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Verbatim Theater: Prompting Reflection and Discussion about Healthcare Culture as a Means of Promoting Culture Change

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ABSTRACT

Mistreatment of student and junior health professionals has been reported internationally. The performing arts have been employed to discuss and address difficult social issues. Turner theorises that research-based verbatim theatre, scripted from interview transcriptions, can explore interrelationships between real-life 'social' drama and performed 'aesthetic' drama. We developed the verbatim theatre play *Grace Under Pressure* to make experiences of mistreatment in healthcare workplaces apparent to lay and health professional audiences, with the aim of creating vibrant debate. We then explored audience responses to ascertain whether the play enabled them to critically reflect on healthcare culture and potentially facilitate change. Semi-structured interviews with 30 medical students and nurses, paramedics and physicians were transcribed and coded, from which the script was created. Following the performances, medical and nursing students and health professionals discussed their responses to the play at three focus groups. Transcriptions were analysed through theoretical thematic analysis. Themes were: recognition of the play's themes in the healthcare workplace (recognition of personal experience, professionalism, training culture and healthcare workplace culture, and

revelations); possible remedies for the healthcare workplace; and critique of the play. Real-life stories and authentic language facilitated recognition of healthcare workplaces by student and practicing health professionals, enabling critical reflection and discussion. We found strong evidence that verbatim theatre can provide an aesthetic frame to consider the voices of those for whom healthcare culture has been unhealthy. This can promote awareness and discussion of the issues, and determination to promote culture change among healthcare professionals, policy makers and the community.

INTRODUCTION

Mistreatment of student and junior health professionals has been reported internationally in research and media reports.[1, 2] In international cross-sectional surveys, Leisy and Ahmad[3] found bullying and sexual harassment prevalence in junior doctors ranged from 30% to 89%. Surveys of Australian junior doctors in 2015 and 2016 found 54% and 57% (respectively) had been bullied and 16% and 19% (respectively) subject to sexual harassment.[4] A 2014 survey of Australian medical students found 74% had experienced and 83% witnessed 'teaching by humiliation' in clinical placements.[5, 6] Bullying and harassment has been reported by 15% to 44% of nurses[7]; 34% of student nurses have reported bullying from nurses and medical staff.[8] Effects of mistreatment among healthcare staff and students include decreased job satisfaction and engagement,[9] poor mental health and suicidal ideation, [10] and potential for decreased patient safety.[11, 12]

Mistreatment is at times embedded and normalised in the hierarchical health culture, both in university health faculties[13] and hospitals.[14] To address these issues, a range of approaches is needed for long-term cultural change. At the time of writing, it is notable that existing policies and processes are frequently not trusted by those suffering from mistreatment in healthcare workplaces.[13] While culture change will require formal changes initiated by educational and

hospital administrations, specialist colleges and governments, such steps only partially address the ethos of workplace culture. [15-17] Methods that illuminate the complexity and richness of experiences in healthcare practice are crucial. This paper explores the use of the performing arts to prompt culture change in health.

The performing arts have often been employed to discuss and address difficult social issues in health care. The performing arts offer useful resources for training health professionals, including activities to foster essential skills, such as clear communication, empathy, interprofessional teamwork and professionalism.[18, 19] Here, we focus on the dramatic form *verbatim theatre,* using as an example the play *Grace Under Pressure*,[20] created in 2017 by playwrights David Williams and Paul Dwyer, in collaboration with the multidisciplinary Sydney Arts and Health Collective (the authors of this paper). We developed the play in the context of our research, training and advocacy regarding students' and clinicians' experiences of health workplaces, including bullying and harassment. Drawing on focus group data, we argue that verbatim theatre can contribute towards cultural change by providing an aesthetic frame in which audience members gather to bear witness to the voices of those for whom the culture of health workplaces has been unhealthy: the theatre experience allows for these stories to be heard, held and critically explored.

Verbatim theatre

Verbatim theatre is a dramatic form constrained by the requirement to create plays using real informants' exact words, spoken, for example, during semi-structured interviews.[21, 22] Script development is an artistic, creative inquiry involving a search for common themes across transcripts, combining contrasting reflections of interviewees and placing these into a narrative arc to be spoken by actors for a public theatre audience.[23-26] The process shares many assumptions with qualitative research, particularly ethnography, narrative/phenomenological

inquiry and grounded theory.[22, 27] It assumes that information may be gleaned from *how* people speak as well as *what* they say.

Verbatim theatre sits in a wider group of reality or documentary theatre,[22] in which the link between audience and reality is central. Verbatim, vernacular language is valuable to an audience because it corroborates that something really happened.[28] Spectators accept this trace of reality and more readily consider their own life experiences in relation to those voiced.[28] Located outside of state, market and educational jurisdiction,[28, 29] reality theatre creates a public space to voice problems that are otherwise constricted by 'social laryngitis' – a sense of being unable to speak - within institutions.[30] Witnessing such problems re-presented on stage is a first step to spectators acknowledging these as wider systemic issues.[29]

Theoretical framework

Grace Under Pressure aimed to address, through discussion, systemic issues in healthcare training and workplaces. We evaluated the impact of *Grace Under Pressure* based on Victor Turner's concept of the distinction between social and aesthetic drama.[31] *Social drama* is Turner's term for conflict in actual social settings and *aesthetic drama* refers to artistic (re)presentations of this conflict (e.g. through theatre or film). Social and aesthetic drama can reciprocally inform one another in a progressive feedback loop. Overt social drama (e.g. a clinical educator demeaning a student in front of peers) produces implicit social processes (e.g. power relations in hospital hierarchies) that can be staged as aesthetic drama (e.g. actors performing the effects of abuses of power in healthcare hierarchies), which introduces new ways of seeing and addressing the social drama (e.g. medical students can recognise abuses of power in clinical settings).

In *Grace Under Pressure*, the social drama of the health workplace, as told by those interviewed, was heightened in the aesthetic drama presented on stage. The play premiered at Australia's 2017 Big Anxiety Festival at a major Sydney theatre. Audiences were comprised of general public, healthcare students, current and former health professionals, administrators, policy makers and academics. Audience members were often tearful, lingering after performances to talk together, or reporting strong emotional reactions prompted by the experience.[32] We later explored audience members' responses to the play to ascertain whether it enabled them to critically reflect on healthcare culture and potentially facilitate change.

METHODS

This study was conducted through a qualitative approach using theoretical thematic analysis,[33] based on Turner's theory.[31] The study consisted of two parts: development of the play and research into audience responses. Ethics approval was obtained from the University of Sydney Higher Research Ethics Committee (2016/1007).

Development of the play

Using passive snowball sampling,[34] we recruited medical students and health professionals from nursing, medical and paramedic backgrounds for semi-structured 60-90 minute interviews. Interviews were conducted by experienced researchers (PD, DW, CH and JR) in Sydney and Melbourne from February to August 2017., continuing until core themes about healthcare workplace culture had emerged from multiple voices. The interviews explored why participants became health professionals, positive and negative experiences of training and work, future plans and suggestions for changes to health care (Appendix I: Interview prompts). Interviews were held with individuals or up to three participants at a time, in a location of their choosing or over the telephone.

Interviews were transcribed and coded to establish categories in participants' experiences, identifying material for the script. From June to August 2017, the script was compiled and edited by DW and PD, then revised by the research team, alongside development of lighting, stage and costume design concepts. The play was rehearsed by professional actors during September and October, with seven performances from 25 to 29 October, two of which were followed by panel discussions.

Audience response

In the week after the performances, University of Sydney medical and nursing students, and medical and nursing staff with University of Sydney affiliations were invited via email to attend a focus group to explore their responses to the play. Three focus groups (84-126 minutes) were held in November 2017, each with six-to-eight participants. These were facilitated by experienced facilitators (CH, JR and PM) and later transcribed. Focus groups explored participants' responses to the play and their positive and negative experiences in health care (Appendix II: Focus group prompts).

Data was analysed by KI, PM, LN, JR and KS through theoretical thematic analysis, following Turner's theory.[31] We used line-by-line coding and the constant comparison process to identify key words, phrases, categories and broader concepts of the data. The researchers independently analysed one transcription, compared their analyses and agreed upon a preliminary coding table. The researchers used this table to analyse the remaining transcriptions, each of which was analysed by two researchers. Through multiple cycles of coding and discussion of each transcription, data were classified and discrepancies resolved.

RESULTS

We identified three themes in the focus group data: recognition of the play's themes in the healthcare workplace, actual or proposed remedies for healthcare workplaces, and critique of the play. The themes are outlined below, with illustrative quotations in Table 1 (each quotation is labelled with the participant's focus group number, e.g. Focus Group 1 = FG1). Conceptual patterns and relationships among the themes are represented in Figure 1.

Recognition of the play's themes in the healthcare workplace

Recognition of own experience. For many participants, the play triggered recognitions of their own experiences of healthcare culture, in particular confronting experiences. Some reported 'painful', 'raw' or 'overwhelming' emotional reactions to the play for days afterwards. Participants acknowledged the high rate of suicide among doctors and their reluctance to seek help. Others recognised experiences of sexual harassment and ongoing misogyny, and bullying in health care culture. One participant noted that, unlike fictional stories, the play portrayed *"what's happened to real people and real experiences"* (FG1). Memories of positive experiences were also precipitated by the play, including a participant who spoke of comforting a patient through the dying process.

Recognition of professionalism. Participants recognised how professionals treat each other and patients as an aspect of professionalism. Comments about participants' experience of professional conduct ranged across a continuum from supportive to hostile. At the supportive end were observations of empathic behaviour, including *"listening to the patient*" (FG?) Further along the continuum, participants recognised situations where staff were publicly rude or failed to show compassion towards colleagues. At the end of the continuum were bullying and harassment of junior staff, including sexual harassment that wouldn't be accepted elsewhere in society. Other difficulties reported included working with abusive patients.

Recognition of training culture. Participants reported that inadequate training leads to unsafe clinical practice and "*high anxiety learning*", and is "*an isolating experience*" (FG1). Some said educators of nurses, social workers and teachers had "*thought about this a lot more than medicine*" (FG1) and that medical education *"doesn't really address humanity enough*" (FG1). Some nursing participants described the benefits of training with a facilitator, who was not their clinical supervisor, and the use of simulation models so concerns could be discussed before trying a procedure on a patient. Participants said this approach contrasted with medical education, which often involved being "*invited to do procedures*" on patients without adequate training or support (FG?). Participants highlighted that because the clinical supervisors of junior doctors were also responsible for assessing their career progression, it was difficult to combat bullying and harassment during training.

Recognition of healthcare culture. Many participants recognised the healthcare system and culture, and its effects on staff and patients. Participants noted that work colleagues can become like family and outlined positive experiences of good team-work, relying on colleagues' knowledge and support. However, participants reported many more contrasting experiences of negative workplace culture in medicine and nursing. One participant claimed the healthcare culture was *"Darwinian"* (FG3), whereby those who remain can carry on despite the bullying. Others said the bullying culture is self-perpetuating, whereby those who are bullied in turn bully others. Nevertheless, participants said that, for the sake of the patient, they needed to be seen to be coping, even when they were not. Some said changing culture was challenging as it "*moves at the rate of glaciers… because there are a lot of invested interests in the way the culture is"* (FG?) and cited *"learned helplessness"* (FG1). Participants reported differences in culture across health, including between nursing and medicine, high- and poor-functioning

teams, and between different medical positions, medical disciplines, hospitals and medical courses.

Revelation. A number of participants reported gaining insights from the play that led to new understandings about their workplace, the importance of mental health or their personal situation in relation to health care. One participant's revelation came after the play, when colleagues discussed their similar experiences in health care, which the participant realised was *"a little step, but… such a big step*" towards improving healthcare culture. Participants also reflected on incidents in the play and generalised these toward broader issues and to other professions, such as law and business; however, one participant noted that more pressure exists in health care and that there is more potential for health professionals to experience trauma.

Possible remedies for the healthcare workplace

Many participants made negative comments about *"nobody does anything about it"* (FG2); however, others suggested ways in which health care could be improved. For change to occur, participants highlighted the need for: improvements in training to provide values-based education that builds self-confidence, emotional intelligence, humility and agency in low-stakes situations that would translate to high-stakes when needed; collegial support and inclusive team communication, including more opportunities for supervision, linking to good patient care; and enforceable policies and empowered administrations, whereby perpetrators of bad behaviour were held accountable and treated as they would be elsewhere. Participants said trainees should not be given the burden of creating culture change.

Critique of the play

A small number of participants critiqued the play for being out of balance. Some critiqued its focus on medical and nursing staff and wanted to hear the *"incredible impact"* of allied health professionals (FG?). Several participants said the play accentuated the negative side of healthcare culture and did not adequately portray the positive side that participants had experienced, such as *"beautiful stories"* of solidarity and support among peers. One participant noted that more encouraging accounts of connection and compassion among health professionals came suddenly towards the end of the play, but failed to *"justify everything"* that had come before, leaving little hope for improvement.

DISCUSSION

Grace Under Pressure offered a research-based, aesthetic theatre representation of the authentic experiences of self-selecting student and practising nurses and doctors. We hoped that audience members would recognise the issues portrayed, and we held the broader aim of potentially contributing to culture change in health care by generating debate beyond the theatre. Our focus groups indicate that student and practising health professionals in the audience recognised workplace issues portrayed in *Grace Under Pressure,* found the play stimulated new insights, and suggested remedies to address some of the issues.

Turner's concept of the interrelationship between aesthetic and social drama in verbatim theatre provided a useful theoretical underpinning to our analysis of audience reactions to the play.[31] Following Turner, *Grace Under Pressure* was created through interviews with student and practising health professionals as a form of aesthetic drama that would mirror the issues out of the social drama in healthcare culture. While not intended to be therapeutic, aesthetic drama does more than merely entertain: it can provide "a metacommentary, explicit or implicit, witting or unwitting" on the social context it represents" (p. 30).[31] Through public performances, messages contained in the aesthetic drama can affect audience members, leading

to change in the social drama, which can feed back into the aesthetic drama . As such, Turner conceptualised the interrelationship between aesthetic and social drama as an infinite loop of continual modification.[31]

As Turner suggests,[31] our findings indicate that verbatim theatre draws attention to real world experiences – in this case, health professionals' experiences of health care - through the aesthetics of drama. This includes the stumbles, pauses and interjections of original testimonies, which gesture to the script's basis in reality while artfully drawing particular experiences or structures into view.[28] As White argues,[35] an audience can perform an outsider witness role which is, "essential to the process of the acknowledgment and the authentication of people's claims… serving to amplify them and to authorise them." Our data support this view, as does a cartoon storyboard published in *The Guardian,*[36] which was created by a medical student audience member who was prompted to explore her own similar experiences.

Audience members in our focus groups projected themselves into the performed experiences of the original interviewees. They recognised and consciously acknowledged the trials and difficulties, as well as the moments of satisfaction, of those in the social drama of health care.[28] The use of vernacular language enhanced the focus group participants' ability to identify with the experiences portrayed.[28] In turn, they contributed rich descriptions of their own, stimulated by the lived experience of others' stories in the play.[28] This can be a first step for audience members to acknowledge systemic issues,[29] and voice their concerns.[30] The feedback from some participants that the play over-emphasised negative experiences and did not include the experiences of allied health professionals (which was beyond the original scope of the play), suggested future directions for the evolution of the shaped-by and shaping iterative interaction between social and aesthetic drama.[31]

As Kershaw argues,[37] while audiences cannot be more than spectators to the aesthetic drama, the theatre may transform them into 'ethically implicated citizens' in the real-world social drama, which may be a precondition to drive culture change (p.117). Our focus group analysis indicates that audience members went beyond mere recognition and acknowledgment of the experiences presented in *Grace Under Pressure*, such that these participants expressed shared values about collegial relationships and ideas for promoting culture change.

Limitations of this pilot study into the impact of verbatim theatre in health care included the small number of focus groups at one site, restricted to students from the University of Sydney and health professionals affiliated with it. However, both student and practising health professionals from medical and nursing backgrounds were included in the focus groups. The focus groups were not separated according to participants' level of experience or health discipline. Although this can conceivably limit the contribution of participants at ostensibly lower levels of health or academic hierarchies, we found all participants contributed to the focus groups; the nursing and medical students made significant contributions and the discussions comparing experiences in nursing and medicine was especially informative.

CONCLUSION

Through *Grace Under Pressure*, we employed verbatim theatre to make personal experiences of healthcare workplaces more visible to lay and health professional audiences, with the broader aim of creating productive debate, especially where those experiences included bullying, harassment and other abuses. In line with Turner's theory, the play's use of real-life stories and authentic language facilitated recognition of systemic challenges in healthcare workplaces by student and practising health professionals in the audience. Verbatim theatre is useful for promoting conversations necessary to promote cultural change by those who work within health, policy makers and the community.

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TABLES FIGURES AND Appendices

Table 1. Quotations

Theme	Sub-theme	Quotations
Recognition of the play's themes in the healthcare workplace	Recognition of own experience	*"I didn't really think about anything for the next couple of days. It's not that there were any particular questions, it was just the raw emotion of powerlessness and pain and isolation."* (FG1)
		"I walked away being confronted but not as, 'I can't believe that happened', it was as, 'I know that happened'." (FG3)
		"They're not unfamiliar stories…by the end of the night I was just emotionally exhausted... You're not allowed to turn away from verbatim theatre, it's like you're in that space and you have to respect people's experiences… You had to sit there, you had to sit through it, you had to bear witness." (FG1)
		"One of the stories where she was talking about when the lights turned off and then that doctor was just that little bit closer and then a little bit closer: I've been in that room." (FG1)
		"Most people don't seek help and that's why there's a high suicide rate for example – and marriage break ups and all those sorts of things amongst lots of professions, but particularly doctors." (FG2)

Recognition of professionalism	*"He had such patience but then he would also be right on it and great in the resus bays as well. He was such a leading by example…* (FG2) *'Rude to somebody else in front of everyone – it happens all the time'."* (FG2) *"One [older male clinician] divided the medical students into two groups. One was all the straight white men and the other one was everyone else, and he would only teach the straight ones… and this has been happening for apparently several years, and the hospital was just like, 'Well, he is a really good doctor and we need him to teach the students, there's nothing we can do'."* (FG1) *"If that doctor was sexually harassing a woman on the street, or in the shops, or wherever, there would be consequences because he doesn't have that power of, 'But I'm a doctor'. The victim wouldn't have that, 'They're in control of my grade, I can't say anything'… It is not okay under any circumstance… and they should lose their job, doesn't matter how good of a doctor they are."* (FG1)
Recognition of training culture	*"Having a facilitator lets you play with the role…. In nursing, if I didn't call for help, I would be reprimanded very severely"* (FG1) *"There's still a very macho culture in medicine that if you need help, you are not up to it."*(FG2) *"It's all very well to speak up anonymously in a survey but if you speak up in practice, the people that are perpetrating this sort of sexual harassment have enormous control over your career… If someone's a troublemaker, they won't get the [next] job and that's very frustrating."* (FG2) *"I hear from my junior staff about their bullying experience. I'm married to a… surgeon who I would say is fairly damaged from his training."* (FG2)
Recognition of healthcare culture	*"You do rely on them in so many different ways. Not just… on their knowledge, but their support and their caring for you too."* *It was about the people that work there… a place where you had all these other gurus that you could work with for your patients… and learn from them and that sort of comradery of the other doctors that make[s] you a better doctor, and not being isolated"* (FG3) *"It feels like you can't say 'I'm struggling' if you have to be here for this noble purpose of being there for the patient."* (FG1)

		"The culture perpetuates itself. It seems to me that those who have been traumatised will go on to traumatise others. I saw this over and over again." (FG3) *"I think that the healthcare culture is Darwinian…: the survivors are the ones that are probably the fittest in terms of being able to put aside … the bullying and putting aside the down-putting and putting aside depression that comes from the work itself, and are able to continue. Whether they become the best people to serve healthcare or not is another issue."* (FG3)
	Revelation	*"One said they realised they needed to be mindful and present in the moments you have with your patients and your families and your colleagues as well. Yeah, I have been thinking about this in the last two weeks and maybe the play had somehow made me think about it."* (FG2) *"There's so much more pressure in the healthcare profession and so much more trauma that can happen to the clinician. I think that's the slightly different thing."* *"It was the one sentence where she said, 'I'm no longer safe'. For me, that stuck to me. I was actually thinking about it yesterday because… your own mental health is so important and just that one sentence… like, 'Somebody needs to be here', to me was just, you know, it happens, it happens all the time."* *"I went with some junior doctors that I work with and some senior consultants that I work with currently, you know, now being in the workplace and hearing them still talk about it and I'm like, 'You know, that's a little step but it's such a big step at the same time'."*
Possible remedies for the healthcare workplace		*"It's nice to feel like you can ask questions and just not be put on the spot. Some of their stories about the interns being grilled by their seniors – I was like, that's awful."* (FG2)
		"There's a great opportunity to create maybe forums for reflection… Ideally what you want to do is have a framework for dealing with these issues that you've worked through in a low-pressure situation, without even realising how useful it might be in the future, so that when those situations come up, you have something." (FG1) *"Better communication, that's what I'd like in the team and that all the professionals are, 'It's not my patient, it's our patient.' … You don't have possession; it's that you are all working together."* (FG2) *"We really need to take care of ourselves as a big group because we all have the same goal to make patients get better, but then we need to make sure we are going on well first to achieve the goal."* (FG1)

	"Whether it is bullying of registrars or failing to follow up patients or whatever, it's just unacceptable. I think people are beginning to accept that it is unacceptable and feel that it has to be acted on." (FG2)
Critique of the play	*"Medicine, nursing, healthcare is… a mixture of good days, bad days, lovely days, whatever."* (FG3) *"A bit doctor/nurse-centric"* (FG2) *"Wasn't much to hold on to for hopes for a better world."* (FG1)

Figure 1. Thematic schema

APPENDIX A – INTERVIEW PROMPTS FOR STUDENTS AND HEALTH PROFESSIONALS INTERVIEWED FOR THE MAKING OF 'GRACE UNDER PRESSURE"

Starter Questions

—Could you start by explaining why you volunteered to speak to us?
—What was the 'penny drop' moment for you? How come you entered this profession?
—Could you describe the first nursing/medical/allied health procedure where you had to take full responsibility?
—What are the characteristics that one needs to have in abundance to do this job?

The transition from early training to early career as a health professional

—Overall, has the experience of being in this profession matched up to expectations?
—What are some of the hard things that you've discovered?
—If you've had negative experiences, how did you manage them?
—What have been some of the most magical, positive experiences you've had?

Looking forwards

—Have you ever had any thoughts about leaving the profession?
—Future Plans? Ambitions?
—In an ideal world, if there were to be sweeping changes to health workplace cultures, what would you like to see?

APPENDIX B – FOCUS GROUP PROMPTS

How did you feel about the ‘Grace Under Pressure’ performance?
Which part of the performance did you relate to most? Why?
Which part of the performance did you relate to least? Why?
From your experience, what are the characteristics of health/ hospital workplace cultures?
How do clinicians and students respond to mistreatment from other healthcare professionals?
What are the impacts of social hierarchy and managerialism in health workplaces?
Would you like to comment on the question, where is the *pressure* in health care?
Would you like to comment on the question, where is the *grace* in health care?
Overall, has the experience of training/working in this profession matched up to your expectations?
What changes would you like to see in health workplace cultures?