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Developing intersubjectivity and teamwork skills through learning circles on clinical placement: A mixed methods study

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ABSTRACT

Aim: To determine the efficacy of learning circles on developing intersubjectivity and teamwork skills and determine barriers to and facilitators of, learning circles as a learning tool.
Background: Teamwork skills are vital for safe, effective nursing care and are dependent on individual team members' shared understandings or intersubjectivity. Work-based learning circles offer a potential pedagogic strategy to promote teamwork.
Methods: In work-based learning circles conducted in 2018, students drew a concept map based on a clinical case and discussed an element of it with the group. Using a convergent parallel mixed methods design, a cross-sectional survey of students using a student clinical experience questionnaire and a qualitative descriptive approach for interviews with clinical facilitators was conducted.
Results: Overall, 128 Bachelor of Nursing students (88.9% response) completed the survey and five facilitators (50%) attended group interviews. Students agreed that core teamwork skills were developed during their placement and clinical facilitators reported (1) student engagement in the learning circle processes; (2) learning much about students' abilities; and (3) developing subtle teaching skills to enhance discussion. Sharing experiences from different wards and clinical experiences was a platform for developing intersubjectivity.
Conclusions: To promote intra-professional teamwork skills, conducting learning circles with students from different disciplines may further enhance intersubjectivity and is an area for further research.

1. Introduction

Interprofessional communication is critical to the delivery of quality, safe healthcare for health services (Foronda et al., 2016) and health professionals (Nursing and Midwifery Board of Australia, 2016). The Australian Registered Nurse Standards for practice include standards that relate to communication and interprofessional collaboration, for example, standards 2.2 and 2.7: 'communicates effectively…' and 'actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care' (NMBA, 2016, p. 4). Standards 4.3 and 5.2 also describe working in partnership to determine factors that affect health and wellbeing and working collaboratively to come to a shared agreement about patient care goals and options. An increasing body of evidence supports a relationship between communication and patient outcomes. For example, a retrospective study in one health service found that 161 critical incidents were associated with communication failures between doctors and nurses and 46% related to a lack of shared understanding (Umberfield et al., 2019). These communication failures caused delays in care, physical harm and dissatisfaction. The ability to develop a shared understanding with others, particularly those with different views, is necessary to avoid negative patient outcomes.

Intersubjectivity is a concept used to describe how people from different backgrounds engage in discussions to develop a shared

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repertoire (Damasceno, 2018) and is central to effective communications amongst individuals engaged in a common enterprise. It has application in healthcare when different disciplines work collaboratively to address individual and group healthcare needs (Billett, 2014). Individuals use communication to promote mutual engagement and create shared meaning (Stahl, 2016). However, intersubjectivity in work settings also extends to how work tasks are undertaken and the dispositions that guide them (e.g. what constitutes safe patient care) (Billett, 2014). In essence, intersubjectivity is required for effective teamworking.

In an integrative review of teamwork training in undergraduate nursing courses, researchers found that constructivist pedagogies were predominantly used to teach, practice and refine teamwork competencies, noting the complexity of assessing nursing teamwork knowledge, skills and attitudes (Barton et al., 2018). In their review, 'teamwork' included communication, collaboration and coordinated actions towards shared goals. Learning to work in a team and be intersubjective, requires interactions with others. In a pilot mixed method study of a constructivist pedagogy - work-based learning circles - researchers found the pedagogy was feasible in a hospital context (Grealish et al., 2019a). Further, students practised skills of articulation, sharing and appraising practice cases and listened to and valued others' perspectives (Grealish et al., 2019a). It follows that through their engagement in learning circle pedagogy, students could potentially develop essential skills for communication, collaboration and coordination that are necessary for teamworking and interprofessional practice.

2. Background

For high quality patient care, interprofessional ways of working are required in healthcare systems and facilities. A key challenge for higher education is how to prepare students to work effectively in interdisciplinary ways. In a systematic review of the outcomes of interprofessional approaches to education, the meta-analysis found a positive impact on job satisfaction, resolution of complex client issues and dispelling stereotypes (Guraya and Barr, 2018). However, whilst the review focused on outcomes it provided little insight into the pedagogical processes that were used to achieve them.

There is general agreement that interprofessional working is based on shared knowledge. In a study of primary healthcare team members, shared knowledge, problem-solving focus and mutual respect were considered foundational (Kim et al., 2019). An emerging characteristic of interprofessional teamworking is the concept of parsimony or being concise (Kim et al., 2019). Teamworking, which can be intra-professional (i.e. an homogenous professional group) or inter-professional, is an ongoing process of learning, through which "similarities, commonalities and distinctive conceptions of knowledge and knowing can be made accessible, shared and comprehended" (Billett, 2014, p.207). For educators, identifying pedagogical strategies to develop students' ability to make their distinctive conceptions of knowledge and knowing accessible, shared and comprehended is a contemporary challenge.

Focused engagement with others, sharing perspectives and attending to others' positions and preferences provides an opportunity for students to develop intersubjectivity (Billett, 2014). Because nurses work with various staff in teams in clinical settings, providing opportunities for nursing students to engage with others around practice may support the development of intersubjectivity and associated teamwork skills. A clinical practice pedagogy that holds promise for developing intersubjectivity in nursing students is the work-based learning circle.

Learning circles are founded in constructivist philosophy that presses students to actively make meaning of experiences in a supported way, through social interdependencies and collaborations (Preston-Cunningham et al., 2017). In an Australian trial of learning circle pedagogy with undergraduate nurses, students demonstrated a richer understanding of practice, expressed as multiple forms of knowing, following participation in a work-based learning circle (Grealish et al., 2019b). In a separate study of work-based learning circles for nursing students, researchers found students valued and listened to others' perspectives and could practice the skills of articulation, sharing and appraising practice cases (Grealish et al., 2019a), suggesting opportunities to develop intersubjectivity.

Given the importance of intersubjectivity for working intra and interprofessionally, further exploration of work-based learning circles as a pedagogical activity to develop intersubjectivity and teamwork skills is warranted. This study evaluated learning circles as a pedagogy to develop both intersubjectivity and teamwork skills and determined the barriers to and facilitators of, learning circles as a learning tool.

3. Methods

3.1. Design

A convergent parallel mixed method design (Schoonenboom and Johnson, 2017) was used, incorporating a cross-sectional survey of nursing students and a descriptive qualitative analysis of interviews with clinical facilitators. A mixed methods approach allows triangulation of experiences of a particular phenomenon (Schoonenboom and Johnson, 2017). Once the two datasets were independently analysed, the tentative findings from each were compared and interpreted to address the research questions. This inquiry is guided by two questions:

- How do learning circles develop intersubjectivity and teamwork skills?
- What are the barriers to and facilitators of, learning circles as a work-based pedagogy?

3.2. Setting and sample

The study was conducted in a tertiary health service in southeast Queensland (750 beds). All second and third-year Bachelor of Nursing (BN) students from two Australian universities undertaking clinical placement together in January to June 2017 were invited to participate. Students were placed across a range of wards and specialty areas. The supervision model involves preceptorship combined with team-based clinical facilitation (for more detail see Grealish et al., 2018 and van de Mortel et al., 2020). Students who volunteered to participate in learning circles were invited to complete a survey. Completion of the survey was voluntary. Clinical facilitators - hospital-based registered nurses who support student learning in practice and facilitated the learning circles - were invited to participate in group interviews. The clinical facilitators were experienced nurses with limited training in educational techniques.

Intervention.

Student-led learning circles (1–1.5 h duration) were used post-practicum to stimulate critical appraisal and group discussion of their experiences. Each learning circle engaged 6–11 students and followed critical reflection steps to create effective learning communities in nursing:

1. Deconstruct a practice to develop questions;
2. Discuss difficult areas raised by these questions;
3. Investigate what could be done differently;
4. Consider alternatives for further exploration (Walker et al., 2013).

Students deconstructed a practice by each drawing a concept map based on their clinical experience with a patient. Their maps were then presented to and discussed by the group to stimulate critical appraisal of these experiences and how patient care might be done differently. Clinical facilitators supported interactions and coached participants on team communication skills where necessary.

3.3. Data collection

After each learning circle discussion, the clinical facilitator invited students to complete a paper-based anonymous survey (~10 min duration). Completion was considered consent. One student collected the surveys in an envelope and sent it to a researcher via the hospital's internal mail. Clinical facilitators did not see student responses.

The survey elicited demographic information including age, gender and year level. The survey items were grouped into two parts. The first set of items were informed by themes obtained from a pilot study of learning circles conducted with 38 nursing students and two clinical facilitators (removed for blind review). The second set of questions were part of the standard School survey to assess students' experience of placement. The survey used a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). Two open-ended questions were included: (1) What are the barriers to learning circles on clinical placement; and (2) What would improve the learning circle experience?

The project lead invited clinical facilitators to participate by email. Group interviews (25–28 min in duration, audio-recorded and professionally transcribed) were held with clinical facilitators in their workplace during work time. Prior written consent was obtained. Questions focused on the benefits and limitations of learning circles and how they could be improved. One researcher conducted all interviews.

3.4. Ethics approval

Ethics approval was obtained from the university (2016/360) and health service Research Ethics Committees (HREC16QGC147). Confidentiality was protected via de-identification of interview transcripts and data storage in password-protected files. Participants received an information sheet on their rights and responsibilities in relation to the research.

3.5. Data analysis

The survey data were analysed descriptively using IBM SPPS Statistics Version 23. Cronbach's alpha and item-to-total correlations were calculated for the scales and scale items. Scale and item mean and standard deviations were calculated. A One-Way ANOVA was used to examine potential differences in scale means by age group, gender and year level.

Responses to open-ended survey questions underwent independent content analysis (Graneheim and Lundman, 2004) by one researcher (LG), validated by a second (TV).

Interview transcripts underwent thematic analysis, which required reading and re-reading transcripts, systematically generating codes, examining the relationships between codes and collating them into themes, reviewing and naming these and reporting them along with supporting quotes (Clarke and Braun, 2013). Qualitative data analysis was undertaken independently by two researchers (VF, MM) who then discussed and finalised the themes. This provided a means to ensure credibility. The use of illustrative quotes in theme reporting provides a form of dependability, allowing the reader to judge for themselves the meaning of these data (Lincoln and Guba, 1985).

The survey and interview findings were compared by the team and interpreted to achieve a deeper understanding and implications of the findings in terms of the proposed research questions (Lincoln and Guba, 1985).

4. Results

A total of 144 BN students participated in 18 learning circles; 128 completed the post-intervention survey (response rate 88.9%). Most participants were female, aged under 25 years and in third year (Table 1). Ten clinical facilitators supported the learning circles and five participated in one of two group interviews (n = 2 and n = 3) at the end of the intervention. Demographic data are not described due to the likelihood of identification.

Table 1
Sample demographics of nursing students (n = 128).

Gender (%)		Age group (years) (%)		Year level (%)	
Female	86.7%	< 20	32.0%	2nd year	46.9%
Male	12.5%	21–29	39.8%	3rd year	53.1%
Missing	0.8%	31–39	12.5%		
		≥ 40	15.6%		

4.1. Cross-sectional survey

The cross-sectional data are presented in three sections. Firstly, students' experiences of learning circles were positive; over 84% (n = 108) agreed that learning circles enhanced their clinical placement (2.4% disagreed/strongly disagreed) and 88.3% (n = 113) agreed (2.3% disagreed) they were satisfied with the experience. Table 2 presents participants' responses to items about their experiences with learning circles. Mean item scores ranged from 3.84 to 4.49 (mean 4.25 ± 0.51). Scale responses did not differ significantly by gender, age or year of the program.

Students reported that the learning circle discussion stimulated them to appraise what they had experienced, think critically about it, listen to others' feedback on their ideas and be creative. There was less agreement with the statement about learning circle discussions being focused on identified personal learning needs.

The second group of survey questions focused on procedural and dispositional outcomes (Table 3). Item scores ranged from 3.89 to 4.27 (mean 4.15 ± 0.55). Scale responses did not differ significantly by gender, age or year of the program. Students demonstrated high agreement on items related to intersubjectivity including the 'ability to build a shared understanding' and 'confidence to express my opinion in a group'. Core teamwork skills were self-reported including: 'ability to brainstorm', 'relate to colleagues' and 'debrief'. In summary, students self-reported developing intersubjectivity and teamwork skills through learning circle participation.

Open-ended responses were received from 109 students. These were grouped into categories; the most frequent are presented in Table 4. Regarding barriers to learning circles, some students indicated that, "Sometimes issues are not common therefore learning about [the] topic will not help for future practice" and "some students could not relate to the incident". Some remarked on the challenge of engaging in the

Table 2
Students' experiences of learning circles.

Item	Mean (± S. D.)
Presenting experiences and discussing them with peers is an active way to learn	4.49(0.63)
Discussing experiences with peers stimulated me to reflect on my experience	4.45(0.65)
I learnt from the experiences of my peers	4.34(0.62)
Discussing experiences with peers helped to build my critical thinking skills	4.34(0.71)
Learning circles allowed me to 'tap into' other students' knowledge	4.27(0.68)
I learnt from the feedback provided by my peers	4.26(0.69)
Peer discussion helped me to 'think outside of the box'	4.24(0.77)
Discussing clinical experiences with my peers helped to break down difficult concepts	4.21(0.81)
Peer discussion provided me with additional strategies for patient care	4.20(0.83)
Peer discussion encouraged a holistic approach to planning and delivering patient care	4.16(0.73)
The learning circles allowed me to target my learning to an area of need	3.84(0.79)
Scale mean	4.25(0.51)

Cronbach's alpha = 0.92

Table 3
Students' perceptions of skills developed through learning circle participation.

Item	Mean (± S. D.)
I developed my ability to build a shared understanding of patient care with my colleagues	4.27(0.61)
I developed my ability to brainstorm in a team	4.26(0.66)
I developed my ability to relate to my colleagues	4.25(0.63)
I learnt how to debrief with colleagues	4.20(0.70)
I developed my confidence to express my opinion in group situations	4.17(0.69)
I developed my teamwork skills	4.15(0.64)
I developed my confidence to transition to a Registered Nurse (RN) role	4.13(0.73)
I developed my ability to communicate with the healthcare team	4.05(0.79)
I developed my autonomy	3.89(0.84)
Scale mean	4.15(0.55)

Cronbach's alpha = 0.92

Table 4
Most common responses to open-ended questions.

Category	Frequency
Barriers (n = 97)	
Initially low confidence to engage (shy)	22
Topic not relevant	18
Strong personalities take the lead, excluding others' ideas	12
Not enough time to complete discussion	8
Suggested improvements (n = 84)	
Provide clearer directions on the learning circle process	21
Do the learning circle regularly	9
More prompting from the clinical facilitator	8
Invite quieter students to share their views	5

conversation, often attributing this to 'shyness' or lack of confidence, while others noted that some ideas were excluded when some students dominate or that there was insufficient time to hear all ideas on the topic.

In terms of improvements, some students indicated a need for improved directions for the learning circle or wanted to engage in learning circles more regularly, which could enhance clarity. Students also suggested that more prompting from the clinical facilitator may assist with clarification and developing ways to encourage quieter students' participation would improve the discussion.

4.2. Clinical Facilitator interviews

Three themes were identified from the clinical facilitator data: i) student-led engagement in the learning circle process, ii) learning much about students' abilities; and iii) developing subtle teaching skills to enhance discussion.

4.3. Student-led engagement

In the first theme, clinical facilitators noted that students engaged in the learning circle discussion. Examples included:

> …they are giving each other a circle of knowledge… assessing a child respiratory [condition]. They were all giving ideas on how to do that and so they were learning (FG1).

> …to see how they can bring that to their own case…this is actually picking out an issue, something that they can all work with. It's something tangible and they can all relate to and share (FG2).

Further, they reported that students valued the reflection process and felt invested in the information being shared. The learning circle structure was considered important for the reflective process:

> [The learning circle] gives them some sort of direction with their reflection…format and structure… and ownership (FG2).

Some suggested the need for a 'warm-up' activity:

> I think a …very short like five-minute ice breaker, just to clear the air… that could be quite beneficial (FG2).

In other groups, the learning circle structure provided an opportunity for some students to exhibit leadership skills:

> They seem to coerce the quieter ones in the group to participate… one of the students actually took a bit of a leadership role (FG2).

Experiences that provided a platform for articulating, sharing and evaluating students' suggestions were seen to generate the deepening understanding and development of further procedural capacities (i.e. how to achieve clinical goals).

4.4. Learning about students' abilities

The second theme represents clinical facilitators' interests in assessing students on placement. The discussion of clinical practices helped them to recognise student understanding of clinical situations, concepts and practices, which enabled more valid and reliable assessment of students' clinical learning. For example:

> I thought that was really helpful, as a facilitator, to get examples on how they're practising in the clinical environment and their understanding (Group Interview [GI]1).

> They share a lot of things there. I was like 'oh, I didn't know she did that.' It's really good (GI1).

Clinical facilitators could guide the flow and direction of the students' discussions, enabling further development of their learning and clinical competence:

> When we saw students on the ward that had a patient with COPD, we could direct them back to the learning circle, of things that [were] spoken about, so they could apply that (GI2).

This quality of guiding rather than transmitting knowledge is a fundamental precept of the constructivist approach to education adopted for the learning circles.

4.5. Developing subtle teaching skills to enhance discussion

Clinical facilitators reported that learning circle facilitation was challenging and required new, subtle teaching skills to enhance discussion. While students valued learning from peers, they continued to seek feedback from their facilitators, particularly around the adequacy of their discussion:

> 'What did we miss, what could you have added to that? Were we on the right track and things like that?' They [students] would have liked to have had our input at the end (GI2).

Clinical facilitators described the need to develop skills to allow students to lead the discussion. Like the students, they were initially uncomfortable with how to start the learning circle:

> I think that's the most challenging thing, is to sit back… they're just looking at us to direct it (GI2).

Given the limitations of some students' knowledge and depending on their year level, the discussion sometimes did not advance. Knowing when to interject was identified as being crucial to the students' learning by some facilitators as was ensuring students had the 'right' information:

> Knowing how much you should interject, or how much you should guide, or what questions you should ask (GI1).

4.6. Data Integration

The survey data indicated that learning circles promoted intersubjectivity (students positively scored items on 'the ability to build a shared understanding' and receiving feedback on their ideas) and teamwork skills (how to work in teams through demonstrating the 'ability to brainstorm', 'relate to colleagues' and 'debrief'). The clinical facilitator theme of student-led engagement points to intersubjectivity processes. Comparison of students' open-ended survey responses and clinical facilitators' interview themes suggests several barriers to learning circles including reticence to start, relevance of the topic, unequal opportunities to speak, lack of clarity about the tasks and confusion about the clinical facilitators' role. Facilitators included students' leadership skills and some students' interest in more learning circle practice to clarify the process. One unexpected finding included the opportunity for clinical facilitators to assess students' understanding of their practice experiences during the discussion.

5. Discussion

From a constructivist educational perspective, learning circles provided student-led discussions of clinical experiences, permitting participants to construct meanings and share understandings with each other and integrate these into what they know, can do and value. Students self-reported the ability to develop a shared understanding and teamwork skills following the learning circle. However, further development of the pedagogy - focused on structure as well as learner and facilitator readiness - is required before this pedagogy can consistently yield such outcomes.

In this study, learning circles offered an opportunity for students to develop shared understandings. Student ratings of the experience suggest that the value was in its provision of an opportunity to share, discuss and appraise their experiences in a safe environment. The value of engaging with and gaining insights from others was reported as generating effective learning. This finding was reinforced by circle facilitators, who reported that students' sharing of learning experiences created common understandings. Although not explicitly reported in this study, the clarification of value priorities, considered an essential element to intersubjectivity (Cody, 1996; Billett, 2014) was not directly addressed but assumed in the development of shared understandings. Further research into how 'what is important' is negotiated in learning circle discussions can inform the development of this pedagogy for intersubjectivity.

Beyond shared understandings (i.e. concepts), students reported developing procedural capacities through these interactions (e.g. strategies). These process outcomes were supported by the relatively high ranking of teamwork skills (e.g. learning how to debrief, work with others and communicate in a healthcare context), indicating that work-based learning circles can extend a shared understanding from conceptual knowledge to the work tasks and dispositions required to undertake them (Billett, 2014). Further research into students' performance in practice, how they work with others to determine care plans and 'do' care, is required to determine the effectiveness of learning circles on teamwork practice.

Several students expressed concerns about sharing their ideas, citing shyness as a rationale for limited participation. Previous research with learners in general practice has similarly demonstrated that lack of confidence is a barrier (Silberberg et al., 2013) and creating trust and ensuring learners can participate without risking embarrassment is key to facilitating robust shared learning sessions when participants are at different training levels (van de Mortel et al., 2013). Student readiness to participate in learning circles could be enhanced by providing more structure - including warm-up activities - and conducting several learning circles over time so that students develop confidence in the processes of articulating, listening and creating shared understandings efficiently. These activities may assist with the requirement for concise inter-professional conversations in practice (Kim et al., 2019).

To encourage active and equitable student participation, knowing when to intervene in discussions and draw in quiet students while preserving the student-led aspect where possible was an important component of learning circle facilitation. Facilitating student-led learning circle discussions required subtle teaching skills such as collaboratively setting up and enforcing rules for group discussion, prompting quieter students to participate and clarifying misinformation. The clinical facilitators in this study were experienced nurses with limited training in educational techniques. To improve their readiness and enhance learning circle delivery, further training on unique learning circle pedagogical elements is recommended for facilitators.

The opportunity for students to assume leadership in a learning circle was observed by facilitators. Marvell et al. (2013) indicate that student-led activities encourage students to take ownership of and responsibility for, their learning and active learning strategies improve learning outcomes (Freeman et al., 2014). In this case, student leadership that encouraged all group members to articulate their views was valued by some students. When this type of student leadership was absent, opportunities for developing intersubjectivity may be reduced. Overall, students provided the least positive scores on the item related to developing autonomy. This may have been due to some students feeling shy while some were more dominant, or have been related to the facilitation style.

Facilitators of learning circles included the leadership skills displayed by some students and some students' interest in more practice at doing learning circles to clarify the process. Students' readiness (Billett, 2015) was also important, including being able to contribute productively to the conversation and having the confidence to do so. The opportunity to share their experiences in a safe environment was considered a facilitator of learning. The ability of the facilitator to role model more difficult discussions such as managing very different views, also seems to be a critical element for student learning.

5.1. Recommendations

Learning circles were positively associated with students' procedural and dispositional outcomes. However, further research is required to determine if this relationship is causal and the approach needs further development. For learning circles to be effective educational experiences, structures in the form practices that encourage participation by all students, avoid the domination of the discussion by a few and activities whose authenticity is engaging and whose value warrants making the time to participate in these activities are required. Structural improvements to learning circle processes may include:

- Starting the session with a 'getting to know you' activity.
- Clarifying the clinical facilitator role and outlining when the facilitator might interject, in the group rules.
- Offering learning circles more regularly so they become familiar learning activities and students can develop greater confidence to practice the skills required for mutual engagement and learning.

Clinical facilitators require the skills to guide discussions and intervene when appropriate to avoid unhelpful diversions and misinformation and promote full engagement. Providing further training for clinical facilitators on the management of learning circle discussions is recommended.

5.2. Limitations

Study limitations include potential social desirability response bias on survey items (van de Mortel, 2008) and the lack of generalisability of qualitative findings. The latter is predicted as qualitative research does not aim for generalisability (Myers, 2000). However, data triangulation (Schoonenboom and Johnson, 2017) from the two different sources

helps to support the findings. While 50% of clinical facilitators participated in group interviews, given the small number of facilitators involved in the learning circles, this of necessity meant a small number of interviewees, which may lead to selection bias, where those who participate may differ from the population as whole. However, there was no intention to generalise from the interview findings. In terms of group interviews, one potential issue is dominant voices where one dominant participant may make it harder for others to provide their opinions. The interviewer ensured that all interviewees had an opportunity to speak.

6. Conclusions

With commonly understood norms and practices and appropriately skilled facilitators, when learning circles focus on authentic situations based on students' experiences, the development of key clinical capacities can be promoted. These include understanding how to secure shared understanding and practices in a clinical setting through the discussion of cases that permit comparisons, evaluation and critical appraisals of the case and the propositions being advanced about responding to it. The structures need to support effective learning circles, include the readiness of students to participate and clinical facilitators to effectively guide the learning circles. While there are no guarantees, consistent with the precepts of this practical enquiry, these guided discussions are likely to be pedagogically rich and directed towards core skills required for inter-and intra-professional interactions in clinical settings that are central to safe, effective patient care.

CRediT authorship contribution statement

LG, TV, SB, LA Conceptualization; LG, TV, CM, VF, MM Data curation and Formal analysis; LG, SB Funding acquisition; All authors Interpretation; JS Preparation of facilitators; LG, TV Methodology; TV: Project administration; TV, LG Writing original draft; All authors led by LG: Review & editing.

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Conflicts of interest

None.

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