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Illness narratives in practice

Potentials and challenges of using narratives in health-related contexts

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Chapter 15

Engaging the vulnerable encounter

Engendering narratives for change in healthcare practice by using participatory theatre methods

Chris Heape, Henry Larsen, and Merja Ryöppy

Identifying issues of practice

By exploring and working with a range of healthcare projects, such as chronic pain, patient falls in hospital, cancer doctor-patient communication, general practitioner(GP)-patient existential conversations, and nursing education, the discovery is that healthcare practitioners are often caught in fixed notions of what their practice entails, and most are reluctant to change that practice. In particular, issues of professional identity seem to influence what practitioners feel they can or cannot allow themselves to do. This appears to be particularly prevalent in situations where a sense of vulnerability arises between doctors and patients, or ‘the vulnerable encounter’. This chapter investigates how the use of participatory improvised theatre (henceforth: improvised theatre) can encourage change in healthcare practices and explore how those involved could otherwise interact in vulnerable encounters.

Informing the improvising

The use of improvised theatre is mainly engendered by four perspectives:

1. Theatre: Based on our professional theatre practice developed over two decades and based on forum theatre (Boal, 1979) and theatre improvisation (Johnstone, 1981, 1999), we developed a practive (Friis, 2006; Larsen, 2006, 2008, 2011; Larsen and Friis, 2006, 2017) that serves as an invitation to share experiences and stimulate reflexivity between those involved (Cunliffe and Easterby-Smith, 2004).

2. The Relational: Our practice and research is highly influenced by a focus on complex responsive processes of relating as initiated by Stacey, Griffin, and Shaw (2000), who understand social interaction as transformative. First described in 2000, their theories build on those of George Herbert Mead (1934) and Norbert Elias (1956).

of imperfection’ that allows for the expression of vulnerability, sharing mistakes, and incorporating not-knowing as a part of professional medical practice where practitioners ‘are aware of and transparent about their emotional reactions to patients and about working on the edge between intimacy and detachment; and most importantly, who acknowledge common bonds of humanity with their patients’ (Shapiro, 2008, p. 7). Arthur Kleinman suggests that medical practitioners should be better able to engage the ‘interpretation of narratives of illness experience … ’ and develop the ability to ‘understand how illness has meaning’ by ‘witnessing and helping to order that experience’ (1988, pp. xiii–ix).

We also wished to explore the possibility of engendering narratives that work with past, present, and future life expectations and the relationships involved. We were inspired by the work of Ochs and Capps, who consider the use of narrative as a means of sense-making in which ‘narrative … is a fundamental means of making experience … . Narrative activity provides tellers with an opportunity to impose order on otherwise disconnected events and so create continuity between past, present and imagined worlds’ (Ochs and Capps, 1996, p. 19) where ‘we use narrative as a tool for probing and forging connections between our unstable, situated selves’ (Ochs and Capps, 1996, p. 29). With this in mind, the final perspective entails:

4. Temporality: As our interest lies more in the processes of how people bring narratives to life as opposed to thinking of narrative as an after-the-fact account, we were interested in exploring how we could better account for the dynamic, relational, and temporal nature of how narratives emerge as a sense-making process. To this end we were inspired by John Gatewood (1985) who, having identified a ‘disregard of action in cognitive anthropology’ and a ‘more fundamental lack of concern with the temporal dimension of knowledge,’ suggested that ‘we change our analytical language habits. Rather than speaking of ideas, concepts, categories, and links, we should speak of flows, contours, intensities, and resonances’ (Gatewood, 1985, p. 216).

Exploring the relational through theory and practice

Informing the practice: complex processes of relating

Our investigations are informed by a focus on complex processes of relating (Stacey et al., 2000; Stacey, 2001; Stacey, 2003; Shaw and Stacey, 2006). This perspective understands the sociality of people’s collective actions and participatory practice by noticing the complex and processual nature of human knowing, doing, making, relating, and organizing. In this context, new meaning and learning (Buur and Larsen, 2010) arises from the ongoing gesture and response interactions between those involved (Mead, 1934) and are as such situated in that practice (Lave and Wenger, 1991). Lave and Wenger consider ‘learning and knowing as social participation, in which person, activity, and world are mutually constitutive, rather than on cognitive processes or conceptual structures. We
do not learn about a practice, they say. Our learning, as the experience of engaging day-
to-day as bodily persons in sustaining and developing meaningful activity with others, is
practice. Practice and personal identity emerge together as our experience of co-created
patterns of meaning’ (Shaw, 2002, p. 166).

The view that social interaction is transformative had a major influence on our work.
Of particular importance to us is the pragmatist George Herbert Mead's notion of the
simultaneous shaping of mind, self, and society. Mead (1934) understood this creation
of mind, self, and society as emerging in local, social interaction. This understanding
shifts the focus from the individual and their relation to the overall situation to a focus
on the processes of relating, which Mead called iterations of gesturing and responding.
Instead of understanding communication as sending and receiving messages to convey
what is already thought, Mead saw communicative interactions as transformative; as cre-
ating and changing mind, self, and society in one and the same action. In this gesturing
and responding, we re-interpret our own gesture according to the response we get. This
idea is similar to Johnstone's (2012) understanding, according to which the role of the
actor in theatre improvisation emerges in the re-acting towards the other actors (Larsen
and Friis, 2006).

Following Mead and Johnstone, conversation and bodily communication is an act
of gesturing and responding in ongoing improvisation. Similarly, in improvisation one
spontaneously responds to another's gestures. As such we do not know the full meaning
of what we are doing until we have done it. Meaning emerges through the process of
having intentions, acting, and getting a response. This is a social process where we create
meaning together by what we are doing, in the act of doing it.

Doing the practice: improvised participatory theatre workshops

Improvised theatre enables professionals', patients', and lay people's narratives to
be co-constructed. Participant reflections are brought into play with actors as real-
time improvisations to explore the relational issues that emerge. We call this process
‘working live’ (Larsen and Friis, 2006, pp. 21–39), which is mainly carried out in the-
atre workshops.

Working live confronts participants with challenges and issues in their social life and
creates space for the emergence of alternative forms of being. It provides a means through
which participants and actors can experiment with and capture the emergence of under-
standing through live, improvised exploration (Larsen and Friis, 2006, pp. 21–39). This
theatre-orientated workshop method allows important issues to surface, which partici-
pants might not otherwise identify or be willing or able to express (Larsen, 2006; Larsen
and Bogers, 2014). Theatre workshops also provide a forum that supports the reflexivity
required for a change in attitudes and practice (Pääsillä, Oikarinen, and Harmakorpi,
2015). Participatory theatre methods have unique capacities for 1) sharing perspectives,
2) using fiction as a way of dealing with difficult and conflictual topics, 3) making sense
by coming to recognize the perspective of the other, and 4) providing opportunities for
working with many people (Larsen, 2011).
Improvised theatre is used to play out small vignettes based on real-life situations, after which people are invited to comment on what they have seen, how it relates to their own situation, and how they think the piece should proceed. Actors then improvise around the original situation by incorporating the suggestions of those present. The audience may improvise by taking over from one of the actors or playing another character to show their perspective or explore alternatives. This allows actors, audience, and researchers to run and re-run narratives to explore nuances of relating, of gesture, and response, and, in particular, to demonstrate how sense-making and meaning emerge from moment-to-moment interactions.

People can see how they actively or passively influence the going-on, ‘rehearse the future’ (Binder, Brandt, and Halse, 2009) by imagining future scenarios and explore alternatives by using ‘narrative as a tool for probing and forging connections’ (Ochs and Capps, 1996) in the unknown. Over time this collaborative layering of situated experience and informed experiment generates narratives that reflect a diverse range of participant perspectives on present and future healthcare practice, situations, and experience.

Although improvisations may be fictional, they are based on empirically gleaned accounts and informed by rich experience from previous workshop encounters. Our aim is to bring as diverse a range of perspectives as possible into play by encouraging disparate voices to be raised, of professionals as well as patients, and lay people. We wish to demonstrate how various attitudes influence, constrain or enable a sense of identity and practice and, in particular, we wish to challenge attitudes that are fostered by current approaches to healthcare situations. As indicated above, ‘practice and personal identity emerge together as... co-created patterns of meaning’ (Shaw, 2002, p. 166). Healthcare professionals often find themselves in situations where they create meaning with patients and, for example, with a patient’s family members. As such, we are not only interested in involving healthcare professionals in our workshops, but also patients, their families and or friends, and work colleagues. Participant numbers range from ten to fifty.

The theatre workshops allow the sharing of experiences that promote finding alternative ways of acting in a particular situation. Issues of fixed attitudes and sense of self inevitably surface. Through iterations of improvisation, discussion, reflection, and suggestion, participants experience first-hand the frustration, hesitation, and doubt of engaging in an unexpected interaction. They sense the dilemma of how to otherwise act in a vulnerable situation and gain new insights as they actively play out alternatives.

**From moment to moment**

This section briefly describes two instances from two improvised theatre workshops. The first deals with chronic pain, where those involved explore the knock-on, relational issues that can arise when a family member suffers from chronic pain. The second deals with GP–patient existential conversations and describes a situation where a patient is wondering if he will meet his now-deceased wife in the next life.
Chronic pain—but how to talk about it?

The following incident occurred at a theatre workshop held at the International Conference on Narratives of Health and Illness 2016 on Tenerife. Keynote speakers were, among others, Professor Brian Hurwitz, Director of the Centre for Humanities and Health, King’s College London, UK, and Arthur Frank, Emeritus Professor at the University of Calgary, Alberta, Canada, and author of *The Wounded Storyteller* (1995). Conference delegates were, for the most, healthcare professionals and illness narrative researchers.

The workshop began with a three-minute scene that was part of a fuller narrative developed over the past three years (an abbreviated version of which is in Larsen et al., 2017). The main characters in the scene are Peter and Hannah; Peter is a 63-year-old man with chronic back pain who lost his job as a result and now helps his daughter, Hannah, by picking up her children from daycare. As Peter is usually medicated, Hannah expects her father to take the bus to pick up the children. When Hannah gets home from work she discovers that her father has picked the children up in his car. A strained conversation takes place, where little is said, but it is clear this is an unresolved issue that has arisen before.

After the scene, the facilitator asked the audience to discuss what they saw. For the next ten minutes there was a lively discussion that focused on the implicit nature of the non-verbal interaction, driving the car, safety, lack of trust between father and daughter, the children being looked after by a medicated grandfather, and lack of communication. The people in the audience, all medical professionals and researchers, tended to suggest solutions rather than pursue the relational implications of what they had witnessed. After the discussion, the facilitator suggested playing a scene where the daughter, Hannah, talks to a friend about her father. A young woman in the front row of the audience offered to act as Hannah’s friend. The actress who played Hannah and the woman who played the friend did not otherwise know each other.

What followed was a four-minute scene between the two. Hannah, played by a trained actor, was clearly distressed, yet reluctant to share her situation with her friend. She initiated the conversation by indicating how overwhelmed she is feeling with work. The friend encouraged her to ‘tell me more.’ Instead of answering, Hannah turned to the audience and asked, ‘What do I say?’ The following suggestions were given:

Audience: It’s my dad.

Hannah turns to her friend: It’s my dad. (She shakes her head slightly.)

Friend: Oh . . .

Hannah: Yeah.

Friend: Is everything ok?

Hannah: Well. . . (Turns to the audience with open arms) Can you help me?

Audience: He won’t use the seat belts in the back seat.

Hannah: He won’t use the seat belts in the back seat.
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Audience: The children.

Hannah: (To her friend) Yeah, because he won’t use the seat belts in the back seat with the children. He’s risking the twins. I mean ... I feel so upset about it. (Hannah slumps in her chair, clearly in despair.) But how to talk about it? I mean, he’s my father who has brought me up. He’s always been there for me. And now I think like it’s changing. Something is changing and I don’t know how to talk with him. To be honest, I don’t know.

At this point the friend turned to the audience to ask for help. The audience laughed as she had clearly adopted the same technique as Hannah.

At this point the facilitator intervened to ask the ‘friend’ how she would act in real life. ‘Brutally honest,’ was her reply to the facilitator. ‘Say it, say it,’ he suggested. As the conversation continued, Hannah became more upset. The person playing the friend turned to the audience, lifted the back of her hand to the side of her mouth as if she was trying to hide a secret from Hannah, laughed a little and whispered: ‘I want to give her a hug.’ The friend then turned to Hannah and they both embraced in a long hug. The response to this genuine expression of compassion was quite palpable. The audience laughed and clapped. Those on stage smiled and clapped.

Existential conversations—will I see my wife again?

At the start of the workshop the participants, 25 GPs, were introduced to a short vignette that described how a doctor ignored a patient’s request for sleeping tablets and prescribed tranquillisers instead without asking the patient why he is troubled, which he clearly is. After a discussion between the participants as to what the issues might be, the patient-actor, Jorgen, interacted in three separate situations with three of the GPs present. Each tried to find a way of engaging Jorgen, with various results. In the vignette, the patient Jorgen is 65. His wife died two years ago after suffering from multiple sclerosis for many years. A couple of years before she died he stopped working to take care of her. During this period he lost contact with his friends and workmates, and is now feeling rather lonely.

Although we invented this story as a baseline for the actor, the development of the conversation was genuinely improvised as he needed to react to the response from the GP. The actor was very experienced in this kind of improvisation, so he was able to stick to the role as well as relating to the GP’s response.

1. The first doctor (‘Alice’) offered to interact with Jorgen. Jorgen became very emotional, and said: ‘My wife was very strong, and what made her strong was her trust in God … Her last words to me were: we’ll meet again!’ He tried to hold back his tears then looked directly at the GP. ‘But will we?’ he asked.

Alice attempted to engage Jorgen, but was rather hesitant and non-plussed by the conversation. After a few minutes she turned to the facilitator and asked for a time out. Although the conversation was short, it still raised a number of issues.

The facilitator asked the participants to discuss what happened. The question as to why Alice stopped the conversation at that particular moment came up. It was clear to many
in the audience that she twice avoided the question of whether she believed Jorgen would meet his wife again. The facilitator gestured to Alice to comment: ‘I understood what was going on,’ she said. ‘I felt it intensely . . . but what can one do?’ Her question resonated with similar struggles the other participants had experienced.

This disclosure initiated a conversation about the difference between a GP’s professional role and their presence as a fellow human being. As one participant pointed out, ‘Sitting here in the audience I was very touched by what was going on. If I’d been the GP in that conversation, I couldn’t have just sat in front of the patient with tears in my eyes. I would have had to put on my professional mask.’

2. The facilitator suggested ‘So let’s continue the conversation with Jorgen,’ but he is interrupted by one of the course leaders who suggested a coffee break. This was immediately vetoed, as the participants wanted to continue. Another GP (‘Beatrice’) accepted the invitation to continue the conversation with Jorgen. She decided to improvise a consultation that happened a week after the first, and she has put 20 minutes aside.

At first their exchange was a little hesitant, but it created a sense of trust. Beatrice, picking up on the thread from the week before, began to discuss with Jorgen whether he will meet his wife again. ‘Will I?’ he asked. She returned the question: ‘Will you?’ He shook his head slowly: ‘No, I don’t suppose I will.’ Once again she returned the question: ‘You don’t think you will?’ ‘I don’t know,’ he said after a while. From here the conversation drifted towards more general topics.

Beatrice made several attempts to return to Jorgen’s question of faith, but as her questioning continued with the circular or mirroring technique, the intensity of the exchange once again receded.

The facilitator stopped the improvisation and asked the audience to comment, and in the ensuing discussion, the point was again made that Beatrice tried to avoid questions about faith. ‘You were asked about your belief, but answered by talking about your sense of community,’ the actor said. Beatrice thought for a while and responded, ‘Yes, you’re right. Community I understand better than faith. I’m more comfortable talking about that. But then of course I could feel how we avoided the main question.’

3. Yet another GP (‘Cecilie’) wanted to try a conversation with Jorgen. She started by going straight to the point about his wife and her faith that Jorgen now misses.

Jorgen: That’s what made her so strong, her faith . . . do you recognize that?

Cecilie: What do you mean?

J: Well . . . that faith is something that helps you?

Cecilie hesitated, and then:

C: Are you . . . are you asking me personally whether to believe helps me . . . is that what you’re asking? If believing helps me?

J: Yes.
Jorgen looked at her intensely waiting for an answer.

C: Yes ... in a way I suppose ... in an unconscious way ... quite often.

J: OK?

Jorgen waited for more to come, and then:

C: It's not something I'm consciously aware of ... but I can sense that it does mean something.

J: (Insistent) But how can you sense it? ... That's just it ... I can't feel it any longer ... 

C: No ... Your wife ... That must be difficult.

J: (looks away as if it is not his wife he wants to talk about) Yes ... no, it wasn't that easy with my wife ... but you say you can sense it?

C: Yes!

J: But how?

C: (Once again searching for the right words) I think ... it feels like ... making sense ... in a different way ... 

She emphasises the words 'making sense.' Jorgen sits back, nodding slowly.

The facilitator moved onto centre stage and asked the others to comment. The intensity we sensed in the room confirmed for us that this was an important move and needed careful reflection. In other work (Larsen, 2008; Larsen and Friis, 2006; Shaw and Stacey, 2006) we have noticed that conversations that lead to a new understanding usually have the character of half-articulated sentences, to which others then respond.

In the ensuing discussion, the first GP suddenly realised that circular questioning (the so-called 'mirroring' technique), albeit helpful in some circumstances, promoted a 'safe' distance towards the patient. Thus, when working with existential conversations in a doctor–patient relationship, the topics that are interacted with, the roles of patient and physician, the understanding of what ill and healthy means, and what caring is, must be challenged.

**Shifting from individual to relational**

**Challenging attitudes to chronic pain**

Current attitudes and practices to chronic pain focus on individual experience, self-motivation, and efficacy (Mann, Le Fort, and Van Den Kerkhof, 2013). Lisa Käll (2013, p. 1) describes pain as the source of sorrow, suffering, hopelessness, and frustration. She contends that there is perhaps no experience that better brings to light the singularity and solitude of our lives than the experience of pain (Käll, 2013, p. 27). However, Kruks (2001) describes a notion of pain as an intercorporeal weave that is established between sufferer and witness to that suffering. In other words, pain can also be considered as relational.
Nanna Johannesen identified a discursive figure, ‘the good chronic pain patient’ with its attitudes and expectations of control, self-management, mastery, coping, administration, organization, and lonely struggle (Johannesen, 2011, p. 169). These expectations demand that a person to be willing to accept their new situation, take on a new identity, fight, battle on, and altogether manage alone. Johannesen is careful to explain that this approach is not necessarily negative, but its singular focus diverts attention from what else is going on for both the individual and those they relate to, which in turn affects their well-being, such as: ‘lifelong and continual identity construction and reconstruction; a lack of a linear sense of time, thereby limiting a person’s ability to structure their self-narrative as a chronological account; a lonely position as a self-reliant and self-organising individual; a lack of witnesses to a person’s struggle and subjective relationship to pain’ (Johannesen, 2011, p. 168). Nuances of suffering are often hidden or silenced by the widespread notion of acceptance and control. Johannesen makes the point that those involved in a chronic pain situation are interdependent on each other and that the individual, even when alone, is in relation to others. Relation and sociality are closely intertwined with identity and sense of self, as on a very basic level identity can be considered something that is established in relation to others.

As became clear in the workshop snippet above, a person’s chronic pain can have an almost predatory influence on the relationships it ensnares. Chronic pain weaves its way into the very fabric of people’s daily lives, both at work and at home, thus influencing the relational. Chronic pain can be seen as an interdependent, communicative, and relational phenomenon that influences, and is influenced by, patients’ quality of life, condition, and interaction with others, both private and professional.

**Changing attitudes to practice**

As a relational understanding of chronic pain challenges known attitudes, this begs the question as to how it could influence professional healthcare practice. One of the contributions of our theatre workshops is that we are able to identify a degree of nuance that further expands, for example, Kruks’ notion of the intercorporeal weave and Johannesen’s notion of the sociality of chronic pain. By asking healthcare practitioners to engage in our improvisations, they are able to experience alternative practices.

Common to our theatre workshops were discussions among the professional participants that often led to a greater understanding of the role of the medical practitioner and of what constitutes his/her professionalism. It became legitimate to consider good doctoring as a process that also involves investing oneself in a conversation, in particular in a vulnerable encounter, by surrendering to its emergent quality and relational resonance. Entering this improvised mode of relating with the patient creates a quality in the conversation (Buur and Larsen, 2010) that can lead to a sense of meaning that cannot be otherwise achieved. This demands having an eye for the overall situation while sensing the nature of the moment as it emerges. In other words, at the same time as engaging in a conversation on a personal level, the clinician is able to keep a professional distance. The sociologist Norbert Elias called this the paradox of involvement and detachment (Elias,
1956)—a paradox that could almost be described as being in two temporal attentions at the same time.

In conclusion, this chapter now look more closely at the micro-narrative of practice that such an encounter entails.

**Being present by staying present**

Both the short exchange between the two friends in the chronic pain workshop and the patient asking the GPs if he will see his wife again touch on the same issue of engaging or surrendering to a shared vulnerability as a natural part of professional practice. Hannah’s friend, who turned to the audience and admitted she wanted to give her a hug, was possibly in a similar dilemma. She was suddenly overwhelmed by an urge to express her compassion for Hannah, but was briefly caught by a need to have her professional colleagues in the audience sanction what she wanted to do. One can almost hear her asking if it is ‘alright if I give her a hug.’ Her secretive hand gesture and whisper strongly suggest this. In the existential conversation situations, it was clear the GPs floundered somewhat as to how to engage a situation where professional distance could not resolve their dilemma. They lacked the means to extend a genuinely compassionate gesture. To do so meant that they, too, had to embrace the vulnerability and risk involved by lowering their professional shield.

Improvised theatre clearly has a role to play in both engaging people and helping them better understand the relational nature of what it means to participate in a vulnerable situation, regardless as to whether it concerns chronic pain, an existential dilemma, or otherwise. But, the theatre is not just describing health and illness narratives that have taken place. It engenders and co-constructs them through its active involvement of all participants as new interpretations and new narratives, while at the same time challenging those involved to fully consider how they both do and can engage a healthcare situation. The interactions described here wavered between a professionally shielded response and an expression of compassion as a surrendering to the situation that emerged. In both the situations sketched above, and in other theatre workshops, it has become clear that in order to improvise, to compassionately surrender to the shared vulnerability of a situation, one has to be present and stay present.

But what is the difference between being present in an improvisation and not being present? Keith Johnstone (1999), who has spent a lifetime training actors in improvisation, defined presence as a degree of listening, but realized it is not enough to be a good listener. Having observed many actors improvising, he comprehended that, apart from listening and being interested in what your partner is telling you, ‘you must be altered by what’s said’ (Johnstone, 1999, p. 59). Being altered in this case means you cannot stay unaffected, but will have to change a little, lose some control, and become someone slightly different from who you are, which may feel scary. The fear here is that you might make a fool of yourself or lose control (Larsen, Heape, and Ryöppy, 2017).

What is needed in an improvisation is to move from something known to something that is unknown that emerges in the collaboration between the actors. Good improvisers are
willing to pick up on new ideas, which means they lose some control. They become vulnerable in the unknown situation, as they don’t know what they are in the midst of, where they are heading, or how they will handle what they encounter. ‘Who am I if I can’t handle the situation?’ also brings questions of identity into play (Larsen, Heape, and Ryöppy, 2017).

Therefore, in order for an actor to improvise with the GP, he has to be present, be willing to follow the GP, and allow himself to get into situations he may not know how to handle. But if we shift the perspective from the actor to the GP in the improvisation, the demands are the same. To be present in a conversation with an existential topic, the GP cannot stick to the well-known role of GP, but has to be willing to be changed through the interaction with the patient and ‘be altered by what’s said’ by following the invitation from the patient to engage in mutual improvisation.

When the patient asks the GP: ‘Will I meet my wife again?’, this acts as an invitation to a mutual improvisation with the GP. By following the invitation the GP allows herself to acknowledge, surrender to, and work with her uncertainty in relation to the patient’s. He is as uncertain as she is! By acknowledging their mutual uncertainty, albeit unspoken, both GP and patient now find themselves in a common ground of vulnerability—not necessarily equal, but common, as it has emerged from their uncertainty. By staying present in this shared vulnerability, it initiates and legitimizes a positioning and repositioning to each other. A re-patterning of the conversation emerges on which each can act and respond from moment to moment. By surrendering to that vulnerability and improvising with it, they can both recognize, respond to, and meet each other in a spontaneous, empathic, and mutual gesture of understanding.

In their moment-to-moment interaction and improvisation a new co-constructed narrative emerges from the re-patterning of the conversation. By exploring the fictitious situation, which is still linked to known practice, those involved are present in the known and the unknown. Together they weave a new, believable, narrative of practice to life and in the process, through a number of iterations, they change their practice as an improvised response to the resonance of the situation as it unfolds. This change of practice may be barely noticeable, but it is change, nevertheless.

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