were unique or in any way similar to those of my colleagues and I wondered what more I could learn from dialogues with colleagues. I have enjoyed delving into the range of experiences offered in my participant’s narratives and being able to find common ground. Doing this has helped me understand my own practice and given depth and credence to my findings. I hope that this research offers some fresh perspectives of the work of the applied theatre artist as simulated patient in Open Disclosure scenarios and helps others to further develop their practice in simulated patient training.
References


Appendix A: Information Sheet for Participants

THE WORK OF THE ACTOR AS SIMULATED PATIENT
IN OPEN DISCLOSURE SCENARIOS
GU ref no: 2018/081
INFORMATION SHEET FOR PARTICIPANTS

Research Team  Professor Julie Dunn;
Professor Michael Balfour;
Jessica Veurman-Betts (HDR Student).
Griffith Institute for Educational Research
Contact Phone: 07 3735 5720
Contact Email: j.dunn@griffith.edu.au

Why is this research being conducted?
Jessica Veurman-Betts is completing a Masters of Educational and Professional Studies Research. The purpose of her research is to examine the experiences of actors in simulated patient scenarios to provide better knowledge and understanding of the competing demands on the actors work including those relating to facilitation, performance and authenticity. In particular it aims to identify the unique tensions that exist for the actor as they make moment-by-moment decisions during the simulated patient scenario. By exploring actors’ experiences in this creative learning environment, it is the intent of this research to realise how actors might contribute more effectively in the education of healthcare providers.

The purpose of this letter
The purpose of this letter is to provide information about the research and request your participation in the research. You have been asked to participate in this research because of your experience as professional actor and your continued work as an actor in simulated patient scenarios.

Participation in the research
This study is focused on the collection of participants’ personal stories around their experiences as actors in simulated patient scenarios. Data will be collected through storytelling and interview processes. The data collected will not be intrusive of personal details, but rather focused on the professional activities of the actor and their engagement within patient simulated scenarios. There will be a total of three participants in this research including the researcher, Jessica Veurman-Betts.

In the first instance, each participant (actor) will be asked to identify and share three stories of past experiences as actors in simulated patient scenarios. This initial storytelling session may be audio recorded or the participants may offer written stories to share. The researchers role in this phase will be to support and prompt memories. A thematic analysis of these stories will then occur in order to generate a series of questions to be addressed within individual, in-depth semi-structured interviews and a focus group session. The semi-structured interviews will be approximately one hour in duration and involve the researcher and one other participant at a time. The focus group session will also be approximately one hour in duration and will involve all three participants sharing their stories and experiences together. The researcher, who will also participate in the discussions as a fellow practitioner, will guide this focus group session. The actual healthcare providers involved in the scenario sessions will not be participants in the interviews. Participants will be asked to avoid referring to individual healthcare providers by name.

All face-to-face data collection sessions will occur at a location determined by each participant.
Your confidentiality
Once transcribed, all material will be returned to the participants for member checking. These materials may be used in academic publications (in print and online) and/or at academic conferences. While all efforts will be made to de-identify the data and protect participant anonymity, third parties known to the participants may still infer the identity of participants. It is requested that participants in the focus group respect the privacy and confidentiality of other participants.

All audio recordings will be erased after transcription. However, other research data (interview transcripts, written stories, and analysis) will be retained in a password protected electronic file at Griffith University for a period of five years before being destroyed.

What are the costs involved?
Involvement in the research project is free of charge.

Potential Risks
There are no foreseeable risks associated with participation in the study.

Participation is voluntary
It is for you to decide whether or not you would like to participate in the research. If you decide that you would like to be involved you will be asked for your written consent. If you decide to participate, you are still free to withdraw at any time and without giving a reason.

Questions / further information
For further information please contact Professor Julie Dunn or any other member of the research team.

The ethical conduct of this research
Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. If potential participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on 3735 4375 or research-ethics@griffith.edu.au.

Feedback to you
As suggested, once transcribed, all material will be returned to the participants for member checking. The research project will generate a thesis containing data and research findings. Participants may also request, via phone or email, a summary of results during any phase of the research. Please contact the research team if you would like a copy of the thesis at the conclusion of the project.

Privacy Statement - Disclosure
The conduct of this research involves the collection, access and/or use of your experiences and stories as an actor working as a simulated patient. This is occurring with your consent. Any additional personal information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded, except where you have consented otherwise. For further information consult the University's Privacy Plan at http://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone (07) 3735 4375
ACTORS’ EXPERIENCES IN SIMULATED PATIENT SCENARIOS

CONSENT FORM
GU ref no: 2018/081

Research Team
Associate Professor Julie Dunn;
Professor Michael Balfour;
Jessica Veurman-Betts (HDR Student)
Griffith Institute for Educational Research
Contact Phone: 07 3735 5720
Contact Email: j.dunn@griffith.edu.au

• I agree to participate in the project;
• I have had any questions answered to my satisfaction;
• I understand the risks involved;
• I understand that there will be no direct benefit from participation in this research;
• I understand that participation in this research is voluntary;
• I understand that if I have any additional questions I can contact the research team;
• I understand that I am free to withdraw at any time, without explanation or penalty;
• I agree to the research team collecting specific data as identified below.
• I understand that if I have any concerns about the ethical conduct of the project, I can contact the Manager, Research Ethics, Griffith University Human Research Ethics Committee on 3735 4375 (or research-ethics@griffith.edu.au).

Specific Data Requested – Please tick those you agree to participate in:

☐ Participation in storytelling of past experiences or memories involving simulated patient scenarios (approx. 3 stories). These may be either audio recorded or the participant may offer written stories to share.

☐ Participation in a semi-structured audio-recorded interview of approximately 45-60mins duration to be completed immediately following a simulated patient scenario.

☐ Participation in a focus group interview of approximately 60 mins duration.

<table>
<thead>
<tr>
<th>Participant's Name</th>
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<tbody>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
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</table>
Appendix B: Questions for semi-structured interview

General Questions for each participant
Q1: What was the scenario/scenarios you worked with today?
Q2: How did you prepare?
Q3: How did you feel before you started today?
Q4: How are you feeling now?

Specific Questions relating to the sessions
Q1: Identify a significant moment from today try to be as specific as possible.
Q2: Why was this significant to you? Repeat this 3-5
Q3: What did you learn today? Prompt from list below (only if required).
   • About your practice, self, skills, acting, facilitating, character.
Q4: Will you do anything differently next time?

Jason Questions
1. Story 1. Do you think that your actor training has set you up for this kind of work? Why is it important to you to do good work?
2. Story 2. Essentially this is a story about performance anxiety, one of things that you talked about here in this story was safety and protection of your self, and your emotional state and fatigue can you tell me more about this?
3. Story 3. In your third story you talk about how the second day had it’s challenges because the HCPs had learnt skills from the previous day and these revelations were coming to you mostly in the moment and you were asking yourself, “ok they’ve got this so now do I have to be more challenging?” You talked about the challenges of making acting/artistic choices in the moment that are truthful for the character but also help to serve the educational outcomes. Can you tell me more about these?

Cate Questions
Essentially your stories were about doing “good work” and you discussed:
1. Story 1. Challenges to performance blocks (scared, held, nervous). Blocks to creating and maintaining authenticity. Would you say that this notion of authenticity and truth is central to the work – what is the most important job for you in the room?
2. Story 2. Care for the doctors and ethical issues around safety. How far do you challenge them before it becomes an ethical issue – can someone learn if you are not challenged?
3. Story 3. Safety for the actor. How do you deal with situations/scenarios that affect you at a personal/professional level?

Jess Questions
In the stories you shared you talked about
1. Story 1. Is essentially about performance anxiety and the need to do “good work”. The story is from 7 years ago, is this still an issue for you?
2. Story 2. You suggest the story is about self-discovery both personal and professional, can you talk more about this?
3. Story 3. Tells of the challenges of working on highly charged scenarios based on real incidents and care and safety for the doctors and the actor. Can you talk about this, how far can you challenge the doctors, can you learn if you are not challenged?
Appendix C: Sample of a memory story and thematic analysis (Cate)

Cate. Story 2: I felt my heart drop
Cate’s second story is about the safety and ethical issues for the healthcare provider and actor when the scenario hits too close to home.

For my second story, I am reminded that the work I do is very powerful. In one session I was playing the character of a woman whose 14-year-old daughter has meningitis. The diagnosis had been missed in the emergency department the night before and now my daughter is in ICU fighting for her life. It’s a really intense scenario so it deserves the truth, and I give them the truth. I was with a doctor and as we were working I was watching them change and I couldn’t understand what I was seeing. I’m thinking, “Am I affecting you that much?” and because I don’t have lines to remember, I’m going in my head, “Oh are you ok?” I started to question what was going on. I could see that they were clearly uncomfortable and I’ve seen uncomfortable but this was just different and I was thinking “Ohhh!” but the little comments in my head were saying things like “Are you OK?”, “Oh! we must be doing really good work”, “I’m really seeing you being affected”, “Where is this going?” Anyway, I thought, “Oh well I’ll just keep going maybe this is just a really intense scene”. I remember that the scenario just seemed to ramp up because of what the doctor was giving me… their response informs what comes out of my mouth. So, I was getting to a very intense emotional place and the next thing they stopped and said, “I can’t do this, I’m so sorry, I can’t do this” and I just felt my heart drop. Obviously, what I had been seeing was a pre-cursor to them losing it. When that happens, it’s a real shock, I didn’t know what to do because the doctor was in pain and I took them to that place - I was one of the people that helped take them to that place again. Sometime later the doctor was encouraged to talk about their story. We were all really emotional, but we had to keep working and...I was thinking, “I don’t want to, I really don’t want to”. But I did. I had never seen anyone break down quite like that before, for some reason with this one, I felt guilty...I’m not sure why. I remember wanting to go up to the doctor and talk about it but not feeling like I actually could. They didn’t make any contact with me, so I gave them space out of respect. This incident really impacted me I think - it probably did change me as it made me take the work even more seriously. I was reminded that the participants are real, and they live these stories every day and they have to go home at the end of the day to their families and somehow let it go and they talk about that in the room it is really powerful.
**Cate Story 2: Analysis.**

**Emerging Themes as they appeared in the text.**
- Intensity of the scenario (high stakes, difficulty of task)
- Scenario requires truth – highly emotional
- Facilitator direction to help control the intensity of a scenario
- Responding in the moment informed by the participant
- Realisation of what happened – what I had been seeing but missing the signals
- Uncertainty of what to do – what should I do
- Sense of responsibility – doctor was in pain and I was on of the people who took them to that place
- The group was affected by it – all emotional
- Professionalism - Not wanting to continue but I did.
- Respect to give personal space
- Respect for the work they do dealing with these stories for real
- Powerful nature of the work – reminded me to be more serious and more careful

**Emerging themes categorized.**

<table>
<thead>
<tr>
<th>Acting</th>
<th>Responding in the moment</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Informed by the participant – ramped up</td>
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<table>
<thead>
<tr>
<th>Facilitating</th>
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<tr>
<td>Safety</td>
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<tr>
<td>Intensity of scenarios</td>
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<td>• Requires truth</td>
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<td>• Highly emotional</td>
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<tr>
<td>Sense of responsibility</td>
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<tr>
<td>• Realisation of what happened – what I had been seeing, but missing the signals</td>
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<tr>
<td>• Uncertainty of what to do – what should I do</td>
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<td>• Doctor was in pain and I was on of the people who took them to that place</td>
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<tr>
<td>Safety</td>
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<td>• The group was affected by it – all emotional</td>
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<tr>
<td>Powerful nature of the work</td>
</tr>
<tr>
<td>• Reminding me to be more serious and more careful</td>
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</tbody>
</table>

| Self        |
| Personal affected |
| • Self affected – I felt my heart drop |
| • Shock |
| • Sense of guilt |
| Professionalism |
| • Not wanting to continue but I did. |

| Other       |
| Multiple heads |
| • Working in character but simultaneously watching from an outside perspective as self – questioning what’s going on? |
| • Comments in my head. Self/actor and facilitator |
| Respect     |
| • To give personal space |
| • For the work they do, dealing with these stories for real |
| Facilitator direction/control – |
| • Offers direction for intensity to be played |
### Super-ordinate theme

#### The Desire to Do Good Work

<table>
<thead>
<tr>
<th>Why is it important for you to do Good Work?</th>
<th>Good work is about both personal and professional satisfaction. Importance of the HCP’s learning communication skills has wider social implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I think it’s about seeking validation that I’m good at what I do and partly it’s the self-doubt not knowing if I am. I get the sense in memory story 1 that it’s very important for you to do good work for the participants as well? • Yeah, yeah and in a way that helps them learn… Because I think that whatever they take from this it’s going to change, affect people and if they get the maximum that I can give then even thought they’re doing great already as much as I can give it’s going to change their work and it’s going to have huge, positive ramifications. (p.10)</td>
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</table>

#### Performance Anxiety

| What makes you anxious? - Because I want to do a great job. (p.2) |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| • I always feel anxious (laughter), but it’s also the unknown for me - what are the expectations and whether I’ve prepared enough, am I ready for it? (p.2) |
| • Self Doubt - Also I have a problem with self-doubt which I’m working on (p.2) |
| • It’s just the fear of the unknown and I’ve got the skills to don’t it otherwise people wouldn’t ask me. (p.15) |
| • I think I’m on this journey at the moment to discover that I’m enough… I’m slowly going “you’ve got it you don’t have to be so terrified - on the inside” … I just register that I’m feeling anxious and I’ve been giving that too much power (p.6) |

#### Professionalism

| Advice to actor’s going into this work - Hear what’s being said and make a choice and it’s not a wrong choice it’s just a choice and you’ll either go, “well that worked or that didn’t” but you can’t know unless you try. (p.10) |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| • I think that’s knowing when you’ve done enough work and when you haven’t, just getting by on your talent. (p.11) |
| • Have you done enough homework and legitimately done the work that you’re being paid to do? (p.11) |

#### Personal pride / professional pride/reputation

| Because it’s what I pride and value in myself and I want others to see that I’ve worked hard and that I’m doing a good job. (p.2) |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| • As an actor you challenge yourself, you are not just giving up because it’s really hard. (p.4) |
| • Yeah and that’s the thing I want to do a great job! Because I feel, I know other people's experiences are hinged on my ability to make it a memorable experience. (p.15) |

### Super-ordinate theme

#### Acting within the form of simulated Open Disclosure scenarios

| AUTHENTICITY |
| Character creation and development |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| • I don’t know that I approach this work the same way that I approach a play. Here the circumstances are all given to you so you don’t to look for them and mine for them in the same way, but I feel like the imagery is something that I have to find. (p.4) |
| • People were like “oh you definitely are like a grieving father, we've seen it”. I guess that reassuring in some sense to know that. I felt like I learnt that it’s not about creating this other person - you are the character. (p.8) |
| • I’m altering (the character) all the time… I don’t know. it’s interesting. |

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105
I'm still fining my way. (p. 8)

**Personal connection to character - empathy**

- Jason's Character name is Darren, his son has passed away, his son's name is Jason - it makes it familiar in a way. It often helps, actually because when they say Jason, I do kinda think of myself. (p. 1)
- Anger and rage I think is something that I naturally don't have, or I shy away from, or at least I deny that part of myself. So I really worked on trying to let myself be angry. (p. 1)
- I imagine things that are personal like my nieces and nephews and if something happened to them. (p. 1)
- It's weird though because I'd planned to focus on my nephew, but in the moment my nieces came up a lot. (p. 1)
- The breakthrough for me though was that I found that I do have the anger and it's fine and it's ok to play with that. It was good to find those things that I could latch on to that would help me. (p. 2)
- One of the participants came out of the room while I was in the corridor preparing saying "I can't do this" – and I thought, Oh that's exactly how I feel I can't do this anymore – I can't even cope right now, then that became my mantra. (p. 2)
- I was seeing all my nieces and nephews running around. With things like that you don't even have to push or try it's just there. (p. 4)
- I think I just learnt about how much of [Darren] is myself. When I recreate something I put the name of [Darren] over me, so much of it is me. (p. 7)
- I remember someone saying to me " you're body doesn't actually know the difference between when your acting and when you're going through genuine pain, the response to it is the same. (p.7-8)

**Improvisation**

- I think last time I memorised it and I monologue it whereas this time I was like I know it and if things come up I'll use them rather than it having to be all set. (p. 9)

**Spontaneity – responding truthfully in the moment.**

- One of the doctors used a trigger word – when they say the wrong thing and what that does to the character instantly – what I mean is that they (the doctors) say something that could potentially send the scene in a negative direction. This one doctor said the word “body” in reference to Zac something like “the body is now with”…. and I was like “ooooohhh I gotta get outta here”. (p. 3)
- Because it was about that responding in the moment and allowing negative comments from the participants help me to find the anger. (p. 3)
- Just seeing them, they gave me a hug, they were like mother figures and that then is what opened the door to more. (p. 4)
- Because it's about what you get in the moment, what happens in those first 10 seconds when you walk in the room and you see them and they go – so sorry or what ever. (p. 5)
- Then I just went oh! no! and just had a melt down as myself and then transferred that to the character (laughter) and then in that time I gave myself time to go “where am I?” I obviously kept in character, but I went I've got nothing and so I'm going to ride with that panic of having nothing and then it came to me. (p. 13)
- Yeah it happens it a split second though. I make a decision to do something and just see where that takes me. It's like that decision of just getting up and just walking and they say "are ok what's going on?" and I say, "no I'm ok just need to get away from you" and then that brings something new to the scene. Today one of things they said to me really frustrated me so I just said "oh I really need to go now, I need to find my wife now, I need to go", so I walked outside and then they came out and said "Simon, come back inside lets talk this out we'll figure it out (p. 14)
**Building and Conserving the illusion**

- What was interesting was that one of the participants said they were afraid of being in front of her colleagues but as soon as it started she forgot that they were there. I said that’s exactly what happens when you’re an actor, all that blurs out and you just here, right here and that just means that you are really, really present, that you were focused on what you were doing and that’s great. (p. 12)

**Participant Engagement**

- So it’s a little easier with the smaller groups… I noticed that we were in bigger groups last time, people felt more comfortable to be shifting and moving and you started to like clock things like that in the room. Whereas today everyone in the room was just on! (p. 12)

**Facilitator Direction**

- He really wanted me to push it hard because a lot of people in this group were high-level practitioners so he wanted me to go harder than I normally would. (p. 1)
- So I wanted to go to places that he wanted me to but also to stay true in the moment. (p. 2)
- Also if they are really struggling the facilitator might just say “time out” and ask the doctor, would you say that differently now, seeing the response that you just got and then he throws you back into the scenario a couple of moments before and they just redirect. (p. 7)
- Often he would come out he would discuss with me what he was wanting and I would say “yeah I can see what you want there I’ll try and do something” and then he would give me a minute just to disconnect form that conversation and get back in the zone. That didn’t happened the last time I did it. (p. 11)
- I feel that today everyone was a much clearer page about what we were doing and where we were at ... It’s much easier and more pleasant to go “ok we are going to go in in a minute are you ready do you need more time?” That's really quite helpful. (p. 12)
- You talked about the challenges of making acting/artistic choices in the moment that are truthful for the character but also help to serve the educational outcomes. (p. 13) to give me permission to go to that place rather than feel like it’s an unnatural place to go. If the facilitator was to say “ok we are going to try something here, I want you to go really off rails I want you to unleash a bit. (p. 13)

**Time**

- In your third story you talk about how the second day had it’s challenges because the participants had learnt skills from the previous day. (p. 13)

**Starting the scene**

- I’ve had little thorns - things that they might say that really gets me and I’ll bring up stuff like I brought up the vaccination to try and see if it opened up anything, so I’ve had little thorns but from the start I haven’t had an agenda so sometimes there are really clear cut agendas and I wonder if I could play with that and mantras a little bit more. (p. 8)
- I feel more confident when they are different, when I know they are different make me feel really confident. (p. 9)

**Exhaustion**

- As the day went on and I got more and more exhausted (p.3)
- When asked how he felt at the end of the day – Exhausted...I do feel relieved and less stressed about making sure I’ve got everything for tomorrows session (p. 2)
- In the last session I was feeling really drained. (p. 5)
- So we walk away exhausted at the end of the day (p. 8)
Keeping it Fresh
• I relied more and more on things that happened in the moment to keep me fresh. (p. 3)

Repetition
• It was just about finding that initial switch... It was a cool moment because I’m waiting outside the room and thinking ok I’ve done this array of approaches and I want to try something else. (p. 3)
• As an actor you feel you don’t want to keep dipping into the same reservoir. So you try to find new ways to explore what it is that your doing and keep it fresh. (p. 4)
• You’ve got the same people you worked with now watching so I didn’t want to repeat the exact same scenario. (p. 5)

Super-ordinate theme
Focus on Education and Learning

Actor as Educator
• The realisation for all of us, participants and myself, to be okay with stillness and quiet... there are moments where you can all just sit there and feel the crap and the pain and that is totally fine. (p. 4)
• We’d say we saw that you used stillness really well and that’s something we have been talking about a lot today. So the next group would really grab on to that, they were really keen to listen and try things out. (p. 5)
• I can really see when people are not giving themselves a chance and saying “I can’t do it”, instead of just saying, “I’m struggling but that’s ok and I will get though it”. (p. 7)
• I just feel like there’s a mutual teaching. (p. 7)
• Today I understood the process more and that this is about training and this is the first meeting immediately after the event so it’s is more about seeing if they are empathetic and whether they actually care, not trying to like tick their boxes just trying to be there and it takes time. (p. 9)
• I also think that there’s the actor but I think there’s a part of me that wants to see people grow. My mum is a counselor and there’s an element of me that wants to help others, strongly. So when I see someone who might have got it sort of, I think I can give them keys that can help them take it even further. (p.10)

Giving Clues/Cues
• I’ll sometimes drop clues. Like I’ll say a line over and over again or I’ll say something to send them in a different direction to get them off their stuck thought. (p. 7)

Challenging the individual HCP
• Then they said something and I just went cold, I just latched on to that then - it felt like it was flavor and the right thing at that moment to test them. (p. 5)
• Because they were doing really well, I just threw in this curve ball that put me outside of my comfort zone but also challenged them. I was aware of doing that too. (p. 5)
• There is definitely an element of knowing when to push it up and knowing when to bring in in. Just sensing it. (p. 7)

Super-ordinate theme
Safe work practice

Ethical Considerations – intensity of scenarios
• I think for the participants, it’s something I’m really aware of and that’s one of the reasons I didn’t want to go far into anger. These people are volunteering their time to come and learn and if they get so terrified in a
<table>
<thead>
<tr>
<th>Training session they might not want to come back. They need little wins to get to that point when then you can go “ok lets just try it with some curve balls”, so they have this thing were they can deal with stuff so then the facilitator can say “ok let’s take it to the next level and it’s not a judgment on their ability it just about going “well you guys have got that lets see what else you can take”. So I’m very aware when I can see someone who is on the edge or vulnerable.</th>
<th>Awareness of the individual’s emotional needs.</th>
</tr>
</thead>
</table>
| **Care, Concern and Empathy for HCPs**  
- They (the doctors) are putting on a face to deal with us, they are going into a scenario just as I am, it’s just that they have got to use this in real life and we don’t. (p. 7)  
- I don’t want to crush them (p. 7)  
- The very first participant I had today his voice was quite high and he sounded very clinical but he was saying all the right things, so I was kind because I knew that he was trying. (p. 10)  
- She was shaking. So I was careful at the start because I could see if I did then it would just go blahh!! But seeing that, made me feel humble. (p. 11) | Adapting to suit the individual’s needs. |
| **Respect**  
- I also feel like they put us up on a pedestal, saying, “what you guys do is amazing”, and I keep saying “it’s really amazing for me to see what you guys are doing”. (p. 7) | |
| **Distancing / Self Protection.**  
- It doesn’t mean that you’re a bad person if you show anger. So that was something that was really cool that I was playing with today. (p. 1)  
- Don’t you thing that things like that are gold for the actor. Even though they can take you to a dark place you kinda go that's so awesome, I do. Yeah, yeah! It's such a weird thing that your crying but your going YES!!!! At the same time  
Yeah on the inside your acknowledging it. Yeah! | |
| **Super-ordinate theme**  
**Inner Dialogue: Conversations in the head**  
- If I’m in a super emotional moment I can’t think. So I’ll say in character – “I’m so sorry just give me a minute” and then I just breath and I let myself think and then I’ll talk and I’ll say something and yes the actor brain is there. So I’m thinking ok they’re doing really well here and it’s been pretty cruisey so far, so I think how can I do a small shift in my sensibility and will they respond in an appropriate way? (p. 5-6)  
- Actually one of the things you said was “sometimes someone will say something that hurts the character, it hits a nerve” and then you said “I have the choice about how I react”. So what I meant is if they do bring it up (the guilt around not vaccinating) I can go right after them or I can choose to let them off or I can go “what do you mean?” (p. 14)  
- I never thought about it that I wasn’t present, more that I’d made a choice that wasn’t necessarily led naturally because they were doing well and I wanted to challenge them. (p. 14)  
- I was up against the wall, because I was thinking I need to be angry but I don’t want to hurt their (the doctors) feelings - actual peoples feelings, and I’m like yes but this is the scenario and you are an actor and the character is angry not you. | Making decisions in the moment – listening to an inner dialogue.  
Still very present in the interaction and still able to make conscious decisions affecting the educational outcomes. |
### Appendix E: Themes from semi-structured interviews

This table was presented for discussion in the focus group

<table>
<thead>
<tr>
<th>Desire to do good work?</th>
<th><strong>THEMES - PROFESSIONAL PRACTICE</strong></th>
<th><strong>THEMES – CHALLENGES, TENSIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUPER ORDINATE THEME</strong></td>
<td>Actor as Educator</td>
<td>Actor Status</td>
</tr>
<tr>
<td>Focus on Education and Learning</td>
<td>Giving Clues/Cues</td>
<td>Appropriately challenging the HCPs</td>
</tr>
<tr>
<td></td>
<td>Awareness of participants’ – group and individual needs</td>
<td>Feedback</td>
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<tr>
<td></td>
<td>Feedback</td>
<td></td>
</tr>
<tr>
<td>Creating a Safe Environment</td>
<td>Ethics and professional integrity; Care/concern, empathy for HCP's Distancing/ Self Protection</td>
<td>Intensity of scenarios: Safe/sacred space Respect / vulnerability / responsibility</td>
</tr>
<tr>
<td>Acting Skills and Working with the form of simulated Open Disclosure scenarios</td>
<td>Authenticity</td>
<td>Facilitator direction Time</td>
</tr>
<tr>
<td></td>
<td>• Character creation and development</td>
<td></td>
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<td></td>
<td>• Personal connection – empathy for character</td>
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<tr>
<td></td>
<td>Improvisation: Spontaneity and working in the moment</td>
<td></td>
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<tr>
<td></td>
<td>Building and conserving the illusion</td>
<td></td>
</tr>
<tr>
<td>Inner Dialogue: Conversations in the head</td>
<td>Questioning yourself in the moment to make decisions on ALL of the above to create high quality learning outcomes for the HCP’s</td>
<td>Multiskilling</td>
</tr>
</tbody>
</table>

### Discussion points from the focus group discussion.

- Using a hook to gain entry in a scene or to make it different
- Finding ways to appropriate challenge participants – based on their individual skills and needs
- Giving feedback as character and actor
- Facilitator skills in managing the educational space – signals question
- Awareness of audience v participants
Appendix F: Extract of focus group discussion transcript

Jess: So at the end of the day even though our skill base and why we are employed is because of our acting skills we bring so much more to it than that and we understand that and I don't always know that the facilitator's understand that we feel as much a part of the educational process. Which I think is the heart of what I was trying to get to the other day about the feedback to us, don't just say “that was fabulous”.

Cate: Because yeah we didn’t come here to be fabulous.

Jess: No we came here because we want to make a difference.

Jason: Yeah.

Cate: Yeah.

Jason: Yeah that's why we come here.

Cate: That's right. Which is why it's really important.

Jess: It’s so interesting though that we are actors, you know we go into the room as actors, and I see myself as an actor but actually I’m really...

Cate: ...a teacher, yeah you are teaching with your acting skills.

Jason: To me it's all applied theatre.

Jess: Of course.

Jason: It's applying theatre.

(There was a conversation here about applied theatre in different contexts)

Jess: It’s about taking our skills more seriously, we are not there for applause and... at the end of the day I believe in the work, and both of you have said it, the powerful nature of the work, it’s very powerful.

Jason: And then there are those responses from people like, “this is the sharpest learning curve I’ve had in ten years” was one of the comments. It’s the intensity of the experience that makes it an important learning curve for them as doctors.

Cate: Some one said something similar recently and it's feedback like that that I like.

Jess: Yes exactly.

Jason: Yeah an another bit of feedback was “what you did in that one was exactly what happens first they take all the responsibly on and they try and deal with it and then they break down, you just absolutely nailed it that's what we deal with”.

Jess: Yes that’s good to know, I like that kind of feedback.

Cate: Yeah it good knowing that.

Jess: Because sometimes you wonder, because I wouldn’t respond like that myself, but the character does and I Jess wouldn't do it like that but the character does and I think am I doing this right?

Cate: Yeah.
Jess: One of the things that we talked about the other day was the notion of audience v's participants. And I think we decided as a group that really we don't view the healthcare providers in any way as an audience.

Jason: Yep.
Cate: Yeah.
Jason: Yeah that's right they kinda blurr out.
Jess: Yeah because when I'm in a scene I'm not even aware that they are there, you (Cate) said that you use it as part of your scene.
Cate: Yeah.
Jess: What about you? There was an awareness was of shifting in their seats?
Jason: I had people coming in and out of the room while the scenario was going. Like in and out.
Cate: What! The other Day? Agghhh.
Jason: Like, she was late so she'd come back in.
Cate: Ohhh.
Jason: And someone would have gone to the bathroom so they come back in.
Cate: Really!?
Jason: Oh yeah, so I almost said "jeez it's a busy room in here", or something like that, but I didn't.
Cate: Yeah, yeah.
Jason: Because it wouldn't have helped.
Jess: Because it wouldn't have helped the scene.
Cate: I only use it when I think it will be useful. I suppose sometimes you do comment on, like before when the guy was using the blender here I thought, oh I hope we can hear the recording, but I'm still in the moment
Jason: Yeah, Yeah.
Cate: I'm still in the scene.
Jess: I think in the [organisation] ones we are sitting in semicircle and you are kinda out the front so it' is sort of set up in a theatrical way.
Cate: It is yeah.
Jess: So, I do get a bit more of a sense of them.. I'm not aware of them as an audience but I think for them they almost see themselves as an audience, do you think?
Cate: Yeah, yeah.
Jess: Whereas I think with the [organistion] ones it's a bit less formal than that because some of them, I noticed on the second day particularly, they would actually get up and get to a place where they could see better.
Cate: Yeah, right.
Jess: Because they wanted to watch the interaction but for me in that instance it wasn’t about them being an audience is was about them wanting to watch the interaction like a fly on the wall.

Jason: Yeah, yeah.

Cate: Yeah, yeah.

Jess: Whereas, the other ones they are set up more like an audience, which I think, then probably promotes the applause.

Cate: Yeah generally I think it’s when they are thanking the actor. I’ve never had spontaneous applause, so I must be doing something wrong (laughter).

Jess: No, that’s what happened. It only happened once, but I thought “oh no I’ve done something wrong”, I’ll never forget it. It was defining moment for me and one of the reasons I’m doing this, it made me think oh I’ve done something wrong and it really made me think about my work and what was this about and why was my reaction to that so strong.

Ok quickly time is running out, what advice you would give to someone coming into this work for the first time

Jason: Ahh, I think it would be, when I say do the homework, I mean know your scenario like actually know and that way you can find your hooks, cause I felt like that I didn’t make it clear about it the other day when I said it, make sure that you know there are little details that you can use as hooks and little things that can help you on the day that if you need to find something fresh that it’s there for you. To go into the room and you are trying to help other people become better at what they do and it’s not necessarily about giving a stella performance you know it’s about being present and responding genuinely with what’s given to you and also moderating that based on your understanding of where they are at in their learning so to get a good nights sleep and eat your veges. (Laughter)

Cate: Yeah I think I ride on the back of that I absolutely agree, this is not about the actor this is about your role in helping the participants become better at whatever their specialty is in communication. You are not there to be applauded in your skills, you are there to use your skills in the best way you know how. Listen, be open, hopefully you can have a discussion with your facilitator and how they like to work so you have an overall picture of what might happen in the room if you are new to it because I remember being really unaware of what I was doing many, many years ago, I’ve learnt a lot.
## Appendix G: Final table of themes from semi-structured interviews and focus group

<table>
<thead>
<tr>
<th>Superordinate THEME</th>
<th>Emerging Themes - Responsibilities</th>
<th>Emerging Themes – Challenges and tensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTING</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| Acting within the form of simulated Open Disclosure scenarios | Authenticity  
  • Character creation and development  
  • Personal connection – empathy for character  
  Building and conserving the illusion  
  • Finding the hooks  
  Improvisation: Spontaneity and working in the moment  
  Awareness of participants (HCPs): interaction | Facilitator direction  
  Engaging the participants (HCPs)  
  Keeping it FRESH: Exhaustion; Repetition; Stopping and starting; time |
| **FACILITATING**    |                                    |                                          |
| Understanding the educational context for the healthcare providers | Understanding purpose of the work (intentionality)  
  • Working as Actor / Educator  
  Giving Feedback  
  Offering Clues  
  Awareness of participants: group and individual needs | Giving Feedback in and out of character  
  Clues not pick up by HCP  
  Appropriately challenging the HCPs |
| **WORKING SAFELY**  |                                    |                                          |
| Maintaining a Safe Working Environment | Safety  
  Safe/sacred space  
  Distancing/ Self Protection  
  Awareness of participants  
  • Care/concern for HCP’s  
  • Respect / vulnerability | Intensity of scenarios  
  Actor Status  
  Drawing on personal experience  
  Safely challenging the HCPs  
  • Responsibility |
| The notion of Self – inextricably linked to the SP’s responsibilities | The desire to good work  
  • Wanting to make a difference  
  • Performance satisfaction  
  • Pride/reputation  
  • Performance anxiety  
  • Professional integrity. | |
| Working from and thinking with - Multiple Positions | Inner Dialogue: Conversations in the head | As actor / character/ educator and self – questioning yourself in the moment to make decisions on ALL of the above to create high quality learning outcomes and deal with the challenges, tensions and constraints.  
  • Multi tasking  
  • Self awareness  
  • Versions of the truth. |