FROM THEATRE IMPROVISATION TO VIDEO SCENES – WHAT ARE THE IMPLICATIONS FOR THE QUALITY OF EXISTENTIAL CONVERSATION

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ABSTRACT

At Sygehus Lillebaelt, a Danish hospital, there has been a focus for several years on patient communication. This paper reflects on a course focusing on engaging with the patient's existential themes in particular the negotiations around the creation of video scenes. In the initial workshops, we have been drawing on improvised theatre. The fiction created on stage enabled the participants to engage creatively and deeply into the themes and the theatre workshops turned out to serve as a very engaging and productive way of increasing the quality of the conversation among the participants about the role of them in engaging with existential concerns in their professional practice. The present paper is exploring the shift from engaging people in conversation with live theatre improvisation to the use of videos for cost reasons. From a quality perspective, the paper contributes to the general theme of "upscaling" from smaller, cost intensive workshops to training programmes feasible for large scale implementation.

PATIENT INVOLVEMENT

Sygehus Lillebaelt in Denmark has for years focussed on improving the communication with patients (Ammentorp et al. 2014). For that purpose, a communication training course has been implemented. During the work with this programme, there has been an increased focus of understanding the way existential themes can be included in the conversation.

Patient involvement is an increasing theme among health professionals in hospitals. Shared decision making has been developed as a concept in which the patient is encouraged to engage in the decisions of their own treatment. According to Katz et al. (2014)) shared decision making are achieved when (1) patients are fully informed about the treatment options and the trade-offs between risks and benefits and (2) when patient values and preferences are incorporated into treatment decisions. With this articulation, the burden lies on the professional, who is meant to ensure that these two demands are fulfilled. By doing so, it is possible to stay with talking about the disease. Cassell (1985) explains illness as what the patient feels on his way to the doctor, and disease what he has on his way home from the doctor. Illness is what the patient feels, and disease is the measurable deviation from normal (Helman, 1981). If the doctor can communicate correctly about the treatment options, and ask the right questions to the patient, a box can be ticked that the patient has been part of shared decision making.

Different from this approach, other researchers argue for establishing a conversation among equals. From this perspective mutuality and empowering the patient to strive for creating equal terms is key (Castro et al., 2016). This perspective of mutuality and empowerment has been criticized by Bishop and Yardley (2004)) as it

attempts to see the patients as consumers and ”rational actors”, neglecting the emotional nature of the themes. Along the same lines Mol (2008) argues that “logic of choice” is linked to citizens, who owe their ability to make their own choices to silence their organs, which is not the case for patients. Thus the idea of a free choice for patients is illusory. Instead she argues for a ”logic of care” taking seriously that the patient is vulnerable and not able to control the body.

Olthuis et al. (2013) have explored lived illness experiences among medical professionals themselves. They underline that medical decision making takes place in a messy and uncertain context, and argue for the need of a logic of care and not just a logic of choice. Entwistne and Watts (2006)) argue that shared decision making is a complex concept and notice differences of opinion about why it is important, what it might look like, and how it should be promoted in practice. Looking at these different rationales the understanding of the involvement of patients in taking decisions and the very nature of communication between patients and the health professionals shows to be nuanced.

Gulbrandsen (2016) argue for the need to engage with the existential themes that are inevitably raised for the patient when a disease changes his of her life. As we will see later, engaging with such themes takes the interaction with the patients to yet another level for the professionals. This raises the question how such themes can be “quality approved” when implemented in structured implementation programs yet still retaining a high quality of reflection among the involved.

DEVELOPING TRAINING COURSES

Sygehus Lillebaelt has for years run a communication programme in patient-centred communication for the professional staff based on the Calgary Cambridge guide for patient communication (Silverman et al., 2016). After developing this, it has been broadly implemented from 2011 – 2017. All health professionals have been through a three-day course with follow-up activities. This has influenced the self- efficacy of the professionals, which has been shown in a series of papers (Ammentorp et al., 2007, 2014; Ammentorp and Kofoed, 2011; Nørgaard et al., 2011)

On top of this work, over the last years there has been an increased focus on how to train the staff in involving themselves in conversations with patients that on the surface apparently go beyond decisions of immediate care. It became stronger and stronger articulated that there was a need to include ways of dealing with existential themes of the patients in the communication training. The work with this has been going on at the hospital, such as in a series of workshops, with the intent to create a next course with a focus on how to engage with patient’s existential themes in conversations with patients (Ammentorp et al., 2017) However, at the same time as this theme developed, it was raised that it could be a challenge to include existential themes in standard consultations due to both the time schedule and a lack of training in engaging in such themes.

IMPROVISED THEATRE TO EXPLORE THE THEMES

In the exploration of existential themes, we have been working with improvised theatre methods to explore these interactions further. Improvised theatre has been used for organisational development for decades (Larsen, 2006, 2011; Larsen and Friis, 2017) and for engaging with themes of the vulnerable encounter in the health sector (Larsen, Friis & Heape, 2017). By the help of professional actors, we organise small theatre plays built on cases from clinical practice. The participants were encouraged to explore the themes further, by reflecting on the play, and in particular by suggesting more interaction that either was played by the actors or by the audience taking over the roles.

Over two years we did several theatre workshops at the hospital, such as workshops with staff and patients at the cancer department and workshops for trainers of the initial communication programme (Ammentorp et al 2017).

Initially we worked with cases from cancer treatment. Themes like “why did I fall ill with this disease?”, “will I be cured?” as well as gaining and loosing hope in relation to religious and spiritual beliefs became themes the actors played out in workshops in which we engaged professional staff together with patients.

In one of the scenes, a patient is meeting the doctor who has to convey the message that from now the treatment is only life-prolonging. We see the doctor engaging the patient in choosing between three different treatments, and it becomes obvious that the patient, although choosing one specific treatment, has reasons for her choices that are not talked about in the open. Many themes emerged in the on-going work in which conversation in smaller groups interchanged with improvised theatre – to mention some: – how can the professional include the life of the patient in the conversation, not just the biomedical disease? How can the role of the relative be understood and be actively worked with? How does the division of work between doctor and nurse work and what does the division imply for the patients and their relatives?

Figure 1: Theatre invites for reflection in which the response can be dealt with immediately

The interchanging of improvised theatre, reflections in smaller groups and in the whole group created a unique opportunity for negotiating practice, at the same time as it allowed for reflexivity (Cunliffe and Easterby-Smith, 2004) understood as a second order reflection of practice in the individual negotiating his or her role with other professionals – and with patients.

At the time of writing this paper, it is decided that the implementation of a training program focusing on engaging with the patient's existential themes will be tested in the orthopaedic department.

Why orthopaedic surgery? Because they have shown their interest. In one of the first workshops with the cancer department, a Senior Physician from orthopaedic surgery took part in the theatre workshop. She was asked what interest she had in this. Her response was that it was important that the doctors had an interest in the life their patients were living, and what the patients were capable of doing in context to the most appropriate treatment in this case counselling, exercise and/or surgery. That this was whole person care.

IMPROVISED THEATRE – INDIVIDUAL TRAINING OR ORGANISATIONAL CHANGE?

In mainstream literature, the use of theatre is usually seen as an already known practice (role play) that is desired by management, and such activities are seen as solely influencing the singular individual. Furthermore, such work is understood as a laboratory, for which the outcome has to later be implemented in the organisation. In their former work with theatre in organisations two of the authors (Larsen & Friis 2006) have however described a radically alternative way of understanding the work in organisations. An organisation can be seen as constituted by the practices people do, as they are interdependent of each other within the organisation. Any change means a change in their interdependencies, and in their patterns of interaction. This perspective on organisation has been described by Stacey et al. (Stacey et al., 2000; Stacey and Mowles, 2015). When people are engaged in a workshop with theatre improvisation, we intend to create invitations for such change in the patterns of conversation.

Since the training programme should be tested out at the orthopaedic department, we invited staff from that department for a theatre workshop, together with patient representants. As a preparation for this, we heard stories in which existential themes might be very serious, albeit easily neglected. From this insight, we constructed a small theatre play that was played at the workshop. A young patient is told by the doctor that what she thought was a simple knee operation turned out to be more complicated. In the play the doctor tells the patient that she has to go to an additional consultation at the oncology department, and she immediately asks whether he believes that it is cancer. In the response, the doctor is trying to balance that this probably is serious, and at the same time he tries to avoid the word cancer. The young patient is in some kind of chock. The conversation between the doctor and the patient on stage is difficult but as the questions from the patient goes on, the doctor tries his best to carefully describe the possible cancer diagnosis, that might be the outcome, the treatment and chances of being cured.

When the patient leaves we ask the audience what happened in the play. It is argued that the doctor should have made sure she left in a better condition. The audience then puts a lot of demands on what more the doctor should have done. Professionals and patients in the audience discuss whether it is OK for the doctor to convene that this is uncomfortable for him. It is agreed that the doctor needs to accept the frustrations that the answer raises in the patient, and that he should be able to stay calm, but there is more.

It becomes a theme what you can and cannot say as a professional in states of uncertainty. The doctor is not sure about the diagnosis, and when it comes to the possible cancer he is not an expert. However, it is articulated that he cannot and should not avoid the conversation. It is questioned by some in the audience whether the doctor is protecting himself from an uncomfortable conversation more than protecting the patient. In the conversation, there is an underlying theme of anxiety related to the fact, that in such conversations there is no clear answers.

The point in presenting a known dilemma in a theatre scene is in line with the theory of abduction, that breakdowns, moments of surprises and the similar might induce reflection and conversation about norms and work practices. Presenting such a scene is an invitation to reflection (Larsen, 2006). The intent is to invite to conversation about such surprising moments, even if they are fictitious. We know by experience that such conversation might continue also after the theatre session and we have seen significant organisational change emerging out of such improvised theatre workshops (Larsen, 2011).

A doctor commented that in situations like the one played it takes quite a deep look into yourself to be able to take the perspective of the patient. One asked about the nurse, that also had been part of the consultation. What could she do? This was followed by a remark that since the doctor was giving the bad message, he could easily be experienced as an "enemy" to the patient. Instead she suggested that the doctor conversation could be followed by a conversation with the nurse. The woman who proposed this was invited to take the nurse-role. On stage, this conversation worked out really well for the patient talking with the nurse about what happened in the consultation and how to interpret what the doctor had said. It was possible for the patient to recognize that the doctor cannot be sure until the next consultation, and there is room for taking time for all the emotions that this raise for the patient, which included periods of silence, temporary rejection of the situation and insights in the life of the patient – such as

whether she could not bear to cancel her attendance to her sister's wedding in a country far away.

In the work with theatre, it is important that the audience accepts what is going on as "could be real". The live engagement with the audience enabled this to be the case in this situation. One participant afterwards said it was like using the bad cop – good cop strategy, the doctor giving the bad, but necessary information while the nurse is experienced more like a friend who helps the patient to understand the message and what it means for the patient. This created a heated conversation among the participants. Some saw this as bad, since the doctor should be able to cover it all.

So in the flow of conversation and improvised play, the themes emerge giving new insights and maybe new "truths" about what is the best thing to do. Themes that are discussed live among key participants at the department, and that might or might not be taken up in further conversations. Whether this will lead to change depends on the next conversations that the participants become engaged in at the department.

WORKING LIVE WITH IMPROVISED THEATRE

The nature of this work is exploring the challenges and possible reactions when it comes to dealing with existential themes. It is not training into how one "should" react, and it is not supervision. It has strong elements of learning, but not of teaching in the sense that someone knows exactly what to do. The work invites the individual to reflect one's own position, but what is even more important is that it is happening in a conversation with peers. The voices of other professionals (and not the least of patients) influence this. So the work is not (just) something that is to be implemented afterwards, but it is immediately changing the patters of interaction, which people bring with them in the further interaction (Larsen, 2006). The live response, in which themes, that cannot be thought of in advance are brought up, serves as an invitation to further exploration. Thus a meaningful mutual journey in which the participants deal with yet unknown themes can be explored and articulated.

As an example, the play with the nurse changed the situation. It was not agreed whether the doctor in principle ought to be able to come as far by his own, but the need for going further in the direction was obvious as richer perspectives of the situation of the patient was explored. For such conversation, in which we mutually at the same time negotiate, substantiate, confirm and change the practice the term "working live" (Shaw and Stacey 2006) has been developed: noticing that such interaction is going on by engaging in new conversation with each other; conversations that are felt risky, since one cannot know the outcome, and in which one's own professional identity is challenged. What is going on is improvised, since one cannot know the reaction towards gestures one makes. The quality of the emerging conversation depends on the ability of the participants to run such risks.

Over the years we have been using improvised theatre as invitations to new conversation (Larsen & Friis 2006, Larsen 2011, Larsen et al in press, Ammentorp et al 2017). As we can see in the situation just described, the ability to engage with theatre not just in the initial invitation, but to explore ideas with improvised theatre (such as the role of the nurse) makes the notion of "invitation" on-going. On the basis of the work of George Herbert Mead (1934) Stacey et al understands learning as similar activity of interdependent people and neither can be understood as solely individual, nor can be placed outside humans, e.g. "learning organisations" (Stacey, 2003). Consequently, a change in behaviour in the individual is a change in the interaction among the involved. In contrast, training is usually understood as an individual change in the singular mind, without taking these interdependencies into consideration.

INSIGHTS ABOUT EXISTENTIAL THEMES

Several themes have emerged over time. We have seen that when engaging existential themes such as death, hope, meaning, significant changes in the life situation of the patients emerge, and this creates a need for the professional to, on the spot, create a particular quality of conversation. We have seen that

- quality of conversation emerges in the on-going responding to each other.
- such quality cannot emerge if the professional works from a detached scientific perspective, since this will retain the patient in the expectations of the professional as not interested in the person, just in the disease.
- neither can it be done by only asking circular questions, meaning returning a question back to the patient.
- engaging with existential themes will frequently invite the professional to reflect own experiences. This cannot happen without serious reflections on what this might mean for professional identity.
- engaging in existential themes frequently questions the generally accepted local practices what Foucault named "regime of truth" (Foucault, 1980). In particular the division of roles between doctors and nurses are frequently questioned, and the reflection invites for a re-negotiation of their interaction with each other in relation to the patient and relatives
- existential themes demand an interest also in the relatives and others that the patients depend on in life. This proves to be a serious challenge to the health professionals who often focus primarily on the patient.

So in the development of the new communication course focusing on existential issues in conversations, the question becomes how such themes can be explored and dealt with in a way that raises the quality of conversation among the involved.

IMPROVISED THEATRE VS. VIDEO

In the creation of a training programme the idea has been to create video clips on the basis of the insights from the theatre workshops. Improvised theatre was considered not to be feasible in this upscaled implementation. One of the authors with a theatre background (Preben) took up the challenge to work with possible scenes, negotiate them in the group that was responsible for creating the course, and for making the final videos. He anticipated limitations of what could be achieved with video material in this context, and it became a recurrent theme in the conversations among two of the authors, who on a daily basis is working with the theatre methods, how to deal with this in preparing the videos for the training programme.

Video is basically a completely different format from improvised theatre. A video is more likely to emotionally engage the spectator by going close to the actor's face, by cutting the movie in particular ways or by inserting music. Videos will be interpreted differently when watched by different people. However, the spectator knows that whatever is shown is thought out upfront and is not influenced by the observer. Paradoxically this awareness can create a distance towards what is presented even if it is emotionally engaging.

When a video it is produced, it is fixed. One might think that this is also the case with a rehearsed scene that is played out by actors in the presence of the audience, but there are significant differences. Even in playing the rehearsed lines, the actors will adjust to the fact that they play for a live audience. Stanislavsky (1989) notice that in rehearsed theatre the "scenic truth" emerge when the actors are able to not just enact their lines, but use any opportunity of disturbance from the audience to be present in their interaction. This cannot happen in a film, because the actors are not with the audience. This creates a different dynamic than watching improvised theatre. Spectators engaged in improvised theatre can detach themselves from the experience, but they articulate their critique more carefully and the live work with theatre allows for re-adjustment under the influence of the audience.

Some of the authors have been working with video scenes developed on the basis of improvised theatre plays at other occasions. At a workshop with 25 General Practitioners a video was played showing a scene that we had quite some experience with from several live theatre sessions with other GPs. Although the video was carefully made, with taking all the comments we have heard on the live enacted scene before, these GPs had much harsher comments towards the way the doctor reacted than we had seen in the live theatre plays. They allowed themselves to take a detached stance, and rejecting the character they saw playing the doctor.

So, in this case, the invitation in the video did not work as an invitation for reflection in the same powerful way as the theatre work using the same scene did with similar audiences. This raises questions about what is possible with videos, or alternatively, how video material should be constructed to engage people in the same kind of conversation as with the improvised theatre.

REFLECTIONS ON VIDEO CREATION

We have seen, that when transferring to video, the smallest details are being subject to careful scrutiny and are being "reality checked" by the spectators in a way that might deviate from the actual purpose of seeing the scene: namely to explore how one responds to existential themes in a patient encounter. The acceptance of the fiction that emerges in the live work cannot be taken for granted when a video is played. With live theatre, on the other hand, the spectators are more likely to abstract from details and to enter into an "experimentarium" with a larger willingness to take risks.

However, we also have had other experiences. The theatre scene in which a woman is told that her cancer cannot be cured has been videotaped and shown as a video at different occasions. At stage we see this being presented by a doctor. Beside him sits a nurse, and beside the patient is her husband. At a particular moment the doctor leaves the room, and the patient asks the nurse for water. They also leave the room, and we see the despair of the husband who is trying to digest the message now sitting for a moment in the room on his own. We see the doctor return to the room, and the husband pulling himself together, with the consequence that the doctor ignores him. Later we also see the wife rejecting him – it is too difficult for her to engage with him and as the audience, we recognise that a lot is at stake for them.

We have played this scene as theatre several times, and in the improvised work that followed, all this has been explored further. We have seen the couple waiting for the elevator after the consultation; we have explored conversations between the doctor and the nurse, all driven by the response from the audience. Thus, this scene provides an abductive invitation to the professionals when being part. However, the taped video from playing the scene has been used at other occasions. And beside a harsher critique of the doctor similar to the one mentioned above, we have seen that people also respond reflexively on the situation of the relative when watching the video – and as such we have seen that video can become a strong invitation to reflect about the responsibilities of the professional staff for relatives. One explanation could be that the theme of relatives is generally unrecognised, and maybe for this reason easier to accept as a challenge?

UPSCALING WITHOUT LOOSING THE QUALITY OF CONVERSATION

The authors are all involved in a working group creating the communication course, in which the videos are supposed to play a role. The role that the videos might play became an on-going theme at the meetings, and

Figure 2: The video gives other opportunities for sharing emotions, but it is up to the participants themselves to interpret and reflect

over time, a nuanced understanding of the implications of working with video clips at the communication has developed. Howeever, from the experiences of the theatre workshops, it was clear that the video clips should in a similar way as the theatre workshops present problematic situations, that could be explored in the interaction of the trainers at the course. In the first meetings, the actor/ theatre director that was also responsible for making the video clips experienced that when he asked for explicit purposes of the video clips, while other members of the group wanted to see the video clips before discussing the purpose. This created an initial frustration that was expressed in a mail exchange initiated by the:

The theatre method and the experience around it cannot be transferred directly to video. The play in itself can, but that is not the important part. So what is it that we would like to produce through videos, and how would we want them to be used? How do we get the videos to interact closely with the participants? "

This created a response from one of the other members of the group *"At first we had an expectation that we could be extremely structured and target oriented in the process of creating videos for reflection. However, with the challenge the actor brought we realised that we needed a more explorative approach towards the videos and the creation of them. Upscaling demands reflection, time and an open approach".*

If we look at the process of creating such a programme, maybe this cannot be seen as first "a clear idea that sets the direction of the videos", nor can it be seen as "making the scripts of the videos, and we will know what to do". Maybe ideas about what we were working with emerged in the conversation – in which enacting ideas about scenes were played. So we decided to suggest playing the scenes from the manuscripts at the next meeting, with the idea that this might lead to another quality of the conversation in the working group about how the videos could be used in the training programme.

Three scenes were played – in a low-key way – with the manuscript in front of the actors partly reading the lines. First scene is causing quite some comments from the group. A man in his sixties is suggested to get a hip operation. He is hesitating, and the doctor interprets this as anxiety for the operation. However, what he really is worried about is his wife. She has dementia, and she cannot live by her own – and she flatly rejects to have any foreigners coming to her house. So, without telling that he is trying to get an overview of what the operation might mean for him being away. Playing the scene leads to a fresh conversation about how this could be used. Several ideas emerged, we could work with also showing the internal thoughts of the patient. In the end it was decided that a way to use the forthcoming video at the course could be to play up to the frustration, let the participants talk about what they experienced, and then see him come home to his wife, which then might lead to another conversation with reflexive qualities. It is also mentioned, that it is important that the participants of the course get in touch with their own feeling of powerlessness, which raises the question of how the videos can invite to that?

The next scene is about a young man, that after an accident will not get his movability back. A physiotherapist is supposed to train him, but he rejects her attempts. She invites for a conversation about his life, and the relation to his girlfriend, but he rejects, and asks her to leave. Although played very low key, by reading the lines from the manuscript this scene created a strong emotional response for the group responsible for preparing the courses. It is noticed, that both the therapist and the patient are powerless, and this is felt by the audience. This emotional engagement is considered as very important as it creates empathy for both parts. However, the discussion confirms the necessity for the video clips to be produced in a way in which the learners would not have much to complain about when it comes to the facts. Consequently, the video material is carefully produced in a clinical setting, and checked at another meeting.

FACILITATING THE TRAINING PROGRAMME

It becomes obvious that the quality of the course will depend immensely on the quality of facilitation. It is discussed whether the participants might continue working with the scenes by improvising in the roles on top of the videos: not with the intent to "train", but with the idea of reflecting own experiences. The intent is, as mentioned earlier, for the participants to get in touch

Figure 3: The videos were shot on actual locations

with their own possible anxiety about engaging with existential themes and how that makes it necessary for them to recognize their own existential themes. However, after having seen professional actors in the video, how can a facilitator encourage people to explore the situations further by improvised acting? Working with improvised theatre we know that when trying out particular ideas usually, it leads to something else than intended. If you go into a conversation with a particular intention, you will often be met with different intentions from the other, and thus the conversation will end in something third. Since this is going on "live" all what we can do is take part in the mutually improvised conversation as it emerges. Dealing with this can be demanding for even a dedicated facilitator with experience.

One of the authors has found an inspiration for trying that in other workshops without the presence of those of the authors that have been working with theatre improvisation for years. She finds the task of facilitating improvised theatre very demanding since she experiences the shyness and insecurity of the participants. The participants have to be convinced about the "format" and "rules" of live theatre, e.g. that there are no "right" and "wrong" behaviours or communication styles and that the common exploration must not involve personal critiquing. Moreover, as a "facilitator", one might fear that nothing convincingly will come out of the theatre improvisation and that one will lack to pay attention to central verbal and non-verbal expressions. In a comment to a draft of the paper she wrote:

I believe that you need to have some kind of training, or years of experience, in order to take on the role of a facilitator – or at least you must be willing to "risk" the situation and to let go of control. I think that this aspect needs to be addressed as well. My experience with working live with students was not very good. The students were laughing a lot, as an expression of insecurity, not taking the playing very seriously, and I had a hard time knowing where to stop the scene and knowing how to proceed.

The question is however, whether working with video might be equally or even more demanding if the task is to encourage the participants to engage reflexively with the challenging existential themes. As mentioned earlier, video will easily give a sense of being taken into a particular direction, and thus not helping in facilitating live exploration. To deal with this, we now know that it is important to convey tools and techniques to the facilitators about how the video clips can be dealt with in the courses.

QUALITY IMPROVEMENT

At the hospital, there is a huge focus on managing the quality, and as an example, Lean methods are being implemented with ideas of zero defects, one piece flow and just in time. In the quality management literature, there is a discussion about whether the focus on quality means that there need to be low variation, to "do things right, which in this literature is named "efficiency". Fundin et al. (2017) argue for the need to also understand development in quality management from terms of effectiveness, in which to "do the right things" for the customer is important. , For such a move Fundin (2018) is arguing for shift from stability to developing skills for emergence in leadership, and for the quality organisation. This discussion is relevant for developing the quality of patient communication and involvement of patients and their relatives. It is obvious that what is needed here is to develop a course that gives room for exploration, in search for "doing the right things". A too early focus on efficiency, such as low variation in the how the course is delivered can destroy effectiveness, e.g. that the participants actually will get into reflections that influences their practice on a daily basis.

At this point it is too early to say how the work with the video clips will develop, but in the conversations about the development, the movement of the conversation has followed this line of thought.

CONCLUSION

The ambition for creating the course is to develop the capacity at the doctors and nurses to engage with the patients about existential themes. We have focussed on an apparently minor theme, how we possible can keep the qualities in the conversations we have seen with live theatre improvisation when this is substituted with the use of video clips. Although this might seem as a minor detail in the larger attempt, we have shown how allowing ourselves to explore this within the group has led to an increasing awareness of significant themes such as the role of the facilitator and focusing on how the course relates to the daily routines in the departments, although we still have to wait for the actual outcome of the courses. From a quality perspective, the paper contributes to the general theme of "upscaling", by reflecting the discussions about drawing on insights from smaller, cost intensive workshops to training programmes that is feasible for implementing on a larger scale.

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