Beyond you and I: role play and reflection-in-action in communication training

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ABSTRACT
This article will explore the development of communication training within nurse training. Beginning by outlining current thinking around this practice, it then discusses Schön's notion of reflective practice and its frequently cited relevance to nursing before pointing out some of its limitations. In particular, it looks at the limitations of the individual being able to critically reflect on their self within a broader social context. Drawing on the theories of Habermas and Bourdieu, it suggests that encouraging a greater awareness of one's own social context, and hence of one's own subject position, would develop a deeper awareness of other potential perspectives and a better ability to listen to patients. Finally, it argues for the use of role play in assisting nurses to gain such awareness, particularly in difficult clinical situations such as end-of-life care.

This article is based on some work done at Buckinghamshire New University where Nursing students worked alongside Performing Arts students. A training programme adopting a well-evaluated simulation model (Agnew, 2009; Fallowfield et al., 2002; Wilkinson, Perry, & Blanchard, 2008) was delivered as a core component of post-registration nurse education for end-of-life care, intensive care and District Nursing. Healthcare policy now strives to deliver patient-centred care, that is care that focuses on patient-centred communication and the development of partnership working (Ishikowa, Hashimoto, & Kiuchi, 2013). This focus on patient-centred care is reflected in end-of-life care policy which identifies the importance of offering patients choice in their care and exploring what is important to them (The Choice in End of Life Care Programme Board, 2015). Communication is central to the paradigm of patient-centred end-of-life care. Recent healthcare policy related to end-of-life care recognises the centrality of honest conversations between the Health Care Professional (HCP), the person dying and their families which support the patient to make informed choices as a central concept and a key indicator of quality of end-of-life care (Leadership Alliance for the Care of Dying People, 2014; National Palliative & End of Life Care Partnership, 2015; The Choice in End of Life Care Programme Board, 2015). A recent audit indicates some improvement in how HCPs communicate with people at the end of life (Royal College of Physicians, 2016). However, many people do not have the opportunity to engage in sensitive and honest conversations about their end-of-life care (The Choice in End of Life Care Programme Board, 2015).

The simulation model used in this training explores scenarios focusing on difficult conversations about end-of-life care issues, such as delivering and explaining bad news, discussing transitions to dying

and dealing with patients' and relatives' anger or denial. These difficult conversations are explored using role play. The performing arts students take on the role of the patient or relative and the nursing students have the opportunity to practise communication skills with feedback from the facilitator and their peer group. Conversations around dying are challenging and evidence indicates that HCPs find these difficult (Barclay, Momen, Case-Upton, Kuhn, & Smith, 2011) and engage in avoidance strategies (Griffiths, Ewing, Wilson, Connelly, & Grande, 2015). This suggested to us that the model of training needed to move beyond skills acquisition towards facilitating HCPs' awareness of using communication skills in conjunction with reflection-in-action.

A key model of reflection-in-action was outlined by Schön. His first book on reflective practice's subtitle 'How professionals think in action' suggests that an action can contain thought, even if subconsciously, and it is this idea that motivates Schön. For him, understanding happens *through* and *in* practice. He coined the term 'reflection-in-action' to describe the activity of professional practitioners. Reflection-in-action involves critical thinking in the moment and gives rise to a multi-faceted experimentation in the moment, being 'exploratory, move testing and hypothesis testing' (Schön, 1987, p. 72). Reflecting-*on*-action done retrospectively is more limited, dealing primarily with hypothesis testing, involving looking back on a situation by which time the opportunity to explore, try out ideas or ultimately change the outcomes has long since passed.

In developing this notion, he was keen to challenge what he calls 'positivist doctrines' where 'practice appeared as a puzzling anomaly' (Schön, 1983, p. 51) to a culture of professionals and educators who found the phenomena of reflective practice 'disturbing' (Schön, 1983, p. 19). For Schön, this disturbance occurs for professionals who rely on 'scientific' knowledge, or what he terms 'Technical Rationality', to solve practical problems. The technical rational skills feel safer, but in fact are rarely helpful for practitioners working in complex and unpredictable settings. In reflection-in-action, Schön posits as an alternative the flexibility of expert practitioners who see, in specific instances of practice, ways to alter and modify their behaviour in ways that are appropriate for them.

He argues that 'inherent in the practice of the professionals we recognise as unusually competent is a core of artistry', and that this 'artistry is an exercise of intelligence, a kind of knowing' (Schön, 1987, p.

13). The 'artistry' reflects a complex understanding that goes beyond what someone who only theorises can achieve. The skilled practitioner presents a challenge to the hegemony of Technical Rationality, a positivistic academic model premised on prior knowledge, by demonstrating instead 'a kind of knowing which does not stem from a prior intellectual operation' (Schön, 1983, p. 51). In this conceptualisation, practice and theory are not separated but co-exist: citing Gilbert Ryle, he states '"thinking what I am doing" does not connote "both thinking what to do and doing it". When I do something intelligently ... I am doing one thing and not two' (Schön, 1983, p. 51, quoting Ryle, 1949, p. 32).

In relation to our specific area, managing end-of-life conversations, the immediacy glimpsed by reflection-in-action to reshape the activity in the moment is important as the opportunities to go back and re-run a conversation or to redevelop a conversation are limited. HCPs routinely manage difficult conversations with both patients and families. The need for patient-centred communication has led to a focus on HCP behaviour (Ishikowa et al., 2013) and skills (Wilkinson et al., 2008). However, communications training needs to move beyond HCP behaviour modification and skills acquisition in order to realise healthcare workers proficient in managing the ebb and flow of difficult conversations. It is important that the focus on the HCP behaviour is not just a further example of developing 'safe' technical rational skills, but rather facilitates and encourages HCPs to reflect-in-action whilst communicating.

Whilst working with the simulated conversations, the HCPs are encouraged to listen to the patient's story and to reflect on what is happening for the patient so that they can reflect that back to them and chose an appropriate response. They are also encouraged to be aware of their own feelings and to consider and share how these will influence their response, becoming aware of their own agenda with regards to gathering information regarding physical information, giving of information and planning of care. The reflection focuses on what is happening here now in this moment for this person: How am I feeling about that? What is my agenda? How can I meet this person's needs rather than my own? This reflection-in-action is achieved by stopping the role play and asking the nurse to reflect on these questions with the help of the peer group, facilitators and feedback from the actor. The importance of

tuning into the situational context of the conversation moves the training from prescriptive skills acquisition to learning to facilitate the telling of the patient's story and exploration of their needs.

What is reflection-in-action?

Reflection-in-action can be broken down into four stages: routinised action, encounter of surprise, reflection and new action (Schön, 1987; also cited in Yanow & Tsoukas, 2009). The suggestion is that reflection-in-action begins with a routine activity which produces a surprise, something unexpected which the practitioner needs to tune into so that they can reflect on what is happening, questioning the assumed knowledge and mode of operating, and leading to on-the-spot experimentation.

HCP engagement with the patient or family could be regarded as a routinised practice in the sense that such behaviour is familiar, and as patient-led conversations develop, HCPs 'hear' the patient's agenda and respond to it. The very fact that the patient has given a cue for discussion may be the element of surprise. Alternatively, if the way a patient responds to information cannot be anticipated, the patient's response becomes the element of surprise. Increasing HCPs' awareness of the process of reflection-in-action alongside developing communication skills may be a key attribute required in transferring the skills developed in training into the clinical setting.

Nurse education has widely adopted the use of reflective practice, and a number of models of reflection have been developed and adopted within nurse education (see, for example, Gibbs, 1988; Johns & Freshwater, 2005). When teaching nurses to reflect, the emphasis usually appears to be on reflection-on-action with a focus on cognition and theoretical concepts, leading to missed opportunities to fully realise its potential as the subtle moment-to-moment cognition and the professional artistry is often neglected in nursing (Edwards, 2014). As nurses need to have scientific knowledge, it is possible that this leads to the restrictions in the opportunities to fully develop reflection.

Like Schön, Carr and Kemmis (1986, p. 132) note the limitations of a supposedly scientific discourse. Discussing the early twentieth century, they suggest that a 'conformity with established ways of thinking' ossified into orthodoxy, meaning that 'questions of the values underlying these courses of

action were believed to be beyond the scope of science and were therefore left unexamined'. Carr and Kemmis, like Schön, invoke the word 'technical' in mapping this approach onto Habermas' notion of the 'technical interest', which is 'the interest of human beings in acquiring knowledge that will facilitate their technical control over natural *objects*' (Carr & Kemmis, 1986, p.135, our emphasis). The word 'object' is an interesting choice in the context of nursing, where the importance of the danger of *object*ifying a patient, presuming they will have a particular response, might be contrasted to a focus on the variety and complexity of responses offered by an individual human *subject*.

As an alternative to the supposed objectivity of the 'technical interest', according to Carr and Kemmis, Habermas outlines two other 'interests' which constitute human knowledge: the practical interest and the emancipatory interest. The practical interest, linked to an 'interpretive' approach, focuses on interpreting the practical specifics of each subjective human act of communication rather than a generalised response. Here, as in Schön's model, there is a capacity to adapt and be flexible in response to a specific situation. The supposed scientific objectivity of the 'technical' response is superseded by a more complex and considered 'human' response. Through these ideas, one might see the practical interest and reflection-in-action as offering a model where moment-by-moment cognition through the practice of communication offers the chance to constantly reassess and modify behaviour.

However, for Carr and Kemmis, Habermas identifies a limitation to the practical interest that might be usefully mapped onto Schön's model above. According to them, he suggests that such a model 'fails to recognise that the subjective meanings that characterise social life are themselves conditioned by an objective context that limits both the scope of individuals' intention and the possibility of their realisation' (Carr & Kemmis, 1986, p. 135). In other words, the subjective interactions employed by individuals in attempts to communicate also exist within a wider social context which influences and limits the capacity of individuals to create and modify their behaviour. Habermas' third 'interest', the 'emancipatory interest', understands a bigger context within which individual acts occur: how the individual and social contexts might interact.

An understanding of the limitations and opportunities of Habermas' three interests supports the development of a socially aware reflection-in-action. The limitations of the supposed objectivity of the technical interest, focused solely on effective reflection leading to the mastery of a supposedly 'objective' practice, are exposed by the potential of subjective negotiation present in the practical interest, and are similar to Schön's critique of 'Technical Rationality'. Yet the practical interest, too, is limited. The practitioner is limited to her experiences. There is limited identification of the need to seek perspectives beyond current known practice. The emancipatory interest, however, outlines the need for the practical interest to be understood as not a universal principle but rather as a subjective experience that is in turn influenced by social structures. Here, the historically specific nature of a supposedly neutral 'interest' is realised. It allows the individual practitioner to move beyond a fixed sense of what would count as successful reflection towards a broader reflection-in-action, which could include questioning the supposed intention and context of the reflection.

During the communications workshop students are encouraged to reflect on their feelings. It is common for them to question whether they have the necessary experience or authority from their organisation to engage in difficult end-of-life care discussions. Cultural issues and past experiences also emerge as barriers to nurses feeling empowered to facilitate these sensitive discussions. The workshop allows for such barriers to be explored and for facilitators and peers to challenge assumptions. The students are then encouraged to engage in the role play moving beyond their perceived boundaries.

Applying socially aware reflection-in-action to nursing practice

This wider context can bear on the relationship in a variety of ways. In a very obvious sense when considering a response to a patient, the social circumstances of time limitations caused by wider funding decisions may influence a nurse's capacity to make decisions. There may be occasions when the luxury of a 'practical' response is not available; where quick judgements have to be made without the luxury of discussion. The nurse's own sense of how s/he is being measured might influence them to see certain outcomes as being more important than others. Yet in the moment, these social considerations can be invisible to the practitioner. Furthermore, the patient's own understanding of what s/he sees as desirable outcomes are socially influenced. A terminally ill patient might imagine

that they do not have the right to feel angry, or they might feel that it is their job to be strong for their family. They might have unrealistic expectations of what is medically possible. For the nurse, grasping the lack of certainty over what is and is not 'true' means that neither they nor the patient can have a monopoly on what the best means of responding to a complex situation might be, and emphasises the crucial role played by effective communication in the nurse–patient relationship. Both parties in the communication will inevitably have limitations to what they can imagine due to their socio-economic background, their ethnic background, and indeed an infinite range of factors determined by their individual experiences. The 'experimentation' identified as part of reflection-in-action by Schön, in a notion of 'routine', may in itself become limited to the 'practical' interest, and fail to address the possibility of alternative approaches located beyond the individual's experience – nurse and patient. Beyond this, it may also limit awareness of broader questions regarding institutions and social, political and cultural contexts. On the other hand, encouraging an awareness of social context as well as the immediate situation means that a 'critical social science' is created that 'goes beyond critique to critical praxis; that is, a form of practice in which the "enlightenment" of actors come to bear directly in their transformed social action' (Carr & Kemmis, 1986, p. 134). (We will discuss the theatrical language employed here later in the article.) In such a notion of socially aware reflection, whilst there are evident links to reflection-in-action, there is a shift towards a need for the nurse to reflect more widely on the specific contexts one is in, and an encouragement to question the assumptions of both oneself and the patient.

The importance of such a socially aware reflection is present in the theory of the French sociologist Pierre Bourdieu. Bourdieu outlines the notion of 'habitus', a 'structured and structuring structure' (Jenkins, 1992, p. 141) within society which structures its human subjects. The notion of habitus suggests that values and truths which occur as universal to people, including workers in the public sector such as nurses and teachers, are actually socially constructed. Bringing this notion into conjunction with a socially aware reflection-in-action further encourages attempts to make the invisible visible; to question what one takes for granted.

This habitus is, however, fluid and changes over time, meaning that '[h]abitus is not the fate that some people read into it. Being the product of history it is an *open system of dispositions* that is constantly

subjected to experiences, and therefore constantly affected by them in such a way that either reinforces or modifies its structures' (Bourdieu & Wacquant, 1992, p. 133, original emphasis). In other words, the human subject is constantly placing day-today experience next to their pre-existing habitus and is modifying behaviour in the light of this dialogue – s/he is what we might call socially reflecting-in-action. In a later essay, 'Understanding', Bourdieu develops this notion by proposing life as a 'regulated improvisation' (Fowler, 1996, p. 10). The human subject, nurse and patient, is caught within habitus, a structure. However, within this structure there is nonetheless the opportunity for improvised moments of negotiated behaviour; chosen patterns of behaviour which offer the potential of a break with habitus and the existing sense of what behaviour is appropriate. In this model, theory (in an admittedly vague way) enables the person in power to examine their behaviour and to critically reflect on it as they do it.

However, more importantly, whilst the theory modifies the action, the action itself is crucial, since it is only through action that discovery is made possible. The theory in itself would remain abstract without the practice of the practitioner. Through reflection-in-action, that questions the social context as well as their own action, the practitioner can see more fully what is happening between them and their interviewee or their patient. By pointing towards a socially conscious reflection-in-action that is aware of other realities than that of the practitioner, by acknowledging subjectivity and eschewing positivism, an ongoing process of reflection aimed at understanding better what is happening between and within people at any given moment can be glimpsed.

Role play, acting and improvisation

For us, such a focus on relationships and communication has an inevitable link with the role play we undertook, and the focus on the word action and the notion of the practitioner as an 'enlightened actor' outlined by Carr and Kemmis (1986) above is also suggestive. We have suggested, via Schön, that through practice, in action, in undertaking an act, in acting, there is a possibility of reflection. Furthermore, through this reflection there may be the possibility for the actor to change as a result of the action. Such a notion concerned Plato, for whom the imitation offered by acting would potentially fragment the performer and the spectator's identity as he loses his grip on his true self, a situation 'unsuitable for Our State, in which human nature is not twofold or manifold, for one man plays one

part only' (O'Toole, Stinson, & Moore, 2009, p. 16). Acting is seen as 'disturb[ing] the clear partition of identities, activities, and spaces' (Rancière, 2004, p. 13). As Joe Kelleher summarises, for Plato 'actorly representation, or *mimesis*, which involves the actor in a division between himself and the character he is imitating or inventing, is a sign of human weakness. It is also a means of provoking weakness in others, and hence a threat to or an infection of the body politic' (Kelleher, 2009, p. 48). As Hallward (2006, p. 116) notes, 'if Plato is especially hostile to theatre it is because those who speak on the stage do not speak in their own name and do not identify with or authenticate what they say'. Acting opens up a space that cannot be reduced to either role or actor. In this space, Marvin Carlson (2004, p. 16) discusses 'not so much the "set-apartness of performance but its 'in-betweenness'", its function as transition between two states of more settled or more conventional cultural activity'. Not only does performance often blur the boundaries between truth and illusion, but there is also an inherent duality in the simultaneous reality of the live acted event alongside its existence as fiction.

Rather than seeing the role play as only being about enacting reality then, it is seen as a space to explore potential ways of behaving. It is a way of reflecting on reality, or reflecting-in-reality, but is nonetheless not reality. It provides a distance from the real. This sense of 'distance' through acting was foregrounded by perhaps the theatre practitioner most famous for developing a socially aware theatre, the German director and theorist Bertolt Brecht. He suggested that the stage can provide a distance through which the spectator can see more clearly. He coined the term 'Verfremdungseffekt' to describe his ideal performance style, variously translated as distancing effect, making strange or more usually 'alienation effect' (Willett, 1978). He said 'The A-effect consists in turning the object of which one is to be made aware, to which one's attention is to be drawn, from something ordinary, familiar, immediately accessible, into something peculiar, striking and unexpected' (Willett, 1978, p. 143). He further states that through his technique 'everyday things are thereby raised above the level of the obvious and *automatic*' (Willett, 1978, p. 92, our emphasis). His desire to resist seeing things as 'automatic' seems to chime with our notion that through role play a consideration of a range of potential behaviours beyond the 'automatic' responses of the protagonists can be glimpsed.

To avoid the situation identified at the beginning of this paper, a nurse working with families in difficult situations who is willing to open up the self to not only experimenting within their own experience but with alternative roles, may find considerable benefit. It may allow him to develop a heightened awareness of what is happening in the live present and adopt a more fluid approach where he is open to what is happening in the moment between him and the patient and/or their families. In contrast, relying on 'instinct' may mean repeating the learnt habitus of the nurse, or adopting the limitations of the scientific models outlined above.

But how might this be achieved? In their paper on reflection-in-action, Yanow and Tsoukas (2009, p. 1356) discuss an expert practitioner – in their case a teacher – stating 'I trust myself to improvise: if I trust myself as a teacher, then I can allow the unpredictable to happen'. This trusting occurs because of a self-confidence that allows adaptation and a willingness to let go of what is currently known and believed. They call this the 'permeability of self [that] entails a setting aside of one's ego, allowing someone else to share centre stage' (Yanow & Tsoukas, 2009, p. 1356). They suggest that this approach is a result of training and the ability to improvise in the safe space of training: 'To educate for reflective practice and reflection-in-action within it, then, we need to train for a sensitivity to backtalk and improvisational ways of responding to it' (Yanow & Tsoukas, 2009, p. 1359).

Improvisation is a pertinent model here. For Yanow and Tsoukas, Schön 'thought of improvisation as action made up entirely on the spot' (Yanow & Tsoukas, 2009, p. 1345). In fact, as they and several other writers on improvisation point out, the best theatrical improviser's work is 'based upon a repertoire that has been rehearsed – practiced – over time'. Heddon and Milling point out, via Foucault, that even when theatrical performers believe they are being original and creative,

> intuition functions paradoxically within the improvisation … An element of material generated by improvisation is recognised by company members as a performance solution and intuition authenticates that moment as original and a creative revelation. Yet, improvisation is always already conditioned by the mannerisms, physical abilities and training, horizons of expectation and knowledge, patterns of learned behaviour of the performers – their *habitus*, to use Bourdieu's phrase. (Heddon & Milling, 2006, p. 10)

Even when a thought or action seems radical and new, it will contain within it links to previous ideas and the limitations and experiences of the originator. As Yanow and Tsoukas put it, in the moment the improviser is participating in an act of what Lévi-Strauss calls 'bricolage', turning back to an 'already existent set made up of tools and materials, to consider or reconsider what it contains and, finally and

above all, to engage in a sort of dialogue with it' (Yanow and Tsoukas, 2009, p.1346, citing Lévi-Strauss, 1966, p. 35). Heddon and Milling, citing Henry Gates, point out that jazz improvisation 'is "nothing more" than repetition and revision', and for them 'a structured set of givens, rules of games can limit and contain the "spontaneous" input of the performer' (Heddon & Milling, 2006, p. 9, citing Gates, 1988, pp. 63–64).

This concept is shared with the students so that they have an insight into the learning opportunities that the workshop offers them and recognise that it is crucial in the workshop not to 'get it right', but rather to try out ideas. The aim is to create a safe place for them to explore and to enrich their own repertoire of skills which they can use within their practice.

If it is not possible to escape one's habitus entirely, improvisation's structures nonetheless provide a creative fictional space within which imagining becomes possible. In the fictional space of 'acting', such 'limitation' and 'containment', whilst inevitable, is more permeable than in the rigid roles laid down by everyday life. Indeed, structure can be seen as necessary and as providing boundaries within which practitioners can feel comfortable to be open to new possibilities. For example, Govan, Nicholson, and Normington outline Clive Barker's comparison of Theatre Workshop with 'a jazz combo', but with this jazz requiring more 'rigorous investigation of form, structure and style than playing in a symphony orchestra' (as cited in Govan, Nicholson, & Normington, 2011, p. 49).

This approach of having clear rules and structure was similar to our model. The communication skills training starts by encouraging students to review their own repertoire and to learn some new skills. Techniques such as asking open questions, picking up cues and using body language are explored before the students face a simulation exercise where they practise these skills. In the way that a jazz musician responds to their fellow musicians, calling on his repertoire of skills, the HCPs respond to the patient or family member in the role play scenario. The action can be stopped by the teacher or the student at any time. It is a space for discussion, not a place to be judged and get it 'right'. Through the use of role play where nurses try out ways of speaking to families and patients, a vocabulary is practised and developed which the nurse can draw on in their conversations with patients and families.

Improvisation may not initially appear to be the most comfortable terrain for someone training to be a nurse. Whilst listening may be a common clichéd expectation of a nurse, genuinely being open to dialogue on an equal basis may not necessarily come easily. Griffiths, Ewing, and Rogers (2010) identified that some nurses find exploration of psychological and emotional issues challenging and use blocking mechanisms such as focusing on practical tasks as a way of avoiding engaging in exploration of psychological and spiritual issues. Indeed, in our work we found that many nurses whose training was primarily focused on medical knowledge and procedural expertise had an in-built tendency to try and solve problems – using their habitus or their scientific knowledge to make things better for others. However, nursing behaviour is not only rehearsed (in the sense of coming from skills and knowledge the individual has developed over time) but also improvised (in the sense of only existing in the moment). Using actors alongside nurses to practise being in conversation with terminally ill patients and their families, in a fictional space where the nurse's focus can be on exploring ways of being present with the families, opening up a space where the skills and knowledge of medical training are combined with the flexibility of exploring different ways of speaking and behaving in a conversation.

What is crucial is that this space of improvisation is practice, not reality. Using improvisation techniques in the safe place of the training room can provide a safe space to try out alternative ways of acting beyond what comes naturally, and allow the nurse to begin to build up a vocabulary s/he can draw on in the reality of the hospital. Furthermore, a crucial aspect of allowing improvisation role play to reach its potential is the social opportunity to learn from others, and it is here that reflection-in-action is able to take on the broader awareness that allows the individual to move beyond their immediate experience. As Yanow and Tsoukas point out, (Yanow and Tsoukas, 2009, p.1345, citing Yanow, 2001, pp. 58–62) improvisation 'is a collective practice more than it is an individual one: "…improv teams practice together – work together, interact together, and observe one another extensively, over time"'. It was often through watching others do role play that our students reported having the biggest insights. Seeing how others speak and behave begins to open up the potential for recognising alternative ways of speaking and behaving in difficult situations. It provides a means of moving beyond reflecting on one's own behaviour by not only trying out other potential behaviours in

a role-play situation, but seeing the different ways others might behave. Similarly, when discussing action research, a process similarly focused on learning through doing, Carr and Kemmis (1986, p. 191) suggest that it 'is essentially participatory; it is collaborative when groups of practitioners jointly participate in studying their own individual *praxis*, and when they study the social interactions between them that jointly constitute aspects of the situations in which they work'. Becoming aware of one's habitus by trying out different approaches and witnessing those of others allows the nurse to become more fluid and open to dialogue with others, and t-o demonstrate flexibility in each individual encounter.

Such a skill is essential for those entering difficult conversations about end-of-life care. Whilst difficult, it is considered immensely valuable by participants. Our own students, whilst initially intimidated, ultimately recorded it as highly valuable. The value of using simulation training to develop communication skills is supported by a research study by Boss, Urban, Barnett, and Arnold (2013). Of the participants, 12 out of 13 rated similar training as one of the most important aspects of their clinical training. The model that we are developing at Bucks New University builds on this: through exploring ways of behaving and being in a safe space outside the reality of real patients' lives can enable nursing students to then feel confident to improvise in the real situation of palliative care. Ultimately, and more importantly, it can mean that patients can feel heard and understood during some of the most difficult moments of their lives.

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