Storytelling during Clinical Facilitation: An Arts-Based Narrative Inquiry

by

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Thesis
Submitted to Flinders University
for partial fulfillment for the degree of

Master of Clinical Education (Research)

College of Medicine and Public Health

21st February 2020

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Declaration

I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Susan Timpani 10/2/2020

Acknowledgements

To my family who have championed me, Joe, Clare, Evelyn, Luke and Monique.

To my principal supervisor Professor Linda Sweet, my guide into the mystery, and sometimes the fog, of academic research. To my associate supervisor, Associate Professor Pauline Hill, my inspiration to care for nursing students. To my associate supervisor, Dr Nina Sivertsen, whose narrative research encourages me. To the academic staff in the Prideaux Centre of Health Professional Research who believed in my vision for improved clinical education.

To family, friends and colleagues who have impacted, or been impacted, by my research story. To the students who so generously participated in this research, I literally could not have done this without you.

To you, the reader, for taking the time to read this story.

Abstract

Storytelling during clinical facilitation. An art-based narrative inquiry.

Background:

Arts-based pedagogy is a growing phenomenon in nurse education. The benefits of the arts to classroom education is discussed widely in the literature. Research into arts-based learning during *clinical* nurse education is less evident. Nursing students can experience clinical placement as complex and challenging. They are required to meet learning goals, adjust to the professional culture, and manage their own social and emotional needs. Clinical educators are required to facilitate cognitive, affective and psychomotor skill development. The competing demands of placement can reduce attention on students' less tangible skills such as caring. Arts-based learning, through storytelling, has been shown to develop skills in the affective domain. This learning strategy has the potential to support students to reflect on their caring practice during clinical placement.

Aim:

Storytelling aims to promote students' reflections on their interactions with patients. This learning strategy seeks to balance the focus of learning on clinical and cognitive nursing with interpersonal skills. This narrative inquiry aimed to discover if storytelling assisted student when they interacted with patients. The inquiry anticipated that some stories would reflect caring practice. In order to avoid bias students were

not specifically asked to reflect on caring, but patient encounters, caring or otherwise. This inquiry also aimed to explore stories for potential obstacles or opportunities students encountered to engage with patients.

Methods:

Over a period of nine months I met with seven consecutive groups of nursing students during their clinical placement. Each group had up to six students, and placements occurred from two to eight weeks in duration. The placements occurred in two different hospitals and on different wards. I visited the student groups up to three times per week throughout their clinical placement, dedicating one visit per week to a storytelling session. I provided the students with a story prompt to focus free writing for ten minutes. Transcripts of storytelling sessions, creative writing pieces, and my research journal were used as field texts for exploration. The methodology predominantly followed Clandinin and Connolly's approach to narrative inquiry. In order to closely examine the written or recorded stories, I also used narrative analysis.

Narrative threads:

Five narrative threads appeared across the texts. These included: students engaged enthusiastically to tell stories about their placement experiences; storytelling enabled students to reflect back on moments of mutual enjoyment with patients; clinical educators can be a barrier as well as a facilitator to students connecting with patients; RNs can be a barrier as well as a facilitator to students connecting with patients, and students from Culturally and Linguistic Diverse (CALD) backgrounds experience unique challenges, the impact of which on patient engagement is unclear.

Significance and Conclusion

This narrative inquiry demonstrates the power of storytelling for students to reflect on their patient interactions. The stories identified moments of caring, and moments of challenges. Stories also demonstrated insight into the obstacles and opportunities nursing students encounter when interacting with patients. As a teaching and learning tool, storytelling has demonstrated the potential to facilitate intentional reflection on patient engagement. Positioned within the genre of arts-based learning, storytelling is only one strategy to enhance affective learning. There is scope for further research on other aspects of arts-based learning in clinical education.

Storytelling during Clinical Facilitation

Arts-Based Narrative Inquiry

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A dissertation submitted in partial fulfilment of the requirements for the
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I want to compose a different story of clinical education. I know it will 'take time for one story to fade and another to emerge' (Clandinin, Steeves & Caine 2013 p.6).

This research forms the basis of a new script.

Part 1: Concepts

1 Chapter One: Background

1.1 Introduction

When a health care recipient and nursing student interact, they do so in a moment along the trajectory of each of their lives. The person's presenting illness and health care experience is an episode within their life story. Their health care story disrupts their social context such as work, family, and lifestyle (Frank 2002). While the patient is acutely aware of the impact of their illness on their own life, the nursing student may not be. Frank (2002) challenges health care professionals to view their patient in their whole of life context. He says "*What happens to my body happens to my life. My life consists of temperature and circulation, but also of hopes and disappointments, joys and sorrows, none of which can be measured* (Frank 2002 p.13). According to Gidman (2013), understanding the patient's story increases the likelihood that nursing students will provide more relevant and empathetic care.

The complexity and pressure students face during clinical placement may contribute to patients like Frank's (2002) feelings of invisibility. Educators have a responsibility to navigate student learning 'in the midst' (Clandinin & Connolly 2000 p.20) of placement challenges. The Nursing and Midwifery Board of Australia (NMBA) have standards of practice to ensure nursing practice is *"person-centred and evidence-based with preventative, curative, formative, supportive, restorative and palliative elements"* (NMBA 2016 p. 2). The clinical educators' role is to facilitate

students' learning to achieve competency in each standard. This inquiry aims to explore nursing standard 2 (2016), *"engages in therapeutic…relationships"* (p.4) This standard reflects the importance of students learning to understand the nursing theory and practice of caring (Watson 1979, 1988, 1999, 2005, 2008, 2012, 2018). Schwind et al. (2015) debate the validity of teaching caring practice using traditional teaching and learning methods. (Schwind et al. 2012) suggest that the nursing student's own life experience is inherent in their encounter with the patient. In order to deliver caring practice, nursing students need to reflect on their own life experiences. Self-reflection during the placement provides opportunities for personal growth and skill development in their caring practice.

Reflecting on personal growth and development is not traditionally linked with clinical education. Evidence in the literature suggests that education during placement tends to prioritize skills which focus on the patient's physical care (Gaydos 2005; Schwind et al. 2014; Schwind et al. 2015). Balancing the domains of cognitive, psychomotor and affective learning may provide a more holistic approach to clinical education (Rieger et al. 2015). Creative strategies appear to favour learning in the affective domain, such as caring (Schwartz & Abbot, 2007; Schwind et al. 2015). A growing body of research into arts-based learning in nurse education exists (Schwind et al. 2014; Schwind et al. 2015). However, research into arts-based learning in *clinical* education appears to be lacking. This narrative inquiry introduces arts-based learning, through the medium of storytelling, to enhance affective nursing skills. Storytelling occurred within the peer group with whom students shared their placement. I invited students to participate in guided creative writing exercises and oral storytelling. Their reflections were prompted by a word or a phrase. Writing prompts came from the work of Adams (1990), founder of the *Center for Journal Therapy*. I set the timer and invited

students to write freely for ten minutes. Students could write about their experience of interacting with patients, or any other aspect of their nursing placement. In this narrative inquiry I aimed to *'come alongside'* (Clandinin 2016 p.33) nursing students *'in the midst'* (Clandinin & Connolly 2000 p.20) of their journey of learning to care. Clandinin and Connolly's (2000) method of narrative inquiry underpins this research. Their approach is discussed in Chapter 2 under Epistemology and again in Chapter 4 under Methodology.

This thesis is divided into two parts. Part 1 explores the concepts which underpin narrative inquiry and caring practice. Part 2 presents stories in greater detail. I discuss my journey of meaning making as the students and I *"lived, told, relived and retold our stories* (Clandinin & Connolly 2000 p.20). The management of field texts, or data, follows twelve touchstones described by Clandinin and Caine (2012) to demonstrate high quality narrative research. These are introduced in 4.10. As a narrative inquirer, I hope to remain true to the community of inquirers by presenting a vibrant account of my research story. As a nurse academic, I also hope to situate this narrative alongside other scholarly work. There is no perfect template to ensure this dissertation meets the ideals of either. Clandinin and Connolly (2000) reassure us that research texts within this genre are frequently an uneven patchwork of *"argument, description and narrative"* (p.155). The literature review is written in the third person, while the remainder of the thesis is in the first person. The first person highlights the concept of temporality in that my own past, present, and future are entwined within this project. Writing in the first person allows me to express my inward or personal voice. Why this research is important to me is a question I can keep in the foreground. The third person used within the literature review ensures the inquiry is also positioned outwards, connected within the wider social and professional context. This perspective

highlights why this research is important to the social world (Clandinin & Connolly 2000). The context of the narrative remains always within the environment of clinical placement. Clandinin and Connolly's (2000) three dimensions of temporality, sociality, and place described in section 4.6 provide a recognizable framework with which to follow the written account of this narrative inquiry.

Most qualitative researchers *'begin inquiry in theory'* (Clandinin & Connolly 2000 p.40). Clandinin and Connolly (2000) argue that narrative research should commence with story *'which is linked to the themes'* (p.40) This thesis commences here with a story written by Samreen, a student in one of the storytelling sessions. It highlights core themes this narrative inquiry uncovered.

Frozen Moment

I asked students to take an imaginary *"snapshot'* of a moment when they interacted with a patient. I set the timer for ten minutes and invited the students to fill their pages with whatever words came to mind. I named this exercise a *"Frozen Moment".*

> *Samreen reads: "There was a very nice, kind-hearted gentleman in one of the rooms. He was so appreciative of whatever help I used to offer, for e.g., talking, giving him a glass of drink, fixing his blanket, holding his hand. It was Friday, late shift, his health was deteriorating. His wife was there with him to stay overnight with him that day. I made the sofa bed for her to sleep. She was sitting on the chair next to him holding his hand and reading something from her mobile phone to him. I just glanced over and looked at them and that was my freeze moment. I went to flashback for few seconds when this gentleman had said that how much he is eager to go home. He wished he could go home one day from the ward. I was finishing my shift; I went close to his room. He looked so relaxed with his wife I didn't want to disturb them. I really wanted to see him and say goodnight and that I'll see*

him Monday. But I couldn't. I went home but had terrible feeling. Will I see him Monday? I regretted not seeing him. When I came Monday, he had passed away. The one thing I remember now when I think about him is that frozen moment".

Samreen had picked up her pen without hesitation and the words just flowed. Within a second she had returned to a moment deeply meaningful for her. She connects with the man, but it came at a cost. An emotional weekend with regret and fear. Her loneliness as she managed her grief and faced death. Perhaps this was her first experience of death. Each story in this inquiry shares the same depth, and degree of honesty. They highlight common experiences of connection and disconnection from patients, peers, RNs and educators. They are raw, and rich with meaning. They are the voices of students to us, their listeners.

1.2 Autobiographical Narrative

As narrative inquirers we commence our research by inquiring into our own life story. Clandinin urges us not to stay outside the research, considering ourselves an observer or *"merely the recorder ... unless I am willing to do this autobiographical narrative inquiry I can't possibly understand someone else's story … if I look into the complexities of my own story I am more awake to the complexities in another's life"* (McKenna 2017 audio). Without including a personal story, narrative inquirers run the risk of discounting the value of their own experience to the research (Clandinin 2016). The autobiography told at the beginning of the inquiry identifies what "*fuels the passion … an important element in the long-term work of narrative inquiry"* (Clandinin & Caine 2012 p.174). Life is always unfolding. The researcher's narrative will alter as the research progresses. The story I tell as I step into the research will change as I step out. I enter the inquiry knowing I will become a different, and hopefully, a wiser person.

My story

I am a woman casual academic, a casually employed registered nurse and a student. I am studying a creative writing degree as well as this clinical education master. I have a loving husband and four children. Our eldest three are establishing their own careers and our youngest is at school. Undertaking this Master of Clinical Education/Research both influences and is influenced by the story of who I am. It is unlikely that this research master will alter my casual academic status, provide a means for promotion in nursing, or increase my income. It has inspired me to continue to write, but it has slowed down my progression to obtain my writing degree. A student in one of my classes listened to my lived story and shook his head, "why are you doing this?" It is a question I have asked myself throughout this study. The answer changes depending on what has prompted me to ask. For the sake of explaining what appears insanity to others, my answer is, "because I care". I care about the experience of patients when they come into the health care system. Caring is the very nature of who I am as a nurse. Caring and nursing are simultaneous. Aren't they? When I entered academia and hence the story of nursing students, my assumption wavered. Nursing students learn to care within fractured institutional narratives. This narrative inquiry is prompted by my care for nursing students' experience of learning to care. I care about the next generation of nurses. I hope I can contribute to educating nurses who want to care. Perhaps my real dream is to validate my own story as a nurse who is still learning to care.

I also wonder if my inquiry is motivated by my own illness story. I have a hole in my abdomen, the size of a fifty-cent piece. It has a medical term, which neatly categorizes it. It's a term that makes others feel comfortable, because it separates the condition from me. By referring to it by its medical term, it's just a "thing"' to live with and manage. I don't have any sad stories of nurses who lacked a caring attitude. Post-operatively the nurses were kind and efficient. But I wonder about the power of the "caring moment" (Watson 1988). What if a nurse had connected with me, and "knew" this was not just a "stoma", but a permanent hole with permanent

consequences? Perhaps I would have faced the unfaceable, with less distaste and more confidence. I approach this narrative inquiry entangled in messy motivations. It has become part of my life story that I am compelled to "live, tell, relive and retell" (Clandinin & Connolly 2000 p.20).

In my clinical nursing practice, I have mostly worked in primary health care. Primary health care nurses work with people and communities made vulnerable by poor social determinants of health. Social determinates "are the conditions in which people are born, grow, live, work and age", (World Health Organization (WHO) 1981) and are the wider set of forces and systems shaping the conditions of daily life. People I have met in my work have told me heart-breaking stories about managing their health while living in dire need. The most heart-breaking stories are those about feeling judged and rejected by health care workers. I've expressed some of these experiences through writing. Many stories remain hidden in a lifetime of personal journals. Some have been published (Timpani 2004; Timpani 2015).

Still, I consider myself a novice writer. In choosing creative writing as an art form for this research I faced a dilemma. To undertake arts-based inquiry requires one to have "an artistic…or creative background" (Crimmins 2019, Episode 141). I acknowledge here that I am not an artist. As a narrative researcher my brief is to facilitate students' storytelling. Their stories may not reflect the flare of experienced narrators, but they do recount the storytellers' genuine experience. While students' experience of connecting with patients is at the forefront of the inquiry, my own experiences cannot be ignored. The following is my first written story in this narrative inquiry. It was just one of many that prompted this research journey.

While working in a child protection team recently, I visited a family referred after a notification of neglect. The toddler had not seen a health professional since discharge from a neonatal unit. A premature baby, he had required regular monitoring. Following my assessment, it was clear that he had significant developmental delay. I was in their home and I could see the cramped conditions, which minimized space to play. The mother had a mental health issue, making it difficult for her to leave the home. There was

little social interaction beyond the parent and child. The mother was "keeping a low profile" from an abusive partner. There were other factors and other services involved. My role was to link the family into child health services. The mother resisted, stating they "had been treated badly during the neonatal stay". Eventually, after varying approaches, she agreed. I phoned the hospital.

"Oh no!" bellowed the liaison nurse into the phone.

Taken aback by this unexpected and unprofessional approach I ignored it and tried to continue with my referral.

"I mean, have you seen them?" She asked. "If you saw them you would know what I mean."

Of course I had seen the family, and heard them, and experienced their stereotypical "druggie" demeanour. I had been in their home and seen other issues as well. These were not my concern. After securing an appointment I contacted the parent.

"No!" was her response after hearing the name of the nurse.

The child needed urgent health care and the health care professional was the obstacle. This narrative inquiry responds to a question I've wanted to ask nurses so often in my work in primary health.

"If you only knew the patient's story, would you care?"

In my current role as clinical educator I ask nursing students to tell me about their patient. They often default to telling me about the medical diagnosis. When I ask them to tell me their patient's story, some are confused. Many are curious. What makes it harder for some to explore patient's stories and not others? This is the place I find myself now. I want to know the story of the students as they come to know the story of their patients.

1.3 Terminology

In this thesis, *caring practice* is an adjective describing the way in which a nurse expresses care. *Nursing care* is a verb describing the tasks nurses do to take care of a patient.

Clinical educator and *clinical facilitator* are interchangeable terms. In this inquiry, the term clinical educator is used, to maintain uniformity with other tertiary settings. Some students use 'facilitator' in their stories.

Group with a *capital G* refers to one unique group of participants.

Medical terminology will be kept to a minimum. Where this takes away from the meaning of the text, an *explanatory footnote* will be applied.

Narrative inquirer refers to the researcher.

Persons or people "*who have entered into a therapeutic and/or professional relationship with a nurse … [are known as] … patients, clients, consumers, families, carers, groups and/or communities …"* (NMBA 2016 p.17). Students in this study are working in acute care hospitals, hence the term applied is *patient.*

Privacy and confidentiality of students and other persons who appear in this narrative have been maintained. All names are pseudonyms. Identifying details have been altered sufficiently to ensure anonymity, while maintaining a work of non-fiction.

1.4 Ethics

My dual role of clinical educator and researcher resulted in limitations from the ethics committee. These initially included not working with my own group of students.

After Group 1, it became evident that if I could not work with my own group of students, I would need a different methodology. Eventually I was able to work with my own students, with restrictions, described in section 4.1. Upon reflection, limitations by the ethics committee may have actually been enhancers. While they recognize the legal requirements, Clandinin and Connolly (2000) describe the process of gaining consent before establishing relationships can be of itself a relationship inhibitor. Approaching participants "*… with a set of already-approved forms and requests for signature is a forbidding starting point"* (Clandinin & Connolly 2000 p.170). It also meant that as the inquiry evolved, "*… some aspects of the inquiry are no longer able to be negotiated"* (Clandinin & Connolly 2000 p.170). The long and frustrating process with the ethics committee also highlighted an important issue. It demonstrated the wider social and institutional factors that inadvertently play a role in influencing research into the care of patients.

1.5 Research Puzzle

This inquiry aims to explore the potential of arts-based learning, through storytelling, in students' learning to care. Creativity opens new reflective pathways to help us understand who we are as individuals. According to Lindsay (2008), *"who you are as a person is who you are as nurse"* (p.19). The art of caring practice must be nurtured alongside the art of self-knowing. Schwind et al (2012) states that, *"expanding personal knowing [impacts] professional ways of being and doing"* (p.225). The standards of nursing practice (NMBA 2016) expect nurses to "…*be sensitive to a person's situation and purposefully engages with them…" (p.7).* This standard returns me to my question which prompted this research. *"If you knew the patient's story would you care?"* This inquiry assumes that there is a relationship between reflecting on self,

reflecting on moments of purposeful engagement with patients and their story, and learning the art of caring practice. According to Bacchi, cited in Bletsas and Beasley (2012), *"what one proposes to do about something reveals what one thinks is problematic"* (p.21). This proposal aims to trial storytelling during clinical education to guide the student to reflect on their caring practice. Applying Bacchi's framework, *"What's the Problem Represented to be?"* (Bletsas & Beasley 2012), students need an alternative approach to learning. The problem representation therefore lies within a potential missing piece of the puzzle in teaching and learning caring practice.

The second piece of the puzzle aims to uncover potential obstacles and opportunities students encounter to deliver caring practice. While this thesis will discuss any findings within the stories, the scope of the research does not include an in-depth analysis. This narrative inquiry will address two research puzzles;

"What role does storytelling play in helping students to reflect on caring practice?" "Do stories identify obstacles and opportunities students encounter to engage with patients?"

2 Chapter Two: Epistemology and Ontology

2.1 Definition

Stemming from the Greek "'episteme', knowledge, and 'epistasthai' 'know, know how to do', epistemology is the 'theory of knowledge'. In research, epistemology refers to the knowledge of methods, validity and scope (Oxford 2019). The concepts, or "objects", within this research are "storytelling", "caring"' and "nurse education". Each of these concepts hold different meanings depending on their context. In order to explore their meanings an understanding of theory is required. To rephrase Brabazon (2017, vlog 77), "you can't know [storytelling] without a theory of [storytelling]… you can't know [caring] without a theory of [caring] … you can't know [nursing] without a theory of [nursing]". This section presents theoretical concepts which inform the epistemology underpinning this research.

Stemming from the Greek "ōn, ont- 'being'+ -logy', ontology is a set of concepts and categories in a subject area or domain that shows their properties and the relations between them" (Oxford 2019). Ontology is the broad context in which to situate the relationship between [storytelling, caring and nursing] and how these concepts, or 'objects' are explored and understood (Brabazon 2017, vlog 78). Understanding the ontology ensures that the boundaries of the research are understood and maintained.

2.2 Conceptual framework

The epistemology of stories, storytelling, and narrative traverse many fields, including nursing (Schwind et al. 2015), medicine (Charon 2006), education (Dewey

1963) linguistics (Labov & Waletzky 1966), and psychology (Lieblich et al. 1988). The multi-disciplinary perspective adds value to exploring the relationship between clinical education, storytelling, and caring practice. The concept of caring in nursing (Watson 1988) informs this research. The ontology of this inquiry is based on Watson's theory of human science and human care in nursing (1988), and Dewey's theory of experience and education (1963). Accordingly, Watson (2012) describes caring science as the "*philosophical-ethical-epistemic-ontological disciplinary foundation to sustain nursing …"* (p.87). Dewey's theory claims that knowledge is based on experience. The passing of time and the interaction of people and society influence experience (Dewey 1963). Educational researchers, Clandinin and Connolly, developed a methodology of narrative inquiry based on Dewey's theory. The methodology for this research is Clandinin and Connolly's (2000) approach to narrative inquiry.

2.3 Watson's theory of nursing: human science and human care

An ethic of human care has always underpinned nursing practice. Since the mid-1970s, nursing leaders such as Watson, have engaged in prolific academic research and writing to explore the theory and practice of nursing care. In 1979, Watson first described nursing as the 'science of caring' (Watson 1979). In 1988, Watson consolidated the research and developed a theory of human care. The rationale for developing a nursing theory was to describe "*breaking away from the traditional medical-scientific bondage…and attending to its own [body of knowledge]"* (Watson 1988 p.13). The theory of human care is still a prevalent framework in contemporary nursing. According to Wei et al. (2019) nursing practice based on Watson's theory of care could *"decrease patients' emotional strains, increase patients'*

self-management confidence and emotional well-being, increase nurses' job satisfaction and engagement, and improve nursing students' confidence in the clinical performance" (p.4). Watson is a strong advocate for nursing to focus beyond the medical needs of the patient. Wei et al. (2019) describe Watson's perspective of patients as "*human beings with both biopsychosocial and spiritual needs and desires"* (p.21). Nurses care for people often when they are in pain, worried, and possibly alone. Nurse educators must empower nursing students to deliver responsive and intimate care during these moments (Hill & Watson 2011). Watson encourages educators to prioritize a *"caring culture over the more traditional bio-medical/ technocure culture that has been so dominant in nursing and nursing education"* (Hills & Watson 2011 p.133). Watson (2018) expresses concern that too often contemporary education remains focused on the *"hospital routines and medical orientations to health…devoid of …deep human caring knowledge …"* (p.215). Artioli et al. (2016) suggests that students are generally equipped to communicate with patients through the use of questionnaires rather than their patient's story.

The way in which a nurse interacts with a patient has the potential to not only influence the person's caring experiences, but also their health outcomes (Wei et al. 2019). Acute care clinical placements situate students within a biomedical context and tend to emphasise diagnostics and therapeutics (Schwind et al. 2015; Pajnkihar et al. 2017). Watson remains an advocate for the caring theory to underpin nursing practice, education and research (2012). In shaping nursing ethics, values and knowledge into a theory, Watson (1988) identified a series of assumptions.

"The profession of nursing views a person in their entirety. "The nurse-patient encounter affects health and healing. Nursing values the non-medical approach to

human care. Promoting health and well-being is central to nursing practice. Nursing is a profession with their own body of knowledge" (Watson 1988 p.14).

To take up these assumptions the nurse is "*to be a scientist, scholar and clinician [and] a humanitarian and moral agent … [and] … co-participant in … care transactions"* (Watson 1988 p.54). Watson's theory of human science and human care (1988) is situated along a spectrum of care assumptions since Florence Nightingale.

In 1865 Nightingale is quoted as saying,

> *"The nurse may be trusting to the patient's diet, or to their medicine, or to the occasional dose of stimulant which [they are] directed to give… while the patient is all the while sinking from want of a little extra warmth" (Nightingale p18 1865).*

Throughout Nightingale's writing, the principal and practice of caring are apparent. In a voice recording in 1890, Nightingale urges future nurses to remember her life work. She says, *"When I am no longer a memory, just a name, I hope my voice perpetuates the great work of my life…"* (1890, 00.15-00.36). Research into care and caring practices was as central to nursing then as it is today. Nightingale recognized that nursing "*required organized and scientific training"* (Watson 1988 p.14). Contemporary nursing theory has shifted along the care continuum, emerging with terms such as "'*holistic care' or 'person centred-care'"* (Feo et al. 2017; NMBA 2016; Wei et al. 2019). According to Kitson et al. (2013), while the concept of person-centred care differs within and across the professions there are at least three commonalities. "*The centrality of patients in their own care, the relationship between the patient and the health professional, and the care context"* (p.4). Further research into the applicability of these commonalities has resulted in a *"Fundamentals of Care Framework"* (Kitson et al, 2013; Feo et al. 2017; Conroy 2018). Watson's theory of

care strongly relates to the second commonality, the relationship between the patient and the nurse (Feo et al. 2017).

Watson describes moments of interaction between the nurse and patient as caring moments (1979, 1988). Caring moments provide students with the opportunity to explore their patient's story. Likewise, exploring the patient's story has the potential to enhance a caring moment. Knowing the patient assists nurses to provide individualized care (Jasmine 2009). Mayer (1971) cited in Watson (1988) states, "*To care for someone I must know…who the other is…what his needs are…[and]…how to respond to his needs …"* (p.30). Within these caring moments, the nurse chooses whether to engage meaningfully with the patient or not.

Engaging in this moment has the "*ability to expand the human capacities … [and] … increases … events that could occur in space and time at the moment as well as in the future"* (Watson 1988, p.59). This caring moment is an opportunity for the nurse to influence the patient's health and well-being. It provides the possibility of the nurse to know the patient, but to also care and understand themselves (Watson 1988).

During clinical placement students are expected to demonstrate values and attributes which ensures the patient is at the centre of their own health care (NMBA 2016; Turkel et al. 2018). A caring nursing student-patient relationship should be collaborative, respectful, partnered, individualised, and respectful of rights, choices and preferences, acknowledging religious and cultural diversity, is inclusive of significant others, and is holistic (NMBA Australia 2016; Schwind et al. 2015). Learning to explore and apply these principals is often situated within a complex environment. Opportunities to care may compete with opportunities to tick off tasks required for academic assessments.

These competing priorities can overshadow caring moments. Learning to care often exists within a conflictual internal or external environment. Students have reported high anxiety about fitting into the clinical environment and developing a sense of belonging (Levett-Jones & Bourgeois 2015). They must learn to confront illness (Manorcha & Manorcha 2007), interact with dying patients or grieving relatives (Gillett, O'Neill & Bloomfield 2016), develop confidence in caring for patients with complex psycho-social or mental health needs (Schwind et al. 2015), and manage cultural and language differences (Arieli 2013). Student experiences are also impacted by staff mix and funding cuts (Feo et al. 2018). Clinical educators have a responsibility to understand, acknowledge and work within placement challenges. Frameworks such as the Fundamentals of Care acknowledge the need to integrate clinical knowledge and expertise in caring relationships (Conroy 2018). Clinical educators must facilitate and assess students' integration of theory into clinical practice. Clinical education sessions in this inquiry attempted to balance competency in delivering nursing care and developing skills to enhance caring practice. To enable caring competency, educators must understand the experiences which either prevent or promote students integrating human care into their clinical practice.

2.4 Story in Arts-Based Pedagogy

Arts-based pedagogy integrates the arts into another topic to assist learning within that topic (Reiger et al. 2016). Storytelling is a method of arts-based learning which promotes personal reflection, improves individual knowing and enhances the individual's quality of life (Casey 2009). A systematic review undertaken by Reiger et al (2016) examined thirty-six arts-based learning studies conducted between 1994 and 2015. The context of the studies occurred mostly in the classroom. Research into the

use of the arts during clinical placement is sadly lacking (Reiger 2016 p. 194-223). Reflecting on clinical practice as the placement unfolds provides students with the opportunity to explore the meaning of their experience. The diversity and complexity of clinical placement requires a combination of cognitive and affective reflection (McDrury & Alterio 2001). Storytelling benefits the storyteller in the act of telling the story (Moon & Fowler 2008). It provides students a means to "engage in reflective activities … crucial for the development of new understanding and appreciation" (McDrury & Alterio 2011 p.72). Arts based nursing interventions, stemming from Watson's theory of care, have been applied to nursing care. Interventions such as "touch, therapeutic conversation … art … music … atmosphere … are effective means of reaching the sacred souls of human beings" (Wei et al. 2019 p.19). The success of such arts in health activities have the potential to showcase the value of arts-based learning during clinical placement.

2.5 Story in Arts-Based Research

It is not uncommon for researchers in nurse education to combine arts-based research with arts-based learning. Schwind et al. (2015) used storytelling, metaphor, drawing, and creative writing to explore student's perspectives on caring. Their arts-informed narrative inquiry also facilitated the students to *"… delve deeper into their own inquiry of self-as-instrument-of-care…"* Schwind et al. (2015 p. 392). Schwind et al's (2015) used their instrument of storytelling as a learning intervention as well as a tool of inquiry.

The use of narrative within qualitative research has grown exponentially over the past two decades. This uptake of a narrative approach to research, particularly in the social sciences, is often referred to as the *"narrative turn"* (Holloway & Freshwater

2007), (Leavy 2015). Narrative inquiry is considered by some as a research methodology in its own right. Others position narrative inquiry as only one methodology in the suite of arts-based research (Leavy 2015). Leavy (2018) describes the connection between research goals and design as one which should *"click together"* (p.295). In this research, narrative inquiry is the primary methodology. The arts-based form of storytelling is applied in order to analyse stories and enhance the opportunity for a learning intervention. The decision to use an arts-based approach to narrative inquiry aligned with the goals of researching students' experience of storytelling.

2.6 Dewey's theory of experience and education

The concept of the meaning of experience in research is derived from philosopher Dr John Dewey (1859-1952). This man is esteemed by some *"to be classed with the ancient stoics, with Augustine, with Aquinas, with Francis Bacon, with Descartes, with Locke, with Auguste Comte"* (Alfred North Whitehead in Dewey 1963 p.1). Dewey's 1963 text was published posthumously. It describes his landmark statement on educational change, made during the Kappa Delta Pi Lecture series (1938). While Dewey's educational theory of experience is discussed here, this is by no means a briefing about its complexities. Dewey was 31 years old when Florence Nightingale recorded her speech (Nightingale 1890). He was establishing his academic work as Nightingale was finishing hers. The relevance here is to demonstrate the far-reaching contribution each made in the changing era of education and nursing, respectively. This illustrates Dewey's theory. All experience has meaning and context. What went before influences what happens now, and what happens now influences what happens next. Dewey writes, *"…we live from birth to death in a world of persons and things which in large measure is what it is because of what has been*

done and transmitted from previous human activities…we don't live in a vacuum" (1963 p.39-40). Dewey acknowledges the importance of *"the surroundings, physical and social"* (Dewey 1963 p.40) to experience. Clandinin and Connolly (2000) describe this aspect of Dewey's theory as, *"temporality"; the world of persons and things as 'sociality'; and surroundings as 'place'.* These concepts form the basis for Clandinin and Connolly's metaphor of a "*three-dimensional narrative inquiry space"* (2000 p.54). According to Clandinin (2013) this metaphor, based on Dewey's theory, is a significant factor in differentiating Clandinin and Connolly's methodology from other narrative research.

2.7 Clandinin and Connolly's narrative inquiry.

Clandinin and Connolly's approach to narrative inquiry is grounded in Dewey's (1963) theory of experience and education. Clandinin explains that narrative inquirers try to understand people's experience as told through their stories (McKenna 2017). In order to study experience, researchers must come alongside participants as their stories are lived, told, and retold (Clandinin & Connolly 2000). The three-dimensional framework of temporality, sociality, and place ensures the inquiry is situated in the broader context of the participants' life (Clandinin & Connolly 2000). Given that Dewey's theory is central to Clandinin and Connelly's epistemology and ontology (Clandinin & Rosiek, 2007) it is important to describe key elements of his theory.

2.8 Overview of Concepts

Watson (1988) urges nurses to shift their perspective of care from the biomedical to deep human knowledge. Watson's theory of care provides the framework for this inquiry and is referred to as *"caring practice"*. *"Nursing care"* refers

to clinical practice undertaken by nurses to deliver patient care. The *"arts-based learning"* method of storytelling provides a potential strategy for students to reflect on their caring practice. Clandinin and Connolly's (2000) method of narrative inquiry provides the methodology for this research. Integrating storytelling into the narrative inquiry indicates that this thesis is reporting on a form of *"arts-based research".* The following section will explore more closely the relationship between storytelling and nurse education.

3 Chapter Three: Literature Review

3.1 Introduction

The method of presenting reviewed literature within narrative thesis' differs across the disciplines. Narrative inquirers often integrate the literature throughout the dissertation (Clandinin, 2013). This approach is evident in some narrative inquiries in nursing (Hubbauer 2015). Another approach is to present a standalone chapter and narrate findings without detailing search strategies (Suen 2016). According to Cronin et al (2008) a narrative literature review selects literature that addresses the research topic but *"criteria for selecting the specific sources for review are not always apparent to the reader"* (p.38). Other nursing students of narrative research include a diagrammatic *"search strategy matrix"* (Price 2011 p.206). Being a combination of the arts and nursing, I have chosen to apply a mixed approach. This is a standalone literature review chapter. Intricate numerical details via charts have been excluded, to enable narrative flow. The overall search process is presented to demonstrate transparency and quality.

3.2 Story in clinical nurse education

The following integrative literature review explored the relationship between storytelling, clinical education and caring practice. It also aimed to find research which highlighted issues students may face when connecting with patients and their stories.

3.2.1 Search Strategy

The search strategy focused on the three themes of *"narrative arts and/or storytelling""; "nurse education during clinical placement"; and "caring practice for*

inpatients". Search terms included "nurse education and/or clinical nurse education"; "clinical practice and/or clinical placement"; "inpatient"; "caring/nursing care". Databases included CINAHL, ERIC, PUBMED, Scopus, and bibliographies within reviewed literature. Limiters included peer reviewed, dated between 2008 and 2018 and published in English.

3.2.2 Exclusions

The search excluded articles which focused on narrative medicine, illness narrative, non-interactive patient stories, and non-narrative arts. Prolific and recent research has been undertaken in the medical profession in the area of narrative medicine (Charon 2006; Engel 2014; Greenhlagh & Hurwitz 1999). Strong similarities exist between the goals of narrative medicine and narrative in nursing. Despite this, practice theories within the two professions differ, and therefore articles on narrative medicine were excluded from the search. Significant research has also been undertaken in *"illness narrative"*. "Illness narratives" are when patients recount the story of their illness and the impact on their life (Yau 2013). Given that this review aims to focus on nursing students' interactions with patients, illness narratives were also excluded from the search. Similarly, stories where there was no student-patient interaction were excluded. Those narratives were often presented in the literature as case studies or narratives in web based, social or general media (Haigh & Hardy 2011). Given that the focus of the review was arts-based learning during *clinical* education, literature discussing general nurse education was also excluded.

Arts-based learning incorporates diverse art forms. The medium used in this research is storytelling, both written and oral. While a combination of art forms is often

referred to in studies, wherever possible art forms such as drama, art and craft, music and media (Casey 2009) were also excluded.

3.2.3 Critical Appraisal

The initial search identified 499 articles. Closer screening eliminated those where exclusion criteria persisted. Details of the remaining 50 articles were collated into a table recording the article title, author(s), date, journal, country, aim, methods, outcomes (Cronin et al. 2008). The articles, all being qualitative in nature, were also checked against the Qualitative Research Checklist (Critical Appraisal Skills Program (CASP) 2018). The lack of usefulness of the studies in addressing the research question formed the basis of 36 subsequent exclusions. Two examples are articles describing students' feelings about using journals on placements (Hendrix et al. 2012; Mahlanze & Sibiya 2017). Another example is a study using stories gathered from clinical placement but used for classroom reflection (Adamson & Dewar 2015). The review identified only one arts-based learning intervention conducted during clinical placement (Manorcha & Manorcha (2007). Conducted in 2007, the project did not meet the year of publication search criteria (2008-2018). However, given the paucity of evidence in the search, and its importance to the present study, the research is included. The final selection consisted of fifteen articles; Chan & Lai 2016; Ekebergh 2011; Gallagher & Carey 2012; Gidman 2013; Gillett 2016; Manninen et al 2013; Manorcha & Manorcha, 2007; Paliadelis & Wood 2016; Perlman et al 2017; Rieger et al 2016; Schwind et al 2015; Schwind et al 2014; van Der Riet 2017; Watson 2012; Webster 2010.

The following review aimed to identify students' experience of reflecting on their patient's story. All articles were reviewed and analysed using a thematic synthesis

approach (Cronin et al. 2008). The findings created seven themes; students enjoyed storytelling; stories dispelled misconceptions about patients; students have more time than RN's to spend with patients; the RN can obstruct or facilitate storytelling; the clinical educator can support or inhibit affective learning; storytelling is a medium for learning; storytelling can promote caring.

3.3 The Review

3.3.1 Enjoying stories

Students on clinical placement often demonstrate enthusiasm to implement caring theories discussed in the classroom. Chan and Lai (2016) conducted an inquiry into the experience of students communicating with patients. They interviewed forty-two participants following completion of a clinical placement, either in a public or a private hospital in Hong Kong. Students described spending time talking with patients as a mutually enjoyable experience. They reported that patients frequently liked to talk about their experiences with the nurses. These students also demonstrated an understanding of verbal interactions as a means of achieving person centred care. They reported that talking to patients provided them with a better understanding of the patient's physical, psychological and social needs (Chan & Lai 2016). Their communication goal was not just to extract medical details but to discover how patients and relatives were impacted by health issues. According to Chan and Lai (2016), this information often resulted in students being able to advocate for the patient, and to direct them to resources which increased their options for more optimal health care.

Listening to patients' stories not only benefits the patient, but it also enhances student learning. In the United Kingdom (UK), Gidman (2013) interviewed nine nursing

students to explore the impact of patients' stories on their placement learning. Their findings were similar to Chan and Lai's (2016), in that listening increased student's learning from their patient's perspective. In a Swedish study, Manninen et al. (2013) examined the experience of 19 first year nursing students in a clinical education ward. They found that students learnt from taking on the primary responsibility for a patient load, supervised but not partnered by qualified staff. They identified that a positive nursing student-patient relationship was not only necessary for caring practice, but also intrinsic to their learning (Manninen et al. 2013).

Exploring patient's stories as they face the end of life can be a challenge for students. Gillett et al. (2016) explored student's storytelling experiences working in a palliative care ward in London. Students who managed their own emotions and demonstrated their capacity to stay and listen, increased the likelihood of their patient expressing their own feelings. Students reflected that patients and relatives who were willing to talk assisted them to develop confidence in their patient interactions (Gillett et al. 2016). Conversely, where student's efforts to communicate were not received favourably by patients, they reported negative emotions, either towards themselves or the patient. To facilitate self-preservation some students acknowledged that they communicated with patients only on a superficial level (Gillett et al. 2016). Other students in Gillett et al.'s (2016) study said they were reluctant to communicate for fear of upsetting patients or relatives by saying the wrong thing. Some students also described how they expected terminal patients to be older and have already come to terms with dying (Gillett et al. 2016). After encountering a young person, one student described how this had displaced his perspective, increased his anxiety and reduced his confidence to spend time exploring the patient's experience (Gillett et al. 2016).

Nursing students not only communicate with hospitalized patients but also engage with people who are well. In a retirement village in the United States of America (US), students had the opportunity to interview well elderly people to engage in Reminiscence Therapy (Gallagher & Carey 2012). A student and a resident were paired, and the resident invited to share a story from their past to reminisce. As the conversations continued residents also discussed current personal issues. Following their experience, 6 students and 21 residents volunteered to participate in individual interviews. Gallagher and Carey (2012) described students' reports of gaining greater insight into issues associated with ageing, such as managing chronic illness, and changes to role or physical function.

In these studies, students experienced an array of emotions when engaging with patients and their stories. While not all stories were 'enjoyable', there is a general theme of having enjoyed the opportunity to story tell. My own experience as an educator echoes this finding. I recently received a 'thank you' card from a group of students exiting placement. What struck me about this card was the comment 'thank you for all your stories'. I expressed surprise to the students because this was not a group participating in the research. They were emphatic that I had told them lots of stories which they enjoyed, and most gratuitously, had learnt from. Without students realizing, they too had developed confidence and willingness to frame their discussions around stories. While not formally part of this research data, this card demonstrated evidence that enjoying storytelling is a valuable contributor to student learning.

3.3.2 Judging by the Cover

Storytelling has the potential to dispel student's misconceptions about ageing (Gallagher & Carey 2012), sick children (van der Riet, et al. 2017), private versus public patients (Chan & Lai 2016) and mental health (Perlman et al. 2017; Webster (2010). In reviewing outcomes of the reminiscence project in aged care, Gallagher and Carey (2012) asserted that it prompted the rejection of stereotypes by students. Supportive statements appear to confirm their observations. Such statements included "*She wasn't what I thought an older adult would be… she never mentioned being lonely"* (Gallagher & Carey 2012 p.579).

Australian students working in a project with sick children in Thailand described how their preconceptions of sick child were unfounded (van der Riet et al. 2017). As part of 14-day study tour, groups of Australian nursing students worked in two children's wards in Thailand. Over a 5-year period, researchers interviewed 96 Australian and 21 Thai nursing students. Thematic analysis of their data centred on the impact of a therapeutic or 'fairy garden' on the children's health and wellbeing (Van der Riet et al. 2017). The authors describe a shift in the stereotypical view of children who are sick. They quoted one student who demonstrated insight into the necessity of viewing children as having "*the freedom to be a child, not a sick one"* (van der Riet et al. 2017 p.90). Although it is unclear whether it was founded, students in a Honk Kong study (Chan & Lai 2016) perceived private patients as having higher expectations of them. This resulted in the students preferring to say very little rather than risk receiving a complaint.

Pre-conceptions in the community towards people with a mental illness is not unusual. Two studies in this review describe creative strategies employed to address

student's mental health care placement. Perlman et al. (2017) describes a 5-day Recovery Camp. The outdoor recreational facility in Australia provided opportunities for student-consumer interaction. As the camp progressed, the 20 placement students recognized their prejudices and assumptions about what a person with poor mental health is like. The researchers described how students' views evolved, often surprising them, "*…individuals with mental illness are capable and have to learn to manage their diagnosis through … medication, exercise, nutrition …"* (Perlman et al. 2017, p.41). In another study in the US, Webster (2010) described a creative educational program which aimed to increased student's empathy for people with mental illness. Two groups of students attended separate 10-week inpatient mental health placements, followed by 4 weeks in the community. The control group of 44 students received traditional teaching throughout their placement. The comparison group of 29 students experienced a creative and reflective approach to learning during the 4-week community component. The imbalance in numbers has possibly weakened the study but reflects the reality of locating adequate space for group reflection in the clinical environment. Webster's (2010) examination of the pre and post placement Interpersonal Reactivity Index (IRI) identified no real differences in empathy in either group. Despite this finding, Webster (2010) concluded that students in both groups showed improvement in other areas of interpersonal functioning (p.91). After analysing qualitative data collected through student journals, interviews and researcher field notes, Webster (2010) concluded that creative reflection did result in a positive shift in student's attitudes.

This research has sharpened my attention to language. Peg holing patients, staff and peers is distressingly common in students' conversations. My natural reaction is to shut down the conversation with a rebuke. What I am gradually learning

is how to facilitate the student to ‘return’ to their scenario. Commonly referred to as reflective practice, it is simply an opportunity for the student to reframe their judgement with an alternative lens, or story.

3.3.3 Time to story

One of the most common rhetorical answers as to why nurses struggle to explore patient’s stories is “*lack of time”.* Evidence in the literature demonstrates that students may have a different experience. Chan and Lai (2016) found that students recognized that being supernumerary provided them with more opportunities than the registered nurses to spend time getting to know patients’ stories. Gillett et al.’s (2016) palliative care study involved both nursing and medical students. They observed that the role difference between the professions appeared to allow nursing students more time to get to know the patient. This enhanced nursing students’ confidence to communicate. Webster’s (2010) mental health study described how students were able to work with the same client over a 4-week period. Students claimed that this provided them with the opportunity to understand the loss and loneliness often experienced by clients with mental illness. This intensive also increased their capacity to view the person as an individual and not just another person with mental illness. Students in Perlman et al.’s (2017) Recovery Camp were not provided details of the consumer’s health or life history. This meant they had to spend time to get to know them. This changed the way in which they interacted with consumers, increasing their respect and empathy. While these studies highlight the increased time, students appear to have with patients, they also acknowledge this may not be the case after graduation. Chan and Lai (2016), and Paliadelis and Wood (2016) report students as attributing environmental factors such as high patient load, low staff numbers, and

time pressures as impeding registered nurses to spend time with patients. With RNs as role models, it is possible that their approach to patient communication may influence the students' practice once they register.

Students have opportunities to self-assess their performance in developing therapeutic relationships with patients. I find it's not uncommon for their scores to be on the highest level. These students explain that they find time to communicate with their patients, during which they listen and demonstrate empathy. The gap here is the lack of an individualized plan of why and how students will develop their therapeutic relationship. Communicating with the patient and demonstrating empathy, is only a means to an end. What I hope to impart to the students is that communication may elicit important stories. These stories have the potential to inform genuine, meaningful and healing nursing care.

3.3.4 Role of RN mentors

During clinical placement students are allocated to co-work with an RN. The allocation may be to the same RN throughout the placement or may change from shift to shift. Regardless of the model, students are influenced by the RN's approach to clinical practice and teaching and learning. Students in a designated clinical education ward (Manninen et al. 2013) believed RNs played an important role in their sense of belonging. They described that feeling part of the caring team often meant that patients trusted them (Manninen et al. 2013). Their sense of collaboration encouraged students to focus and take good care of their patients. At the end of each shift, students and supervisors met to debrief. The researchers reported that the opportunities for discussion and reflection contributed to student's feeling acknowledged, adding to their personal and professional development (Manninen et al. 2013). Students in Chan

and Lai's (2016) study described a less supportive approach. They felt that nurses often treated them poorly, resulting in high anxiety, reduced confidence and potential poor performance. They also perceived that RNs preferred them to focus on physical tasks rather than talking to patients. In Paliadelis and Wood's (2016) study, final year students were asked to write about two meaningful incidents which occurred during clinical placements. A recurring theme in the 92 narratives was the importance of fitting in. While students described both positive and negative accounts, many of their stories of isolation concerned the educators / researchers. Students sometimes experienced disrespect and ridicule from qualified staff. This environment made learning to communicate with patients a significant obstacle.

Students in a community mental health placement recognized their relationship with the RN as central to their experience of placement. Students participating in the Clinical Recovery Camp (Perlman et al. 2017) claimed that in previous placements they felt like 'shadows' to their designated RN. "*It is important to note that five [cohort of 20] students used the term 'shadow' as a means of explaining their role in previous placements"* (p.38). Students in the Recovery Camp placement perceived that RNs and consumers were a significant and accessible source of learning. On the other hand, it appears that not all students in Perlman et al.'s (2017) study had a designated supervisor. Students attributed high anxiety and uncertainty in relating to consumers to this oversight (p.39). Supportive learning is particularly important in complex placements. Unfortunately, this does not always occur, as described in Gillett et al.'s (2016) palliative care study. Students described feeling unsupported by their placement mentor when facing difficult situations such as death and dying. In Schwind et al.'s (2015), inquiry into how students learn to care, they believe that placement

RNs and clinical educators should collaborate more closely to improve students' caring practice.

RNs are a strong influence in students' experience of clinical placement. Students soon decide amongst themselves which RNs teach and which RNs barely acknowledge them. Where possible, the students manipulate their allocation and take turns to work with the more congenial RNs. I find the students approach to maximizing their learning opportunities creative and commendable. I also enjoy the humorous tales about how they manage to dodge the 'bad' ones and stay close to the 'good' ones.

3.3.5 Role of Clinical Educators

Clinical educators have the responsibility to guide the student through the milestones of placement. Their relationship with the student can either enhance or inhibit students learning experience. In response to student's challenging experiences of placement, Chan and Lai (2016) highlighted the critical role of clinical educators in actively listening to students and in facilitating their sharing. Gillett et al. (2016) suggest that clinical educators are an important source of support for students managing challenges such as grief. They recommend that educators should focus on student's personal needs rather than delivering passive information on the topic of empathy. The relationship between the clinical educator and their student is not only vital for support, it models the values of person-centred care. Ekebergh (2011) examines a clinical education model which proposes that educators need to be as mindful of their student's story, as students are of their patient's story. Without acknowledging the student's learning and personal needs, Ekebergh (2011) argues that the facilitation session is unlikely to be useful. According to Schwind et al. (2015), the same values

apply to student-educator collaboration as student-patient therapeutic relationships. Another study by Schwind et al. (2014) describes how learning encounters between educators and students should model the concept of person-centred care. A participant in Gillett et al.'s study (2016) described how she felt let down and unsupported by the clinical educator in managing issues of grief and loss. Another participant in Gillett et al.'s (2016) project claimed to have attended a research focus group as the only option to debrief their palliative care placement. van der Riet et al. (2017) conducted a focus group the day after students participated in the recreational fairy garden. The researcher describes students as *"very eager to participate … and talk about their experiences"* (van der Riet et al. 2017 p.89). It is not clear whether students' stories were actively facilitated throughout the placement. In Paliadelis and Wood's (2016) study, third year students submitted their placement narratives as part of an assignment. The researchers recognized how valuable the narrative reflection exercise was to student learning. Unfortunately, despite their conclusion, they failed to consider narrative reflection as a facilitation tool during, as opposed to following, clinical placement. Students in Perlman et al.'s (2016) Recovery Camp were required to complete 6 journal reflections during and following their placement, to assist their learning. The journal entries were also described as a research measure and an important part of their data analysis. There is no description of how student's learning was actively facilitated during the camp. Nor is there any indication that the journal entries were used as a means of education as the placement progressed. In Webster's (2010) mental health placement, students were required to keep a journal as well as create an artefact. These items were examined and used as research data. While Webster (2010) reports positive findings, it is not clear whether any learning was facilitated through these items during the placement.

Clinical educators are responsible for facilitating learning as well as conducting assessments. I realise now that arts-based pedagogy has helped me to understand the learning and personal needs of individual students. When I sit down to write my reflections on students' performance, I feel much more capable to demonstrate authenticity. Conversely, I have also found that arts-based learning requires commitment to professional development and personal reflection. It is also exhausting. The literature demonstrates potential for clinical educators to expand their practice in this field. To fulfil this goal will require academics from higher levels to capture the potential of arts-based learning in clinical education.

3.3.6 Art of Learning

The response to arts-based pedagogy appears to have evoked a mixed response in nurse education. A systematic review conducted by Rieger et al. (2015) reported themes of crowded curriculum, insufficient evidence of beneficence and no staff training as barriers to arts-based interventions. They concluded that no evidence existed that arts were effective in achieving learning goals. They also recognized limitations in the findings. Studies focused less on measuring learning outcomes and more on students' experience of arts-based learning. They concluded there was sufficient evidence of the potential of the arts in nurse education to warrant further research. In Rieger et al.'s (2015) systematic review fourteen of the forty-one articles referred to the narrative arts. Only three were situated in clinical placement, one of which met the criteria for this review; Webster, 2010 (Rieger et al. 2015). It is not possible to conclude if this absence of publication reflects little interest in the arts during clinical placement. It does signify that research is worth pursuing.

In the study conducted during clinical placement by Manorcha and Manorcha (2007), students attended an arts workshop at the end of each shift. 16 first year nursing students participated. The clinical placement occurred one day per week for thirteen weeks. The final ninety minutes of each placement day was devoted to clinical education. In 9 of the 13 education sessions an arts-based approach was used for learning. Students were free to reflect on any aspect of their day. Using guided imagery, creative writing, drawing or poetry, students expressed personal challenges, patient narratives or other experiences of interest to them. The reflection was followed by discussion. The evaluation concluded that students experienced deeper self-awareness, recognition of their emotions and coping strategies as well as better rapport with patients. Manorcha and Manorcha (2007) recommended that further research into the use of the arts in clinical education is worthwhile.

The use of “Arts in Health” (SA Health 2012) and the curriculum addition to of “Narrative Medicine” into the medical studies (Charon 2006), extends a challenge to nurse educators to consider the arts. As Reiger (2015) suggests, further research on the benefits of arts-based learning in nurse education is warranted. This research aims to encourage other academics to inquire into the potential of the arts to enrich nurse education.

3.3.7 Art of Caring

Caring is the central theory of nursing practice (Watson 2012). Schwind et al. (2015) explored students’ concepts of learning to care. The art medium used for reflection also doubled as a research tool for their narrative inquiry. In examining student’s work Schwind et al. (2015) concluded that a close relationship exists between student’s personal knowing and their delivery of person-centred care.

Professional nursing is influenced by rapid advances in technical and scientific knowledge. Caring is a nursing theory commonly expressed through high quality nurse-patient relationships. If, as Schwind et al. (2015; 2014) insists and Rieger et al. (2015, 2016) demonstrates, there is a close connection between caring and personal knowing, educational strategies in this field are essential. According to Schwind et al. (2015) and Rieger et al. (2015), arts-based learning demonstrates its effectiveness in developing caring knowledge, reflective capacity and relationship skills. Along with Manorcha & Manorcha (2007), findings indicate its particular value in situated learning. It is a reasonable conclusion that implementation of arts-based learning during clinical placement is appropriate and worthwhile. Re-examining the studies in this literature review, simple adjustments to the educational approaches would have added important value, and possibly improved student outcomes in caring skills. This is confirmed in Chan and Lai's (2016) study. Their discussion identified that educators needed to actively listen and encourage student sharing. In their conclusion they recommended that students use a diary during their placement. They stated that this could be used as a means to record patient interactions, personal reflection, and importantly, provide educators with insight into student's needs as the placement progressed (Chan & Lai 2016 p.5). In the two mental health placements (Gidman 2013; Webster 2010) students kept a journal. Analysis yielded important data as to the effectiveness of the educational placement. Intentionally meeting with students during the placement to reflect on journal entries had the potential to address the anxieties and uncertainties students had recorded. In the palliative care placement (Gillet et al. 2015) students attended the focus group after the placement to share common experiences and feelings of grief and isolation from staff. Schwind et al. (2015; 2014) describe narrative reflective practice as an important medium to explore

feelings such as these and open the opportunity to develop empathy for patients. In the clinical education ward (Manninen et al. 2013) students and supervisors had the opportunity to debrief at the end of each shift.

Students in Manorcha and Manorcha's (2007) study also met with their educator at the end of each shift. They employed an arts-based approach to reflection. Manorcha and Manorcha's students used their artefacts to prompt discussion of their day. It is unclear what framework Manninen et al. (2013) used for debriefing but they argue that *"reflection and dialogue are essential to enhance learning"* (p.140). A comparative analysis of arts-based and non-arts-based learning as a means of debrief and reflection may be a worthwhile endeavour. Students in Paliadelis and Wood's (2016) digital storytelling study reflected back on clinical placements. Participants highlighted the value of the storytelling activity to reflect on clinical incidents, as well as the act of reflection itself (Paliadelis & Wood 2016, p.41). They described how students mostly selected challenging stories, using descriptors such as, *"confronting"; "extraordinary", "alarming" and "intimidating". They experienced "shock, puzzlement and confusion", or felt "really scared" or "astounded" …"* (p.40). The authors concluded that their storytelling project fostered students' *"…links between … "knowledge" … "experiences" … and realties of clinical practice …"* (Paliadelis & Wood 2016 p.44). If storytelling has unlocked such genuine and emotive experiences in backward reflection, the proposition of creative reflection during placement is logical.

Storytelling highlights to the student their own capacity to care. When reading or sharing their creative writing to the group, I found that students frequently ended with gentle tears or a soft crack in their voice. This emotive response often came as a surprise to the student. It was usually triggered by the realization of how much they

cared for the patient. These moments are ones which allow the student to consider care as tangible and not only theoretical.

3.4 The end of the beginning?

This review has examined students' experiences of storytelling during their clinical placement. The placements were diverse, situated in Hong Kong (Chan & Lai 2016), Sweden (Manninen et al. 2013; Ekebergh 2011), the United Kingdom (Gidman 2013; Gillett 2016 et al.), Thailand (van der Riet et al. 2017) Australia (Paliadelis & Wood 2016; Van der Riet et al. 2017), Canada (Schwind et al, 2015; Schwind 2014) and the United States of America (Webster 2010; Gallagher & Carey 2012; Manorcha & Manorcha 2007). The studies have included hospital care, aged care, community and mental health. This provides a broad picture of common experiences of clinical placement.

The articles describe how students usually attend clinical placement keen to listen to patients' stories. They appear to demonstrate that students have a good understanding of the importance of communication in delivering person-centred care. During clinical placement students also encounter obstacles to developing their communication skills. The literature has identified obstacles as developing proficiency in clinical skills, coping with grief and loss, managing patient stereotypes, lack of a sense of belonging, and uncertainty of support from mentoring registered nurses and clinical educators (Chan & Lai 2016; Gillett et al. 2016; Manninen et al. 2013). Researchers have correlated the student's strong sense of self with developing competency in caring skills (Schwind et al. 2015). Some researchers have trialled arts-based pedagogy in nurse education to develop affective skills, closely related to caring practice (Gidman 2013; Webster 2010). Students have provided positive feedback in

their experience of using arts-based methods, and according to some researchers, these have improved student's capacity to deliver person-centred care (Schwind et al. 2015). Only one study (Manorcha & Manorcha 2007) facilitated arts-based pedagogy *during* clinical placement to reflect on practice and develop caring skills.

Over one decade since the Manorcha and Manorcha (2007) arts-based learning stands alone in the clinical placement environment. Clinical educators have barely turned the page to discover what would happen if students used the arts during placement. Research has already established that creativity increases empathy, improves personal knowing, reduces misconceptions, manages complex emotions, enhances confidence, and develops caring skills (Schwind et al. 2015). The arts also open the window for clinical educators to glimpse into their student's story and model a collaborative, caring relationship (Ekebergh 2011). While these findings are evident in the literature, applying them to clinical practice is not. There is a gap between what we know and what we practice. Research which contributes to closing the gap also contributes to improving patient care. Caring is widely accepted as the central epistemological theory of nursing (Watson 2012). A new, creative, and simple intervention which aims to improve the caring practice of nursing students should rate highly in the priorities of educational research. It is time to move on to a new chapter in the story of arts-based pedagogy in nurse education during clinical placement.

4 Chapter Four: Methodology

I considered that inquiring into students' stories a considerable privilege. Reshaping stories to understand meaning required me to respect, and to come to know each storyteller. To ensure accountability to the students I needed to understand the methodological boundaries in which to use story as data. Uncovering the meaning of data to the research community required standardized criteria. In addition, the research puzzle aimed to explore storytelling as a method for learning in clinical education. Narrative research appeared the logical choice. On closer examination a wide scope of narrative research methods exists under the qualitative research banner (Wertz et al. 2011). Josselyn (2011) understands the methodology of narrative research as 'constructing, deconstructing and reconstructing story (Josselyn 2011 p.224). Nurse researchers have expanded narrative inquiry to include 'arts-informed' (Haydon et al. 2018; Lindsay & Schwind et al. 2015) and 'arts-based' (Leavy 2018). Nurse researchers have used Clandinin and Connolly's (1990, 2000) method of narrative inquiry and their experience resonated with my criteria (Wang & Geale 2015). Clandinin and Connolly's methodology includes the three-dimensional framework to provide context around the research.

Stories cannot be separated from the life story of the storyteller. To understand story is to understand the storyteller. To understand the storyteller is to walk their life journey with them. As a clinical educator I already work in the midst of students' experience of placement. When students begin their clinical placement, I begin their journey with them. I experience their highs and lows, and I feel similar relief at the end when they pass. Selecting arts-based narrative inquiry was only the first part of understanding the methodology. The long lead up to mutually acceptable ethics

approval provided me with time to improve my understanding of Clandinin and Connolly's approach. It also consolidated my knowledge as I "argued" my case for this less traditional method. Participants

Between February and November 2018, I facilitated seven consecutive groups of nursing students during their clinical placement, following university ethics approval (number 7938). In Groups 1-3 the methodology of narrative inquiry was considerably restrained by ethics requirements. The methods were not ideal and the data reflected this. Considerable renegotiation with ethics improved the second part of the inquiry with Groups 4-7. Regardless of the frustration and less than ideal circumstances, it is recounted here because it was the reality of the story of how participants became involved.

Group 1

The initial ethics approval restricted participation to students other than those I was facilitating. My principal research supervisor emailed an invitation to all second-year students about to go on placement. Two final year students, who were friends, responded to the email invitation. In addition, one clinical educator agreed to invite her students to attend my first storytelling session. Two students from her group of ten students attended session one, along with the two volunteer students. In session two only the two original volunteers returned. These two students participated in a creative writing exercise and expanded their story as they read it out. The experience for all three of us was moving. One of the students told her story about growing up in China in a family that rebelled against the one child policy. When the students left to return to the ward, I remember sitting, stunned at their honesty, trust and heartache. I knew this research could work. I knew it was important. But it was not narrative inquiry.

These were not ‘my’ students. They already had a clinical educator. The storytelling session would remain as only that. Important, interesting, but would not respond to my research puzzle. I had to return to ethics for permission to work with my own group of students. I suspended the sessions but arranged to interview the students once their placement ended. In the interview they responded to questions about their experience of clinical placement. However, the impact of stories told ‘in hindsight’ lacked the three-dimensional approach to narrative inquiry.

Group 2

We approached the ethics committee and sought recruitment modification. Ethics agreed that I could work with my own group of students, with restrictions. I could not record storytelling sessions, collect stories, or interview students until after the placement ended. I could describe my research to students but could not invite their participation. My supervisor could email the students the evening before placement ended. The email included research information and consent forms. I worked within these restrictions and conducted storytelling exercises over the four-week placement. I relied on my own journal entries to document experiences. While these ethical limitations were frustrating, they did not inhibit weekly storytelling sessions, as they were already a part of my regular clinical education sessions. I maintained field notes through audio and journal reflections. My written and audio journal provided an important method to *“freeze [moments] and fill in the gaps which may otherwise be forgotten”* (Clandinin & Connolly 2000 p.83). On the final session I invited students to email me their stories and make a time for an interview. All five students signed the consent to participate. However, only two students emailed me their stories and made a time for an interview. The two interviews, once again, reflected their backward

reflection on their clinical placement. I suspected that students did not email me their stories due to finishing and forgetting placement, as opposed to consciously choosing not to participate. I had no evidence for my assumption so I needed to repeat the process with the following group.

Group 3

Six students participated in the storytelling exercises throughout their four-week placement. With the same recruitment process as above, only one student sent me their stories following placement. She declined an interview based on busyness. The restrictions needed to be reviewed once again.

Groups 4 – 7

We met with the chair of the ethics committee to explain the situation and its impact on the research process of narrative inquiry. Some restrictions were lifted. I was able to continue to conduct storytelling exercises during the placement, but not record storytelling sessions, collect stories, or interview students until after the placement ended. I could invite the students to stay behind on the final day of clinical placement rather than the following weeks. Students could consent to participate in a recorded storytelling session. They could submit their stories to me. The information sheet and consent for this stage are shown in appendix 1 and 2.

Group 4

With the modified recruitment process, all five students stayed behind on the final day. They agreed to participate in the recorded storytelling session. Each student gave me their creative writing pieces. Students mostly chose to take photos of their stories and email me these. Ethics approval is shown in appendix 3.

Group 5

This group were first year students on their first, two-week placement. Their placement environment was tough and I spent much of my time with individual students. There had been very little opportunity to undertake storytelling sessions. Still, when the final day of placement arrived all five students agreed to stay behind and try the exercise. One of the five students said she would stay but did not want to participate or be recorded. I agreed but asked her not to comment during the recording. Despite this being our sole session, I felt amazed by the depth of everyone's stories, and the willingness to share.

Group 6

All four second year students agreed to participate in the recorded session and submitted their creative writing pieces. I have used the stories from Group Six as key field texts to work with in this narrative inquiry. This decision was based on my improved confidence in working with groups and the quality of their stories. I had also achieved a confident grasp of the methodology by this time.

Group 7

Group Seven consisted of five final year students, in their final placement. By this stage I was deeply immersed in studying the field texts and had decided not to collect any more. Throughout the eight-week placement I found myself discussing my research with the students. They responded with stories confirming or adding to my meaning making. By the final session I felt I could not let the wisdom of this group disappear. The five students agreed to a recorded open discussion about their overall experiences of clinical placement. Themes collated from this transcript are integrated

throughout the inquiry as a measure of quality. This concept is discussed further in section 7.2.

Twenty-five students actively participated in providing research material for this study. Their written stories and/or audio recordings combined with my written and audio recorded field notes and journals make the dataset for this research.

4.1 Arts-Based narrative inquiry

The terms “arts-based” and “arts-informed” research is often used interchangeably to describe the use of arts within research. Arts-based research can stand alone as a qualitative methodology or be integrated to enhance other methods (Cole & Knowles 2008). Art mediums are diverse and may include narrative, fiction, poetry, visual arts, drawings, photo voice, photography, drama, film and theatre (Cole & Knowles 2008). Arts-based research is particularly helpful in narrative inquiries as they aim to illuminate and extract meaning from people’s experiences. According to St Pierre (1997) arts within research *“produces different knowledge and produces knowledge differently”* (p.175). The arts infuse traditional methods of qualitative research with life (Cole & Knowles 2008). They hold our attention, challenge perceptions, and highlight stereotypes (Leavy 2018). Some theorists’ position narrative inquiry within the genre of arts-based research (Leavy 2018). However, narrative inquirers who apply artistic form to enhance their inquiry sometimes distinguish this as arts-informed narrative inquiry (Cole & Knowles 2008; Schwind et al. 2015). Arts-based research captures experiences in ways that traditional qualitative research methods do not (Cole & Knowles 2008; Leavy 2018). The stories collected in this inquiry *“… evoke emotions, promote reflection and transform the way we think”* (Leavy 2018 p.292). Storytelling can produce knowledge in a way that is more

engaging and potentially more genuine. Research exists within the power of the stories to advance knowledge (Cole & Knowles 2008). In addition to the unfolding narrative of participants' experience, this research analysed written and recorded stories. It is the examination of creative works that indicate that this is an arts-informed narrative inquiry.

4.2 Clandinin and Connolly

Delving into what Clandinin and Connolly's methodology is and how it works is described as this inquiry unfolds. In Clandinin and Connolly's (2000) landmark text titled *"Narrative Inquiry; Experience and Story in Qualitative Research"*, they suggest that their method of narrative inquiry is best understood *"contextually by recounting what the narrative inquirer … [did]"* (Clandinin & Connolly 2000 p.xiii). Their discussion unfolds throughout their book, illustrated with examples from their own narrative inquiries. Their text provides a significant guide to this narrative inquiry. Similar to the approach in their book, this thesis revisits the concepts throughout the text. In this section a number of foundational concepts are discussed to set the scene. Research commonalities of ethics, methods, data, discussion, recommendations and conclusion remain intact. However, unique terminology evolved along with their concepts (Clandinin & Connelly 2000 pp. ix- xii). The remaining chapters of this thesis are written in a way that demonstrates their concepts, or *"touchstones"* (Clandinin & Caine 2012 p.169). In following the "language" of narrative inquiry, the layout of this thesis differs from a traditional structure.

4.3 Narrative thinking

Experienced teachers, Clandinin and Connolly worked for many years within the accepted theory of cognitive thinking in school education. When a theory is widely accepted in professional research and practice, Clandinin and Connolly describe this as the *"grand narrative"* (2000 p.22). In the late 1990s they joined a team invited to introduce narrative thinking into the accepted cognitive perspective. As they developed their narrative view of experience, they also explored emerging "*postmodern ways of inquiry"* (Clandinin & Connolly 2000 p.24). Dissatisfied with methodologies in which to situate their narrative concepts, their own methodology of narrative inquiry evolved. Their theoretical framework considers stories told within narrative inquiry as *"situated on storied landscapes"* (Clandinin & Connolly 2000 p.128). In positioning their approach to research at the boundaries of other forms of qualitative research, they state that,

> *"Learning to think narratively at the boundaries between narrative and other forms of inquiry is the single most important feature of successful narrative thinking" (Clandinin & Connolly 2000 p.25).*

Narrative thinking permeates each 'stage' of conducting a narrative inquiry.

4.4 Experience as story

Based on Dewey's theory that all experience has meaning (Dewey 1963), Clandinin and Connolly refer to experience as story. *"As we live, tell, relive and retell our story" (p.20) we develop and grow as people* (Clandinin & Connolly 2000). The experience of living the narrative inquiry provided a new story for the participants. Clandinin and Connolly explain that "*as we lived out our life story, we told stories of*

those experiences, and modified them by retelling them and reliving them" (2000 p.10). Narrative inquiry explores the meaning of these stories using specific concepts.

4.5 Three-dimensional framework

Clandinin and Connolly (2000) developed an analytical framework using a metaphor of three dimensions. The metaphor provides narrative inquirers with directions in which to explore stories.

4.5.1 Time

The first dimension is *"temporality"*, also referred to as "backward and forward". The inquirer must "come alongside" the participant and experience the impact of time on the phenomena under study. I began my relationship with students knowing they came into the inquiry with a past and a present, which would influence their future. There is no true end to the research because our life experiences continue beyond the study. This narrative inquiry is only a snapshot taken within the period of time lived during clinical placement.

4.5.2 Sociality

The second dimension, *"sociality"*, refers to personal and social factors which influence our experience (Clandinin 2013). Nursing students experienced an array of emotions as the placement progressed. They encountered multiple social contacts which included patients and their families, staff, educators, and new peer relationships. Placement disrupts the routine of students' personal life. For some this affected paid employment, child minding, transport, and study pressures. The students' personal-social experience could not be ignored in their storytelling

sessions. Equally important was my own experience of witnessing students' challenges, sometimes advocating for them, and always trying to understand their meaning.

4.5.3 Place

The third dimension, *"place"*, refers to the fact that all experience must occur somewhere (Clandinin 2013). In this inquiry students worked in a hospital ward. Apart from the clinical challenges of the hospital placement, students were faced with a new social setting. The hospital environment has accepted norms, many of which are unspoken. Acknowledging the influence of "*place"* on storytelling assists to physically contextualize the stories.

No one dimension is effective without the other. Viewing stories within the three-dimensional context is one of the most significant factors that differentiate Clandinin and Connelly's narrative inquiry from other narrative research (Clandinin 2013).

4.6 In the midst

Understanding the participants' experience of the phenomena is possible as the narrative inquirer becomes immersed in their stories. They "experience the experience" of the inquiry (Clandinin & Connolly 2000). Narrative inquirers enter the research in the midst of their own, their participants, and social narratives (Clandinin 2013). The researcher's life cannot to be bracketed out of the inquiry. For me, this narrative inquiry occurred in the midst of a busy family life. Working as a clinical facilitator while undertaking the research required continual self and professional reflection. Throughout the research I continued to teach other students, during clinical facilitation, in skills workshops, and classroom tutorials. I was also a student; a student

of research and a student of creative writing. Each had milestones to achieve. Rippling out of the central focus of this master's research were recreational, social, and financial commitments. In addition to these personal narratives, experiences are influenced by institutional, social, and political factors outside our control (Clandinin 2013). Positioning the narrative inquiry in the midst of these complexities is essential to maintain the three-dimensional concept.

4.7 Interpretive-analytic considerations

The goal of analysing field texts is to discover meaning, situate findings and understand significance (Clandinin & Connelly 2000). Clear boundaries separate narrative inquiry within the field of narratology (Clandinin & Rosiek 2007). In analysing stories with the view to identify themes there is the risk of "talking over" participant stories to verify apparent themes (McKenna 2017). While the three-dimensional approach permeates this inquiry, I also chose narrative analysis to review creative writing stories. Narrative analysis draws on the field of linguistics and psychology to probe the text for embedded meaning (Labov & Waletzky 1966; Lieblich et al.1988). Analysing the creative writing pieces in this way aimed to understand the depth of reflection which creative writing produces.

4.8 Understanding Rigour

A narrative inquiry aims to add meaning and significance about the phenomena under review. The narrative inquirer uses "*creative texts that offer readers a place to imagine their own uses and applications"* (Clandinin & Connolly 2000 p.42). As the methodology developed so too did a set of more relevant terms associated with narrative and rigour. Formalists discuss *"validity, reliability and generalizability"*

(Clandinin & Connolly 1990 p.7). This is language relevant to other research methods and do not sit comfortably with narrative inquiry. A narrative inquiry text must be 'invitational'. As the reader reflects on the text, the researcher extends an invitation to the reader to participate in *"a mutually enriching experience"* (Clandinin & Connolly 1990 p.8). Readers of narrative inquiries are invited to reflect on their own insights into the phenomenon, develop their own knowledge, and arrive at their own conclusions. Research texts are contextualized "*attuned to the institutional, professional, cultural, linguistic, and familial narratives that impact on those stories"* (Clandinin & Caine 2012 p.170).

Stories must also be examined closely to capture authentic elements and *"rings true"* (Clandinin & Connolly 1990 p.8). It is vital that the researcher is aware, or *"wakeful"* (Clandinin & Connolly 2000 p. 184), to the evolving terminology and contemporary meanings of this unique approach to narrative inquiry. It is essential that the wider research community considers the inquiry trustworthy. To assist others to understand the rigour of narrative inquiry, Clandinin (2016), Clandinin & Caine (2012) and (Clandinin & Connolly 2000) structure their inquiry according to a series of measures, or *"touchstones".*

4.9 Touchstones

Touchstones refer to the accepted concepts in conducting and assessing a narrative inquiry of high quality. Clandinin and Caine (2012), describe this metaphor;

> *. "A touchstone is a hard-black stone, such as jasper or basalt, which was used to test the quality of gold or silver by comparing the streak left on the stone by one of these metals with that of a standard alloy. We wondered if we*

metaphorically touched or scratched a narrative inquiry, what kinds of streaks or marks would be left" (p.169).

To demonstrate that this narrative inquiry is one of high quality, this research is guided by Clandinin and Connolly's (2000) *"touchstones"* (pp. ix-xii). Accordingly, the remaining chapters of this thesis are presented according to twelve touchstones. Each touchstone is identified and discussed in Part Two under chapter headings.

4.10 Overview of Part One

This section described the commonplaces associated with the methodology of Clandinin and Connolly's (2000) narrative inquiry. It explained that *"arts-informed"* refers to the integration of storytelling into the methodology. To ensure rigour and provide direction narrative inquiries, Clandinin and Caine (2012) described twelve "touchstones". Touchstones one to six discuss the importance of establishing and maintaining responsible relationships between researcher and participants. Touchstone seven analyses and discusses the field and research texts. Touchstones eight to twelve explore the potential impact of this narrative inquiry on nursing. The subsequent chapters are structured according to these touchstones.

Part 2: Twelve Touchstones

"Here is the miracle. The experience as experienced, as lived, remains private, but its sense, its meaning, becomes public" (Ricoeur 1976 p.16).

5 Chapter Five: Touchstones 1-6

5.1 Touchstone 1: Relational responsibilities

This inquiry worked within the shifting limitations expressed by university ethics. However, "*ethics"* goes beyond working within committee guidelines. While negotiations with this department continued, I had to maintain an ethical, caring relationship with each student. Their stories were not only data for my research but were often deeply personal for the participants. Black (2017) suggests that *"Creative writing can take us into vulnerable realms where intense emotions are processed ... letting out pain ... but allowing in new ways of being, seeing and thinking..." (*p.4). As students engaged in creative writing and oral storytelling, I had to demonstrate empathy and respect while searching for meaning. It is also important to recognize that the terms *"relationship"* and *"relational"* are different (Clandinin & Connolly 2000). Relational meant that my ethical responsibilities extended beyond my communications with the students. My focus had to face outwards, to the wider world, which influenced the inquiry (Clandinin et al. 2018). The inquiry had to be beneficial to nurse education, clinicians, researchers and ultimately to the recipients of health care.

Throughout the inquiry, relational responsibility proved to be an ongoing challenge. The dividing line between this research touchstone and my role as clinical educator was not always easy to differentiate. As a clinical educator, I had a "triangular"' relationship with students, RNs and academics. Too often I actually felt like I was "meat in a sandwich" between students and ward RNs. Clandinin et al. (2018) describes how an ethic of care has the potential to change the inquirer. In reliving and retelling the following stories I seek evidence, or lack thereof, of improved relational awareness and caring for each of the three stakeholders.

Susan's Journal

I was in the nurse manager's office. She was just really angry. She was - in fact she was starting to raise her voice about the university. "Look universities don't care they just want the money and they don't really care that these international students aren't going to make good RNs". I don't think that's true. I care.

As I reflect on such stories, I observe that my inquiry has returned to my personal question. "If you only knew the patient's story, would you care?" This inquiry has redirected and expanded the question. I would ask RNs, "If you only knew the student's story, would you care?"

Throughout the inquiry there were numerous disturbing accounts of poor attitudes of RNs towards nursing students. A significant portion of these involve field texts with particular reference to students from CALD backgrounds. This discovery prompted me to reflect on the second part of the research puzzle. I wondered if nursing students, in particular CALD students, would find such an attitude an obstacle to their caring practice. My role as researcher and clinical educator were difficult to separate.

A journal entry written soon after the research left me in a dilemma as to managing a field text and advocating for a student.

Susan's Journal

> *One of the students was talking about how she was pregnant. It's her first baby and she was asked to look after a person who's got MRSA*[1] [infection]. She said, "can I just go and look it up and make sure there's no risks to my baby?" and the person [RN] was very rude about it. As a consequence, she went and debriefed with another RN to try to explain "this is what I feel I need to do is to keep myself and my baby safe". Then the next day that same RN, the one she debriefed to, gave her a bay of four patients all who had MRSA and laughed and said, "well this is just the way it is". One of the hard things was her feeling that the university had let her down. Clinical educators, they are in the middle. I know listening to students is important but it's also one sided. What do I follow-up and what is 'normal'? But I don't know. I just think if a ward is treating - if a student feels the ward is treating them poorly then you need to, I don't know. Not just take that on face value but follow it up. That's just what I've learnt from this research. In getting to know the students and then listening to the staff, I can see a discrepancy there. I even look back on my own previous students who the ward has identified as being problematic and wonder now whether I wasn't listening enough to the student. I don't know it's just worth reflecting on. I think this way of facilitating is actually helping me. You know, I'm trying to get students to think about helping them in their practice but I'm actually finding that it's helping me in my practice as a facilitator. Because I'm starting to gain insight into what it's like for students.*

This was the first of many entries with similar stories. I still feel deeply emotional as I reflect back on this one. This was an international student with almost no support

[1] MRSA - Methicillin-resistant Staphylococcus aureus is an infection caused by bacteria that has become resistant to many antibiotics

here. She had only been in Australia for a few months. Whether the pregnancy was planned or not, I do not know. This was only her first placement and she had a lot to learn. Instead of teaching, the RNs ridiculed her fears. They had breached their ethic of care. Watson's nursing theory of caring is incongruent with intolerance and disrespect towards nursing students. Nurses are urged to *"engage in genuine teaching-learning experience that attends to … the other's frame of reference"* (Watson 2008 p.31-41). Waghid (2019) addresses similar difficulties within student-academic relationships. Teaching and learning encounters should reflect the ethic of human care. He states that all students should expect and receive freedom of speech and equality with their mentors and educators. Waghid (2019) also challenges the view that the responsibility for care lies entirely with individuals. He advocates for developing a caring environment. I knew that my relational experience in the clinical education space must extend beyond singular incidents. Some aspects of nursing appear to have developed a non-caring approach to students. This apparent accepted norm in nursing culture is often referred to as "eat one's young", derived from the *"zoological phenomenon of animals killing and consuming their own young for sustenance"* (Phrases 2019). Birks et al. (2018) describe this acceptance of ridicule and disrespect as rooted in the belief of the *"rite of passage"* (p.45).

5.2 Touchstone 2: In the midst

Researchers must position their inquiry within the midst of their own, and their participants' lives. At the beginning of each new group I invited students to undertake a *"Who am I?"* exercise (Adams 1990). These are the instructions to the group:

> *"Begin by reflecting on "who am I?" on the outside, such as birth country, occupation and family. Or on the inside, such as qualities, values, emotions*

or feelings. Write quickly and fill up as much of the space as you can in ten minutes".

The exercise is structured to position each student within the three-dimensional space. In turn this provides a framework with which to understand students' subsequent stories. Students have never hesitated to read out their work. I also share mine. Narrative inquirers need to show participants that they *"become part of [their] lives and they part of [mine]"* (Clandinin 2013 p.23). Telling my own story makes me visible within this narrative inquiry. Visibility invites vulnerability. In choosing narrative inquiry as a research method, I choose not to *"stay silent… or to [appear] perfect, idealized, inquiring and moralizing…"* (Clandinin & Connelly 2000 p.62). This is important because I bring my living and valuable history of nursing to this narrative inquiry. Clandinin (2016 p.23) explains "*…we are part of the present…and past landscape…and we helped to make the world in which we find ourselves".*

Benita: "Who am I?" Creative Writing exercise

"My name is Benita. So, I was born in Nepal. I have two siblings. I finish schooling and high school in my home country. I came to Australia in 2016 for nursing. Currently doing nursing second year at Flinders University. Initially coming to Australia for study by myself was really hard decision for me. I have got some nursing experience from my different placement in different hospital in Australia. Being nurse is not very easy especially people like me who get emotional very easy".

Benita brings us "backwards and forwards" within her temporal space. She takes us back to where she was born. She tells us she has been in Australia for two years. She is in her second year of nursing and she has previously completed a clinical placement. In her conclusion, she brings us forward to the present to describe how she is currently feeling. Benita initially describes her sociality *"outwards"*. She

describes the social setting of where she was born, grew up, and went to school. She tells us the number of her siblings. Still on the outside, she describes her purpose for coming to Australia. Then she moves *"inwards"*. She tells us that coming here by herself was *"really hard decision…"*. She concludes with a personal statement *"…who get emotional very easy"*. Benita's story also has a clear description of *"place"*. We sense that her belongingness might remain in the place where she was born and lived. We know she is in Australia, studying in a university. Benita has been in another hospital to undertake a placement. At the time of writing, she is allocated to an acute care ward for her clinical placement.

Benita's story provides context to make meaning from her upcoming stories and unfolding experience. The purpose of narrative inquiry is not to seek facts, but to understand meaning. In using a recognizable framework, we are able to identify meanings within and across stories (Clandinin & Connelly 2000). This "who am I?" exercise allowed her story to remain intact, while its meaning is grouped with others like a *"patchwork"* (Moon & Fowler 2008). Acknowledging that our stories continually change and develop according to inner and external influences ensures that the inquiry remains *"in the midst".*

5.3 Touchstone 3: Negotiation of Relationships

Touchstone one and two discussed the importance of establishing and contextualizing relationships. Influenced by the evolving three-dimensional context, those relationships never remain stagnant. *"Research lore [describes] negotiating of entry as a step completed at the beginning of an inquiry and [ends]…once the researcher [finishes]"* (Clandinin & Connolly 2000, p.73). In narrative inquiry, negotiation and renegotiation occurs throughout the entire research. The dual role of

clinical educator and narrative inquiry required manoeuvring around educational objectives. Based on subjective observations, my role as assessor at particular moments acted as a barrier to me truly entering students' experience. The ongoing challenge was to renegotiate those relationships once episodes of assessments passed. The final renegotiation was to shift from my role as clinical educator to narrative inquirer on the final day of clinical placement. The commitment to following the touchstones paved the way to engage meaningfully with students' experience on the final storytelling session.

5.4 Touchstone 4: Narrative beginnings.

As the inquiry evolved so too did my autobiographical narrative. In narrative inquiry *"neither researchers nor participants walk away from the inquiry unchanged"* (Clandinin & Cain 2012 p.180).Knowledge gained from students' experience empowers the inquirer to shift clinical *"…practices, and to create possible social-political or theoretical changes… [in nursing]"* (Clandinin & Caine 2012 p.181). From the very first storytelling session, in Group one, I felt overwhelmed by the depth of emotions the storytelling evoked in me. I felt unprepared for the degree of vulnerability students were open to reach. At home, in my researcher journal I write:

Susan's Journal

Next time I'll bring tissues. For me as well as the students! When I went to pick up a student from the "Day of Surgery Unit" I remembered back to 18 months ago.

I was there, waiting for my own surgery and it brought me back. It brought me back to the coldness of the experience. Back to the weeks, months, and years, building up to this experience. I shared some of those feelings with the students today. I shared how I had felt really anxious. I was

having…major, life changing surgery. At the time I think I would have really appreciated it if someone had asked me, "how are you going? How do you feel about it? Do you have support? How do you think you might manage afterwards?" It would have made a difference.

While a level of honesty is evident in my story, my role as clinical educator required certain restraints. The reason for my illness was of no one's concern, nor the true extent of devastation. The story prompted students to relate my experience to their own. It was the student's unfolding narrative throughout their placement which would help me reflect on the research puzzle. My story could only ever be a prompt, or an instrument to provoke student narrative.

Susan's Journal

A student in the group had tears too. She told us that she had been there as well, soon after her arrival in Australia. Her English was quite limited at that time and she had been asked lots of questions and the nurse was ticking her answers. She didn't know what they were writing down. She was really scared.

Students based in this Day of Surgery ward discussed how difficult it is to relate to patients in a more personal way in their allocated 15 minutes. However, on the final session, one student said:

Group 1: third year:

"Actually, in the first Group session you asked us to ask questions of the patient, but for us generally we just follow the paperwork.... Today I just try one time, I just ask the patient how they get the injury. The patient just told me a lot which I found a good way to maybe communicate with the patient and get more information from them. Is also good for us to provide more maybe more safe… care for them... Normally ... you just fill the form - it's just mechanism, just like a machine you know, a computer. But when you

just talk or ask the question for the patient... it's a really good way to contribute to their care…"

This recorded transcript demonstrated a student reflecting back on their placement, and what she had learnt from the storytelling exercises. Ethics restrictions at this point of the inquiry resulted in only backward reflection. Since this was not considered narrative inquiry, the sessions were suspended. Still, the interview has demonstrated the power of storytelling on the practice of at least nursing student in Group One.

5.5 Touchstone 5: Negotiating entry into the Field

In narrative inquiry, the *"field"* is the interpersonal space between inquirer and participant (Clandinin & Caine 2012). This requires the inquirer to listen to the participant's experience. In the following written story, the student has completed her first placement. She is leaving for China soon as she nears the end of first year. This story of her encounter with a patient is interwoven with homesickness.

Group 4: first year

"So, one patient who was a complicated patient, I saw her husband always there with her and sit beside her bed ... I think the patient looks very weak, there's no muscles. Just left to the bone. One day when I came into the room and saw husband was kissing her forehead. He loves her very much. It reminds me of my parents because I came here last year. So, my parents very far from Australia in China. We talk China with our phone and others, so I saw their hair was white. So, it just reminds me of my parents and my grandparents. Yeah, that's all".

This student has invited me, and her peers, to enter into her interpersonal space. As she retold and relived her moment of patient engagement, we entered into her social world. This narrative inquiry is interested in the *"the ways that individual*

narratives are embedded in social, cultural, familial, linguistic and institutional narratives" (Clandinin & Caine 2013 p.172). This student's story has the potential to provide the clinical educator with insight into the meaning of the student's practice. It contextualises the experience of nursing students as a whole, and in particular, that of CALD students. I too extended an invitation to the students to enter my story. I wanted them to experience what I experienced when I cared for the boy in the following story.

Creative writing provided a teaching opportunity. A more typical discussion may have included information on oxygen levels, skin care and nutritional needs. While these are essential areas of knowledge, this exercise encouraged reflecting on the individual.

Susan's Journal

"The boy who smiled" by Susan

"This is M. He's 14. He smiles, just a little, but he can't talk, or cry, or eat food, or drink water. When I feed him by the PEG [tube into his stomach] I call it his breakfast and his mum smiles. He is very weak. Sometimes I have a silent conversation with him. M, I say, your oxygen plays in the background; in, click, out. What does it feel like, that constant air coming in from the outside and tickling your nose? I adjust the tape your mum has so carefully applied to your face to attach your tubing. But look at you, you have the tubing clamped firmly in your mouth. I wonder if it's expensive. It's funny that in the hospital you never think of such things. But this is your home, and your mum, she must add oxygen to her "shopping list". Home delivery. Are you smiling at me?"

5.6 Touchstone 6: Moving from field to field texts

Data collection in narrative inquiry is referred to as field texts. Data in this inquiry included my written and recorded oral journal entries, students' and my creative writing

exercises, individual interviews and group storytelling sessions. The different types of fields texts help us to understand *"how others make sense or meaning from experience…"* (Connolly & Cain 2012 p.182). Each time I met with students I documented the experience. My feelings, emotions, insights and observations were captured on my voice recorder immediately after each encounter. In this way, I was able to *"slip into"* the participants experience and *"slip out"* again into reflection (Clandinin & Connolly 2000 p.82). The point of keeping field texts is to maintain objectivity. My feelings and beliefs about the inquiry changed over time. Yet the data remained the same. Meticulous data collection, or field text documentation, ensures rigor. For example, there are many texts which describe RNs lack of support of students. I know that I have experienced many emotions about this issue. However, while reading back over stories there are also many accounts describing students' positive experiences with RNs. In a group discussion, a student shared:

> *Group 6: Second year*
>
> *"If someone has MRSA and is on precautions * and if they are calling, the RNs will go in. They don't care they are MRSA; they will not stand outside too lazy to go in". Another student agrees, "the RN's communication is also really good with the patient. They maintain really good communication and everything. They crack jokes. Even though they have lot of paperwork, lots of work to do .... every time they go to the patient, they will just crack some joke, make them smile". The first student continues, "They are also doing their work and at the same time they smile at the patients and listen to them". Another student said, "Yeah, really cheerful all the time".*

The goal of analysing field texts is to discover meaning, situate findings and understand significance (Clandinin & Connelly 2000). It is crucial to read and re-read the data to discover *"patterns, narrative threads, tensions and themes…within or across [the narratives]"* (Clandinin & Connolly 2000 p.132). In analysing across these

field texts there is not necessarily an equal degree of attention given to structure, content and form. The main consideration was to link mutual threads back to the purpose of the research (Lieblich et al. 1988).

Before analysing the compilation of all the field texts, I focused on eight recorded stories told in a storytelling session in Group Six. Analysing these stories identified the depth of reflection creative writing can produce. The ultimate hope of story deconstruction goes beyond personal meaning for the student. Justification for this process lies within the hope of uncovering practical and social meaning for quality patient care (Clandinin 2012). While evidence-based methods of data analysis are essential, the nature of narrative is unpredictable. Working with *"unstructured life stories … are [as]… multilayered and complex"* (Lieblich et al. 1988 p.5) as the storytellers themselves. While acknowledging these essential truths to analysis in narrative inquiry, it was my belief that the close scrutiny of the eight short stories required a systematic model.

5.6.1 Narrative analysis

Collected field texts needed to be examined closely in order to determine meaning. These included the written and told stories from each group, recorded or annotated group discussions, and my own journal entries.

Labov and Waletzky (1966) created a model to evaluate the storyteller's individual words and phrases, known as the Labovian model. Details are extracted from the text such as word emphasis and stressors. In this method, a story must first have a recognizable universal narrative structure. Their method is a six-step model.

> *"Abstract is a summary of the story. Orientation describes who is in the story and where and when it is set. Complication action refers to what happened. Result describes what happened in the end. Coda is 'sign off', sometimes used by storytellers to address their listeners with a final comment. Evaluation emphasises the relative importance of some narrative units as compared to others" (Labov & Waletzky 1966 p.37).*

Extending the Labovian model, Lieblich et al. (1988) describe strategies, which analyse fine details within narrative form and content. Their concept is based on the view that studying linguistics can uncover deep feeling and emotions. They argue that "*Events evoke emotions...to deal with those emotions…coping mechanisms are reflected in the linguistic features of [the text]"* (Lieblich et al.1988 p.33). Close reading identifies words and phrases which may highlight emotions, reactions, and moral responses (Lieblich et al. 1988). Similar to Labov and Waletzky (1966) evaluation, Lieblich et al. (1988) suggest that close reading of words and phrases will elicit meanings, which other methods may fail to identify. They say *"…formal aspects of emotionally charged narrative can be used as a tool for understanding an episode of the life story"* (Lieblich 1988 p.34). Lieblich et al. (1988) also describe how to examine the content of a story. Major and minor content categories are identified within and across field texts. Findings are then examined against contemporary professional research. In order to demonstrate the significance of the research, the findings are positioned within the personal, practical and social justifications to be described in Touchstone Ten.

6 Chapter Six: Touchstone Seven (a): Moving from field texts to interim research texts

6.1 Field texts Group Six

The field texts in the section are the stories told by the students in Group Six. Their stories were collected on the final day of their four-week clinical placement. *"Field texts are read and reread, looked at and relooked at, and attention is paid simultaneously to temporality, sociality, and place"* (Clandinin & Caine 2012 p.172). While examining the field texts in this section, I am also creating interim research texts. These *"interim research texts…is the place to begin to make meaning of our field texts*" (Clandinin & Caine 2012 p.172). Each student wrote one piece of creative writing and had the opportunity to read it to the group. After this each student spontaneously told a story. The field texts in this section are the four pieces of creative writing. Following their examination, the four oral stories will be discussed.

The creative writing prompt was to "*write a character sketch of a person you have encountered in your work this week".* This open-ended approach provided space for students to decide whether to write about a patient, a patient's relative, a staff member, or even themselves. Students were familiar with the "rule" that the prompt was just that; a prompt. Students could write about anything they liked. The four students wrote one story each. Each student volunteered to take a turn reading their written story. Reading the story aloud was often followed by the reader providing verbal clarification and context. The reading of stories resulted in interaction between the students before the next readings. While Labov and Waletsky's (1966) method was useful in structuring these written and oral narratives, it was less helpful in

analysing the conversations. This was also the experience of De Fina and Johnstone (2015). Narrative theorists, such as Polanyi (1989) pointed out that Labov and Waletsky's (1966) approach to analysis focused on the single narrator. When others join the narrative, this can result in completely changing the point of the story. In analysing the stories this happened frequently. The story the participant had written had often changed upon telling, as a result of interaction with other students.

To have a sense of the flow of themes throughout the session the students' stories are analysed according to the order in which they were told. One story went on to influence the way the next participant presented their story. When all the students had finished sharing their written story, they each told an impromptu oral story. Analysis of each story occurs as the story is told and retold. Integrating the storytelling and story analysis aims to provide a seamless connection between the original story and the examined story. Each story underwent intensive examination before identifying potential meaning. Labov and Waletsky's (1966) method of extracting details from the text, such as word emphasis and stressors, is evident in the discussion. Lieblich et al.'s (1988) method of close reading to identify words and phrases which highlight emotions, reactions and moral responses are also made obvious.

The stories in Group Six were audio recorded and transcribed. I listened and re-listened to the recordings and reflected on my associated audio and written field notes. I examined and compared handwritten stories and read and re-read the transcriptions. I deconstructed and reconstructed the vignettes using the form-content (Lieblich et al. 1988) and problem-solution approach (Labov & Waletzky 1966). I then established colour coordinated codes to identify similarities in the texts and isolate

differences. In align with warnings not to separate fragments of stories from people's lives (Black 2017; Clandinin & Connolly 2000), the overall story analysis remained situated in the three-dimensional narrative inquiry space.

6.2 Story 1: 'Frozen', by Anusha

Story summary

Yesterday Anusha looked after a 60-year-old lady who had just returned to the ward following an echocardiogram. The nursing care plan said the woman did not require assistance with mobility. Anusha observed the lady as she walked to the toilet. There was someone else in the toilet. The lady made some dance like moves, lost her balance and fell. Anusha froze, uncertain what to do. She called the RNs for assistance. Three to four RNs came in immediately and followed the correct post-fall protocol. Unhurt, the woman walked back to her room without assistance. Anusha finishes the story and addresses the group, saying that it was fine, nothing serious had happened.

Story Meanings

There are three "versions" of Anusha's story. The written story, the slightly amended story during her reading, and the expanded story following encouragement to elaborate. Anusha chose to reflect on a recent scene, which had clearly upset her. It is not uncommon for students to choose difficult incidents when reflecting back on clinical placements. In Paliadelis and Wood's (2016) digital storytelling activity the majority of reflections described challenging and emotional situations. That particular storytelling project occurred sometime after students finished their placement. The advantage of reflecting close to the event is evident in Anusha's story, as each version

shifted her reflection deeper. It began with a character sketch of a woman who fell. At the conclusion of the third re-telling Anusha demonstrated a significant shift in self-awareness. Anusha began:

> *"Yesterday I was looking after a 60-year-old lady. She was about to go to toilet… she was wobbly on her feet. She took a slow step and reached to the door… she got wobblier on her feet and fell straight on the floor".*

So far, the focus of the story is the build up to the fall. The word 'fall' or 'falling' appears across the three accounts seven times. This is a potential indicator that Anusha's point of telling the story is to describe the fall incident. This is common in a clinical education session. Students often default to describing a physical clinical event. Unfortunately, the student's experience of the event may go unnoticed. Re-reading Anusha's story later shed doubt on the fall as her main point. It was definitely important to Anusha that she describe the lead up to the fall. However, the central point to the story became evident in the final line.

> *"... and I forgot all the DRABCD [Danger Response Airway Breathing Cardiac Defibrillator] I was taught …. I stand freezed until RN came in".*

It is possible that Anusha's initial intention was to write a character sketch of the woman. Midway through her oral version, she expands her description.

> *"She was just going to show me some moves - like, some random.… She was loud, and, mm and yeah… and then she was going to show me some moves like this, like this… Then she got more wobbly on her feet… and then just fell down".*

When Anusha read her story to the group, she read without hesitation. The story comes to an abrupt halt after reading her final line:

> *"I stand freezed until RN came in".*

After a long pause followed by encouragers from myself, Anusha retells the story, but it no longer flows smoothly. There are long pauses, and according to Lieblich et al. (2011), these may indicate that she is trying to avoid talking about something uncomfortable. Labov and Waletzky (1966) describe the use of *"intensifiers"* (p.38) which narrators use to highlight parts of their story which hold more meaning to them. Anusha describes how she felt by using the word *"freeze"* three times. *"Freeze"* belongs to the *"flight-fight-freeze"* response. Caught *"like a deer in the highlights"* is a common metaphor for the freeze reaction. An animal's impetus to freeze in the face of danger may be based on their conclusion that fighting or fleeing are unlikely to be successful (Alban & Pocknell 2017). This choice of word gives us important insight into the impact this incident had on Anusha. Soon after Anusha takes up her retelling, she digresses from telling her story to explaining why she had experienced such a strong emotional and physical response.

"That was my first experience of someone - observing fall".

According to Lieblich et al. (2011) this *"intrusive"* adverb from storytelling to explaining describes mental processing. We can locate the exact place that Anusha moves from telling her story to reflecting on its meaning. Her clarification is important both to Anusha and me as her educator. Anusha justifies to herself why she became immobile. I learn that her inaction was based on this being a first-time experience. This is important because ward staff may have considered the student to be incompetent. This then reinforces Anusha's self-incrimination that she should have done better. It is also important in my role as clinical educator when situating staff feedback regarding Anusha's learning progress. Anusha continues after a pause.

"Yeah, she was independent in her care plan. But still I was giving her…mmm... visual observation".

Anusha is now able to describe accurately what she should have done.

> *"And then, I should have gone… [pause] and … [pause] and ... [pause] do the post fall protocol, like… [pause] danger and ABCD and all…. "*

Anusha knew what to do and expresses frustration with herself that she did not do it.

When re-reading the story, I noticed another shift from telling to explaining. In three out of the four recounts, Anusha precedes her description of the fall with the statement:

> *"I was observing her".*

The word "observing" or its diminutive is used in this story five times. Anusha appears to stress the point that she was observing the woman prior to the fall. It is unclear from the first and second accounts whether Anusha's intention was to relay a fact or justify that she had been watching over the woman. In the third retelling, Anusha omits "observing".

> *"Then she got more wobbly on her feet and then just fell down and, and then I should have gone…"*

By this point it seems that it is no longer important to Anusha what she was doing just prior to the fall. Her emphasis now is on what she feels she should have done immediately after the fall.

In the background, Benita now murmurs her encouragement, and Anusha turns to her for assistance to continue to retell the story. Benita had witnessed the fall from the nurses' station. Benita takes up the story with the 'walking to the toilet' scene. Instead of focusing on the woman, she focuses on Anusha as the main character. Benita says:

> *"[Anusha] was about to go to toilet with her".*

She supports Anusha's subtle claim that since she had been observing the woman, she had done nothing wrong. It is possible that Benita's support then helped Anusha vocalise that she could not be blamed for 'freezing'. Anusha said:

> *"Yeah, because I was told to not go into the situation like that until it's danger free. Or just don't hold her when someone is falling down. And I was just freeze there whether should I go or not.*

It is possible that Benita's inclusion in the story has altered Anusha's original intent (Polanyi 1989). In this context, peer engagement has provided a positive enabler for Anusha to explore yet another level of her story.

The storytelling experience empowered Anusha to share her feelings of shock and subsequent inaction. As she reflected, she identified that her inaction did not lie with poor knowledge. Her 'freeze' moment highlighted an automatic response to stress. Unlike the conclusion in her written story, the focus at the end of Anusha's oral story had returned to the patient.

> *"But it was okay she was…she was fine, and nothing happened".*

Storytelling had helped Anusha move the focus of her reflection from herself back to the patient. An interesting finding in examining Anusha's story was her lack of connection with the RNs. This point brings to light issues beyond her personal story.

Students work under the supervision of a designated RN. Anusha makes no reference to the RN facilitating her learning or offering an opportunity to debrief her experience. Her references to the RNs are distant.

> *"RN also observe that".*
>
> *"I just called RN mmm".*
>
> *"There were three or four RN…".*

"Yeah, they did follow the danger then that whole thing".

According to Clandinin and Connolly (2000), absence of detail tells us as much about the story as the detail. The response of the supervising RNs is an important influencer on students' confidence and performance (Chan & Lai 2016). Without the storytelling opportunity, it is unclear if Anusha would have received any support to learn or debrief from her experience. Anusha's story raises the issue of RN invisibility and lack of interest or knowledge in their mentoring of students' experiences.

In addition to the important role of RNs, the literature refers to that of the clinical educator (Chan & Lai 2016; Gillett et al. 2016). After Anusha read her story, she rested the paper on the table and her eyes focused downward. After a lengthy pause I leaned forward and asked quietly*, "how did that make you feel?"*

After a long pause, interjected with a couple of *"mm",* she replied*:*

"Mm…scared... that was my first experience of someone - observing fall".

Clinical educators need to listen and encourage students to reflect and share their experiences (Chan & Lai 2016). Instead of just discussing caring practice, we need to demonstrate and model care to our students (Ekebergh 2011; Gillett 2016). My personal justification also extends to my professional responsibility. Students are in a unique state of transition. Their experience during clinical placement not only impacts their present reality but also the way they practice as future RNs. Conscious of the low profile of the RNs in her recount, I tried to steer Anusha to reflect back on their response. Had she learnt anything from them? I asked, *"… how did you feel with the RN, did you feel...that the RN then came in and took [responsibility]?"* The ensuing conversation highlighted the RNs' lack of encouragement in involving Anusha with the post fall care.

I have previously described my feeling of being sandwiched between the student and the RN. A journal entry written at the time of the incident contextualises Anusha's story. It represents not only my personal justification but also the social significance for undertaking this narrative inquiry.

Susan's Journal

It's the final day. I spend time with each student before we meet as a group. Tears roll down Anusha's cheeks. Her voice is barely audible. I feel frustrated. Every time I meet with students someone cries. I now definitely carry a packet of tissues with me. I'm not annoyed at Anusha. I feel frustrated that clinical placement can be so hard. Anusha asked, "Is it okay for an RN to raise their voice and poke me in the arm?" "Of course not!" I'm outraged. Why did this happen? How can we treat students like this? Is nursing in a vacuum? The rest of the contemporary world have strict anti-bullying and harassment policies in place. Do we have hidden norms passed down from matrons with iron hearts and stiff faces? I reassure Anusha of the university's support in following this up. Anusha doesn't care. Her time is over and it's unlikely she will return. It's also unlikely that she will forget.

6.3 Story 2: 'She doesn't listen', by Dashita

Before the next volunteer reads their work, Dashita asked if she could add something about the woman in Anusha's story.

Story summary

During today's shift, Dashita had looked after the same woman Anusha had just described. She said the woman had fallen a few times, due to postural hypotension. The woman had diarrhoea and she had to go to the toilet frequently. According to Dashita, the woman did not listen to anyone's instructions to stand up

slowly. Each time she stood up she fell. Benita and Anusha enter the conversation and all three students concur that the woman falls because she does not listen to directions.

Story Meanings

Dashita speaks rapidly and over the top of Anusha and Benita's attempts to ask questions. She explains to the group that the woman had fallen frequently over the past two shifts.

> *"She fell down because her blood pressure was low. She did not want to stop [rise slowly] to stand up…".*

She tells us the woman gets up frequently to go to the toilet.

> *"…and she go to the toilet because she has diarrhoea as well…. she goes to the toilet again and again".*

Dashita's frustration is evident that if the woman only stood up slowly, she would not fall. As she draws towards the end of her account, she slows down. Looking over at Anusha and Benita she states:

> *"But she doesn't listen to anyone, right?"*
>
> *The others nod.*

Dashita's account appears to lack emotional connection either to her patient or to herself. Her response lacked insight into her own values. In "Frozen", a sense of Anusha's unfolding self-awareness emerged. In Webster's (2010) arts-based learning activities during a mental health placement, students confronted their personal biases. Webster (2010) witnessed an improved understanding of issues their clients faced. A five-minute writing exercise may have encouraged Dashita, and the other students, to reflect deeper on their response to this scenario. I may have asked the students to

reflect on the story from the woman's perspective. Would the patient tell us how difficult it is to stand up slowly when frightened of missing the toilet? In order to *"promote empathy [we] require… self-awareness"* (Webster 2010 p.42). This scenario has provided a glimpse into the level of reflection ordinarily experienced during clinical education. The subsequent stories will reinforce that growth of self-awareness and empathy responds favourably to the creative writing exercises.

6.4 Story 3: "Mr Teddy Bear", by Chandra

Story summary

A few days ago, Chandra cared for a 90-year-old woman, in Coronary Care Unit (CCU), who had dementia. Chandra described an encounter with the patient, the patient's partner, and daughter. Chandra felt happy when her patient introduced her to her husband and daughter, clearly important people to the patient. The woman surprised Chandra with her happy demeanour, despite the dementia. When the patient was leaving CCU she told Chandra she would miss her, because she had provided good care. Although Chandra knew the woman would forget, it made her feel good. The woman teased Chandra, saying she too would miss the woman. Chandra said she really did.

Story Meaning

Chandra's story represents the value students often place on patient's feedback. It also demonstrates the importance of connecting with patients to dispel myths and stereotypes. Chandra's recount is rich with positive verbs and is interspersed with laughter. In a funny, yet respectful tone, she imitates the patient's happy sing-song voice. Her written story is 160 words. When she reads it out, she

adds a generous number of enhancers and clarifiers. Along with new details the oral account expands to 420 words. Most of the verbs are enhanced with *"really"* or *"very"*. *"…really cheerful…really special…really happy...very very nice…very cheerful"*. These draw attention to the importance Chandra places on these characteristics (Labov & Waletzky 1966).

The story began with Chandra reflecting on her surprise that a patient with dementia could appear so happy.

> *"Even though she has dementia she is really cheerful, and [has a] … sense of humour. I didn't expect that, but she was really happy and good and greeted me with [a big] smile. Later in her story she quotes the patient, "I'm happy dementia, I like to be happy, even if I forget, I like to be happy".*

Gallagher and Carey (2012) describe positive results from a project connecting nursing students with the elderly. Being with and listening to elderly patients helped to dispel myths and stereotypes. Regardless of where students work as registered nurses, there will almost always be older people to care for (Gallagher & Carey 2012). Chandra's experience provided a learning opportunity for both her and her peers, as they listened to her story.

As Chandra continued, she expressed her appreciation that the woman:

> *"…was so happy to meet me… and she also introduced me to her "partner in crime" …in her words, "Mr Teddy Bear" … She has a loving daughter who is also her carer".*

Chandra's verbal and non-verbal story demonstrated pride at being welcomed into the patient's family.

> *"I feel really like she introduce me to someone special, so I feel really happy".*

Feedback from patients can boost a students' confidence. It can be as valuable as that of educators or nursing staff (Chan & Lai 2016). The main point of Chandra's story is to describe the patient saying she will miss her. The word "miss" occurs eight times in the verbal account and twice in the written. Chandra writes:

> *"When I went to transfer her, she said, "I'm gonna miss you!" Even though she will forget eventually, that made me feel good".*

Chandra expands her feelings in her oral account:

> *"When she said she was going to miss me I feel "oh my god!""*

It is only when Chandra retells her story that she recognises why the woman will miss her. The woman says:

> *"Oh, I will miss you because you were so good". I feel really special at that time because she said, "oh you left me here - to care for me…oh I will miss you because you were so good".*

In sharing these words to the Group, Chandra reinforces to herself that she is progressing well. I have listened to similar stories at times when feedback from staff is not as encouraging. A journal entry written a few days earlier reflects the significance this interaction with the patient and the family held for Chandra.

Relevance of Chandra's story: Susan's journal entry

> *"Can I talk to you?" The nurse unit manager catches me as I wander down the corridor. I already know what it's about. Chandra spoke to me yesterday. In between hiccups and streams of tears and through broken English I got the gist of her having received poor written feedback from her RN. There are always two perspectives and it's difficult to understand the whole picture. What I didn't like was the RN writing the feedback and handing it to the student without any verbal feedback. Hit and run. Jane took me to her office and closed the door. I received her perspective. Then*

she tells me she is exhausted, tired of repeating herself to students. "It never stops. I have another whole group beginning Monday". She's tired. She says she knows they are a teaching hospital. Her voice gets higher and I feel like escaping. Staff see students as just an extra workload on top of a high workload. Does anyone see the students as a great help to manage the workload?

6.5 Story 4: "Compliments", by Dashita

Story summary

Dashita cared for a man the previous evening and this morning. He had encouraged her in her student role, permitting her to undertake his nursing care, under the supervision of the RN, and complimented her in her practice. Dashita's patient provides her with encouraging feedback after she helps with his care needs and taking five minutely vital sign observations. Dashita felt good when the patient's wife and daughter told her that he was praising her. Dashita tells the group that this was a good experience for her.

Story Meaning

In the previous story, the group had listened to Chandra as she relayed the encouraging message that she would be missed by the patient, and that this was based on her delivery of quality care. When Dashita reads out her story, she reshapes it, and the oral account reflects Chandra's theme. Dashita's written story was 94 words and the oral narrative, 456 words. Dashita's original character sketch emphasised the patient's physical health needs.

"I asked about his pain because he had many health problems; peritonitis, cardiac disorder".

She appreciated his support of her as a student and related this to practical care.

> *"He let me to do all procedures in front of the RN. She described these procedures; I gave him shower and changed his clothes".*

She connected briefly with his social world.

> *"He was quite happy because his wife was coming to meet him".*

The oral account is much more self-reflective. Dashita uses the words 'I' or 'me' four times in the written story. The oral version contains twenty-nine. Her focus moves away from describing what she did for her patient. Instead, she describes similar compliments to Chandra. The patient's family told her that he had been praising her. Dashita described this to the group. He said to his family:

> *"She was very keen and when she will be a RN, she will be a very good nurse".*

In addition to this echoing of Chandra's' theme, Dashita includes a quote referring to 'missing'. She said the patient said:

> *"You're missing me that is why you come back today … I really miss you because you give me care, and you are very keen on the older person".*

Her written story does not refer to missing at all.

Following a brief prompt from myself, Dashita connects her positive relationship with the patient to having spent time with him.

> *"I needed to do five-minute Obs [vital signs] … five minutes after five minutes … then I stayed in his room because I was free from other patients … so that is why I got time to spend with him".*

Dashita concludes the story with an explanation to the group of the procedure that required her to take frequent vital signs. She slips back into her self-designated

role as a peer instructor revealed in "*She doesn't listen"*. This is a different, yet valid use of storytelling in clinical education. Dashita's story reflects the benefit of the peer group to develop both inward and outward learning. In particular, arts-based learning tools have the potential to increase self-awareness. The importance of personal knowing is its relationship to knowing others. This has the potential to deliver enhanced person-centred care (Schwind et al. 2014).

The combination of the patient's affirmation of Dashita's care and the groups' acknowledgement of her academic knowledge were important to her. A journal entry I made the previous week provides a little more context to Dashita's story.

Susan's Journal

Dashita cried when she saw the High Distinction, she received for the Viva Voce today. She had earned it. Her time and effort and knowledge were amazing. Dashita has a baby back home in India. Her mum and dad are caring for him. How sad is that! She has shown us pictures of him and speaks rapidly and proudly when telling us about their video chats. To be separated by being an overseas student! "I'm smart in India," she tells me, "but here, I just can't do it. I've never got a mark so high." I have to look down at the page to stop myself from crying.

6.6 Story 5: "You'll be fine" by Benita

Story summary

On the first day of placement, Benita cared for a man following his angiogram. When Benita asked the RN questions about the patient's care, the patient replied and surprised her with his knowledge. He asked her about her country and her experience of being an international student. He told her that he used to be a nurse but had to leave because of a skin condition. On the day of his discharge, he and his wife gave

Benita a hug. He told her that being an international student is hard but that she will do well.

Story Meanings

Benita retells her story without reading or referring to her written account. When I read her story later, I found it had been written in the style of a medical case note. Benita's oral recount began with a description of the connection she felt with the patient.

> *"Immediately when I saw him, I feel he was very friendly".*

The patient surprised her that he knew so much about his own health.

> *"He knows everything about that and he started to tell [explain] everything". While the RN supervised her with the BGL and insulin, he explained, "you have to use that this way and he started to teach me everything".*

Students frequently report learning from patients during clinical placement. This is supported by research describing patients as a *"valuable source of knowledge for students…and …that patient stories promote learning"* (Gidman 2013 p.4). If clinical educators are aware of scenarios like these, they can facilitate further learning (Gidman 2013). Likewise, assisting Benita to explore her patient interaction as a story, rather than as a medical note, allowed her to develop knowledge from a different perspective.

Her story reflected her positive feelings about the encounter.

> *"He was very friendly actually"; "He was very friendly"; "And he was very friendly;" "They [patient and his wife] was very friendly"; "he was very nice"; "very friendly".*

Benita then shared how the patient had taken interest in her own situation.

“[The patient] asked me where I came from. I just told him that I'm from Nepal and currently studying in Flinders”.

Students often converse with patients simply because they enjoy it. By spending time with patients, they develop a better understanding of their needs (Chan & Lai 2016). This is an important starting place for nursing students to develop nurse-patient communication skills. This natural approach to communication helps students to find out more about their patient.

“But he just wanted to become a nurse…he... studied but … left because he got lots of skin problem during his study”.

As Benita’s recount ends, she returns to the kindness of the patient and his wife.

“He was about to [be] discharged…he just called and gave me hug… his wife also gave me a hug… he said to me you will be fine…because you...came from the different country and it will be very hard…you will be fine later”.

The other students murmured their approval. This affirmation by the patient was not only for Benita. As international students, it held meaning for everyone. The audio-recording captured the informal conversation that immediately followed Benita’s five-minute story.

Dashita said: “Most, well maybe two or three, patients told me “you will be a good doctor in future!” Everyone laughs. Dashita laughs and continues, “I told them, “I’m just a nurse, I will [always] be a nurse anyway”. But they told me, “you will study trust me; you will just study more than that”.

Benita said, “yeah, most of the patient in here I noticed most of them are friendly”. Everyone mutters, “yeah”. Dashita repeats, “very friendly”. Chandra joins in, “the patients are really kind and friendly. They're not “oh, this is a student and they're not doing it right…” She mimics a patient’s voice. Benita agrees, “Yeah”. Anusha said, “They treat us well and not think

we don't know anything." Chandra laughs and describes how patients compete with each other for the students to care for them. She mimics their fun, "Yeah, they call out "come and do it on me" …"no on me", "no me." Everyone laughs.

The value of patient affirmation is a common thread through three of the four short stories. Benita's story takes the theme deeper and makes the connection between feeling accepted by the patient and empowered to communicate with them. The focus in the group has swung outwards onto the patient.

Shifting focus, Chandra launches into a new story. With the opening line:

"I knew one lady, and she had lost any hope…" the group quietened, all jesting aside.

6.7 Story 6: "No hope" by Chandra

Story summary

A patient is admitted to CCU newly diagnosed with heart failure. She tells Chandra that she just wants to die. Chandra noticed that the patient was not eating or drinking. She coaxed her but the patient told Chandra she had lost all hope of living and it was better that she died. No matter what strategies Chandra tried she knew they would not help. She wanted to express to the woman that she understood, but she knew she could never feel what the woman felt. Chandra tells us she feels powerless. She says that she wishes she could do something but she can't.

Story Meanings

Chandra's opening statement establishes the sad theme of her story.

"I saw one lady, but she had lost any hope of living".

A few lines of context follow and then she repeats the statement, this time using the patient's own 'voice.'

> *She said that, "I have lost any hope of living, it's better if I die".*

Chandra changes points of view throughout the story. Switching between her "*speaking self and experiencing self… [can occur when] …reencountering a difficult experience"* (Lieblich et al 1988 p.35). Whenever Chandra describes the woman's strong emotions, she does so with the woman's own voice. The woman's narration repeats the theme of lost hope.

> *"I had lost any hope of living, its better if I die"; "I don't have hope to be better, 'I know I will not get better…its better [if] my heart [stops] don't give life support. It's better I die"; "I don't want to go on living like this".*

Chandra uses the woman's words again to express her feelings of lost dignity.

> *"No, look at me, I'm using a [bed] pan and I missed"; "I'm really feeling guilty because I'm not supposed to do that…. look at me how I have become…I was independent, now look at me. I better die".*

Using the woman's own words helps Chandra separate which is the patient's story and which is hers. They are both managing difficult emotions. Chandra frequently stops the flow to address her listeners with comments about how she felt at the time. Her comments are often tinged with a *"sense of helplessness"* (Lieblich et al. 1988 p.35).

> *"What should I tell her? … I can't tell her I understand her problem"; "I don't [feel] like she does"; "I'm not expert in anything [like] that"; "So it was really hard, it was really hard caring for her"; "So it's really stressful".*

As Chandra shared her difficult experience, it was also important for her to describe what strategies she had tried. In narratives, the speaker usually tries to

present themselves in the best light (Labov & Waletzky 1966). In one section, she repeated dialogue describing herself coaxing the woman to eat and drink, the woman refusing, then complying. Building on the theme evident in the three previous stories, it is possible that Chandra needs to highlight the patient's affirmation of her care. She tells us that the woman said:

> *"I really appreciate what you do but I don't have any hope left".*

Chandra also describes how she learnt that the woman was from Germany and correlates that to not liking the food. She persists in encouraging the patient to eat and drink and concludes:

> *"… and she ate, I feel at least she is eating something"*

Understanding this part of the patient's story helped Chandra to develop empathy (Jasmine 2009; Gidman 2013). When Chandra finishes describing what she did, she goes on to share with us the distress she feels.

> *"But I have never seen such person … she don't have any hope".*

Such comments situated alongside the storyline are an indicator of Chandra's consciousness and *"mental processing"* (Lieblich et al. 1988 p.35). Telling the story is helping Chandra to reflect back over her clinical practice. Other studies have found that reflecting on patient encounters *"with supervisors and peers promote [students'] personal and professional learning"* (Manninen et al. 2013 p.9). Chandra's frustration is evident throughout the story. She tried various strategies to help the patient.

> *"I tried to think what I [can say] that makes her happy or use some sense of humour…or go for a walk. But eventually she ends on that note; "I don't want to go on living like this".*

At this point in Chandra's story, another student interrupts. Anusha describes a similar situation, concluding with advice on the importance of listening. Chandra did not comment. She returned to her own story with a series of questions she had already asked. Finally, she said:

"So, I feel powerless. It's like I can't do anything for her".

Chandra's feeling of powerlessness is not unlike Anusha's feeling of being frozen in the first of these eight stories. Both students attribute this feeling to be the first time they had encountered such an occurrence. In this story Chandra tell us:

"I have never seen such person… she don't have any hope".

Feeling alone in learning is an element common amongst nursing students (Manninen et al. 2013). Chandra is allocated to an RN who assists and supervises her practice. Yet the RN is invisible. Even if the RN was aware of the situation, student learning is often focused on practical tasks (Manninen et al. 2013; Chan & Lai 2016). This patient encounter had a profound effect on Chandra. The opportunity to share it in this storytelling session allowed the other students to support her. It triggered a response from one student to reflect on a similar situation. It is possible that other students could either relate to it or learn from it. As a clinical educator, it allowed me to facilitate learning. Unconsciously Anusha had followed the five steps associated with the Fundamentals of Care framework. These are described by Feo et al. (2017) as trust, focus, anticipate, know, and evaluate (pp.56-5). According to these steps, developing trust with patients is important in establishing a caring relationship. Chandra's story reflects that trust can also be established once the student has demonstrated interest in the patient. Chandra describes how she noticed that the patient was not eating or drinking. To notice this is a sign that Chandra had already

been anticipating the patient's needs. In communicating her concern to the patient, the patient takes Chandra into her trust. She tells Chandra that she just wants to die. Chandra demonstrates that she gave the woman her undivided attention. This is evident by Chandra telling the group about the ongoing conversation they had. As the conversation unfolded, Chandra learnt more about the women's story. Chandra was honest in sharing with the Group that this was a new experience and she did not know how to act appropriately. Telling this story to the Group provided her with an opportunity to evaluate her relationship and subsequently her own practice. According to Watson's theory (2008), Chandra and the woman experienced a caring moment. Watson (2008) says *"Caring moments are 'the moment-to-moment human encounters between…the care giver and the…recipient of care"* (p.81). Being aware of the overall theory of nursing as a caring profession provided me with expertise to facilitate the discussion following Chandra's story. The valuable role of clinical educators in facilitating learning to care is evident in this story. Storytelling provided a learning intervention, which went beyond the cognitive domain, enhancing the affective approach.

6.8 Story 7: "The Gown" by Anusha

Story summary

Anusha's elderly patient told her that she was a fashion designer. When she looked at her hospital gown she broke into tears. Anusha tells the group that when is a patient is distressed it is best to listen, encourage them to talk and avoid giving advice. The woman expands her story, sharing details of her love of fashion. She concludes with urging Anusha to dress beautifully while she is young.

Story Meanings

Chandra's story," No hope", reminded Anusha of a similar situation. She interrupts Chandra, offering encouragement that this feeling is experienced by other patients. The storytelling session had become less formal, and Chandra appeared comfortable with the interjection. Students' impromptu stories still held a recognizable structure, making evaluation possible. Anusha's repetition of her references to listening *"when we listen to them and just listen and listen"* may indicate her motivation for telling this story. Anusha appears more comfortable to separate her own emotions from the patients. She is able to name the woman's feelings with more overt descriptions. The phrase "*I was so happy"* tells us that the woman no longer experiences happiness. The woman is also feeling frustrated with herself and her deteriorating health; *"She just breakout [cried out], why I am wearing this gown?"* Anusha is able to recognize the patient's grief; *"I imagine [remember] my previous days what I used to be"; "just look at me now what I am wearing".*

These, and similar phrases highlight the woman's self-loathing and loss of identity. Similarly, to Chandra's story, Anusha uses the patient's own voice to express her deepest feelings. Being able to nominate how the patient felt demonstrates the student's capacity to empathize and reflect beyond their self. Parallel to this side of the story Anusha also provides the group with tips on how to manage.

> *"Say yes, no…and ask what else happened, and how did you feel at that time. They will feel encouraged …and tell you everything. At the end of that they will feel [more] relaxed".*

The value of peer learning is evident once again. However, Anusha also has a moment of personal insight through telling this story. Her voice becomes animated when she repeats the woman's advice to her,

"she suggested to me to just dress beautifully when you are young…".

Anusha is a beautiful looking young woman. It is possible that she connected with the patient on this point. She includes visual detail when she repeats the woman's words,

"I really love dressing…I was a fashion designer, I used to dress myself. I used to [like] silk cloth. I really love yellow, red….".

Anusha describes a heart-breaking scenario but her reflection demonstrates self-confidence that she had managed it appropriately. The RN is missing again from the story. Comparing this story with Anusha's original "Frozen", shows a different perspective on her capabilities. In listening to Anusha's two stories, it helped me as a clinical educator to know her better. Similarities have been drawn between an educator and student relationship to a student and patient relationship. In the latter, knowledge leads to understanding and subsequently empathy. In the former, it can help the educator develop the desire for student advocacy if required (Ekebergh 2011, Schwind et al. 2014, Schwind et al. 2015; Gillett et al. 2016).

6.9 Story 8: "Isolation" by Benita

Story summary

Benita told us about a patient who had been in hospital for over a month. He had an infection and required isolation nursing. He believed that the nurses avoided coming into his room. The patient said that he needed someone to listen to him. Benita said the he trusted her and told her about his story surrounding his illness. He was an artist, and in appreciation of Benita's care he painted her a picture of her name. Benita said the picture is up in her home and it reminds her of him and his story.

Story Meanings

Benita told her story in response to the theme of listening. Addressing Anusha and Chandra she said:

> *"You were talking about listening, yeah. My placement was in [a different] hospital".*

When a storyteller stipulates the time and place of the event it *"may be indicative of attempts to distance…or bring it closer to [themselves]"* (Lieblich et al. 1988 p.35). Given the theme of poor listening, it was important to Benita that her peers knew the story did not occur in this placement. The patient had MRSA*[2] requiring staff to don a disposable gown and gloves on entry and remove same on exit to his room. Benita quoted the patient as saying:

> *"The nurse will ask you to do everything…they will not come inside".*

Benita received the impression from the patient that the nurses did not care about him. He had been there for one month and felt the staff ignored him. She told the group"

> *"I feel now people don't care…nurses don't care about him; they really don't care; they just ignore him".*

The patient told her that he wanted someone to *"listen to his feelings"*. Benita said that she,

> *Used to talk with him and he always used to share lots of things*

He had been in an accident in previous years, which resulted in the amputation of one leg.

[2] MRSA - Methicillin-resistant Staphylococcus aureus is an infection caused by bacteria that has become resistant to many antibiotics

“He used to love someone but she just left…

He didn’t want to burden others so he now lives with his mum. Benita said, Yeah, he was heartbroken actually”.

Building on the theme of patient appreciation, she showed us a photo on her phone of a painting of her name.

“He was a very good artist…at the end my shift he gave me this picture”.

Benita then quoted him as saying the picture would ensure she would not forget him. Once again, this reinforces a theme from previous stories of remembering.

“He said you will remember every time when you see that; I still remember him; when I see some patient, I just remember him”.

During the story, Anusha interrupted and explained that Benita had asked the RN’s advice on whether she should take the gift. This also reinforces the theme of peer support during clinical placements.

Benita’s story triggered an immediate response by Dashita stating that RNs during this placement would never ignore their patients. This stimulated further discussion about the students’, mostly positive, experiences of working with RNs.

7 Chapter Seven: Touchstone Seven (b) Moving from interim research texts to final research texts (cont'd)

7.1 Searching for narrative threads

The field texts collected from the entire narrative inquiry require close exploration to identify meaning. Before searching for narrative threads in the field texts, I returned to those discovered in my literature review. These provided a loose parameter in which to search for general themes associated with storytelling in nurse education. There were seven themes in the review. Students enjoyed storytelling; stories dispelled misconceptions about patients; students have more time than RN's to spend with patients; the RN can obstruct or facilitate storytelling; the clinical educator can support or inhibit affective learning; storytelling is a medium for learning; storytelling can promote the art of caring. The literature also indicates a relationship between self-reflection and developing caring practice. In holding my field texts against the reviewed literature, I was also aware of the limitations of this method. In applying the concept of the three-dimensional framework, the contexts between the literature differed widely. The field texts in this inquiry were gathered in the field as the research unfolded. While topic headings from the literature review provided a guide to situate findings, I remained mindful of the impact of the difference of context.

At this point I also returned to the research puzzle to provide a boundary around the search.

"*What role does storytelling play in helping students reflect on caring practice?"*

"*Do stories identify obstacles and opportunities students encounter to engage with patients?"*

Another consideration in approaching the field texts was my personal-social relationship with the stories and storytellers. Working "in the midst" had resulted in an *"entangled relation of data-and-researcher"* (McClure & Koro-Ljungberg 2013 p.228). Reading back over the texts I could not escape returning to the space which Clandinin and Connolly (2000) consider the core of narrative inquiry. That is, immersing myself into the "*stories lived, told, relived and retold"* (p.20). In reading and re-reading the texts I relived moments in the field. Not only did this prompt recall of narrative threads it recalled feelings and emotions. McClure and Koro-Ljungberg (2013) urges us not to ignore data which speaks to us in non-cognitive ways. "*We may feel the wonder of data in the gut, or the quickening heartbeat…"* (McClure & Koro-Ljungberg 2013 p.229). Reducing the analysis to counting the number of people who repeated a similar meaning a number of times was incongruent with working with people and their stories. Numbers are often considered limited and even 'sterile' in interpreting words (Pinnegar & Daynes 2007). Drawing on McClure and Koro-Ljungberg's (2013) work, Crimmins (2019) suggests that "*we should be mindful of the data that speaks most resonantly to us, and not just be very cognitive in our deliberation or categorization of research"* (Episode 141). These moments for Crimmins (2019) also happened to be the moments which "*were generally shared, so they were stories that were generally experienced by others"* (Episode 141). "*This ruin of a well-wrought coding system [and] to epistemic certainty"* (McClure & Koro-Ljungberg 2013 p128) leads us further away from answering the research puzzle. Instead it only opens up new questions and "*astute crafting of a problem and a challenge: what next?"* (McClure & Koro-Ljungberg 2013 p.128). The narrative inquiry approach to examining texts is not to discover a solution to a problem. *"It carries more of a sense of search, a "re-search," a searching again"* (Clandinin & Connolly 2000 p.124).

I began the analysis with stories told in Group Six. I listened to the recordings along with the transcripts. Once I had identified what appeared to be commonalities in the stories, I moved on to examining the remaining field texts. I returned yet again to the recordings and transcripts of every group. I needed to immerse myself in any underlying, unstated meanings. In this part of the process I faced the dilemma of which stories, and which parts of the stories do I include. Black (2017) states *"if I can't include it all, which bit am I privileging and what does that mean if I leave this bit out?"* (Episode 84). Like Crimmins (2019) there were moments when reading and listening to recordings excited me. After listening to the audio recordings repeatedly of individuals and groups conversing, one group after another, I discovered another layer of findings. These findings were almost invisible in stories and transcripts but dominated and confronted through the sound of tears, through sniffles, voice wavers, sighs, pauses, giggles, and exuberant laughter. In closely analysing individual stories, written or told, I remained mindful that no one story sat isolated. While this was an inquiry of personal narrative, it also has clinical and institutional significance (Clandinin & Connolly 2000). To maintain the three-dimensional approach to working with field texts it was important to consider the "*wider social, cultural, and institutional [narratives] informing the stories that are being told"* (Black 2017, Episode 84). It was essential that a sense of the whole narrative *"should drive the reading and writing of the individual"* (Clandinin & Connolly 1990 p.7) stories.

7.2 Five narrative threads

Searching the narratives identified five significant threads. The first two threads addressed the first part of the research puzzle; *"What role does storytelling play in helping students reflect on caring practice?"* Thread one demonstrates that students

engaged enthusiastically with storytelling to reflect on their placement experiences. Thread two showed that storytelling gave students the opportunity to reflect back on moments of mutual enjoyment with patients. These reflections helped students to link the impact of communication on their caring practice.

Threads three to six addressed the second part of the research puzzle; "*Do stories identify obstacles and opportunities students encounter to engage with patients?"* Threads three and four highlighted how clinical educators and RNs, respectively, can be both barrier and facilitator to help students to connect with patients. Thread five showed that students from Culturally and Linguistic Diverse backgrounds experienced unique and difficult challenges related to their cultural and language heritage. The impact on patient engagement is unclear. In presenting these five threads, the danger lies in reducing the discussion to a list separated from the storyteller's life story (Lyons 2010). For this reason, the discussion includes samplers from stories told throughout the inquiry.

7.3 Research puzzle part 1: *"What role does storytelling play in helping students reflect on caring practice?"*

7.3.1 Thread 1: "Students engaged enthusiastically to tell stories about their placement experiences".

Students demonstrated enthusiasm towards storytelling sessions by their high level of participation and openness to sharing honest, often emotive stories. Initially I wondered how comfortable students would feel to provide a verbal evaluation of their participation in the research. From observation, I had found students to be eager to write and tell their stories. I felt that by the end of each clinical placement there was

enough trust in the group for an open evaluation. Students' responded favourably and expressed an overall feeling of appreciation at having had the opportunity to story tell.

> *"Hearing the others share their stories definitely adds to your experience, sharing the knowledge helps understand the other patients which you have not dealt with personally. The things that I'm experiencing it's only with me and if I'm not telling anybody or sharing it, I'm not getting the opportunity, it stays only with me".*

This student recognized creative writing as a learning tool impacting her future clinical placements.

> *"there will be so many patients that you will be looking after. So, if you can write those stories in your notebook and when you read them back later, I can remember the patients' face. I can ask, 'how did I approach them or what were the situation like?'"*
>
> *"I have learnt so much that I think it has reshaped how I will undergo on my next placement".*

7.3.2 Thread 2: "Storytelling enabled students to reflect back on moments of mutual enjoyment with patients".

A common thread in each Group was the depth of care and joy students expressed when they described encounters with patients. On the final storytelling session there was often a great deal of laughter and fast talking as students recalled anecdotes about their 'favourite' patients (within the bounds of confidentiality). Students interrupted each other, agreeing or disagreeing with what their peer was saying. In a recorded interview with Group Seven I said:

> *"It sounds to me that when you're talking about engaging with patients your whole demeanour lights up, there's laughter and you're enjoying your work".*

The students nodded and murmured their agreement and continued to story tell.

> *One student said, "one day there was one patient who was supposed to go home but she had pain and bleeding. I was looking after her that day and she was telling me about her family and stuff. I was just listening, and the next day she went home. I wasn't on that next shift, but she gave good feedback to the nurse about me. The nurse said the patient said you were a good nurse and you are very kind and to pass my thanks to him".*

The other students murmured comments that identified with the student's words.

> *One student replied, "even when the patient is discharged and you are not around, they still look for you to say thank you and it's like really good".*

I have also experienced the appreciation a patient had for one of the student's caring practice.

Susan's Journal:

> *Group 2: First year: It's the final day of the group's first placement. In the entry of the hospital I saw one of my students with a patient in a wheelchair as she was being discharged. I came over to greet both. The woman told me the student was a good nurse, put the student's hand to her heart and said, "I will miss her".*

Along with the theme of enjoyment, students' stories also demonstrated their desire to understand the patient's story. In making a connection with a patient students told stories which demonstrated empathy.

Susan's Journal

> *I visited Group Five today. A student talked about a woman who was quite elderly, and she only had one family member, and wasn't very vigilant in coming to see her. She had told the student about her life and some difficulties that she'd had. How she lost her husband. The student was quite*

emotional. Then she talked about how she wanted to wash the lady's hair because she said she'd been in there for a little while and it just looked quite matted and greasy. She had to go to two or three different wards to be able to find the equipment she wanted. The student said, "oh, the lady was just so grateful. It made her look and feel so much better". Also, she said, "I really felt like bringing her some flowers from my garden because no one came to bring her flowers and it would cheer her up".

7.4 Research puzzle part 2: "Do stories identify obstacles and opportunities students encounter to engage with patients?"

7.4.1 Thread 3: "Clinical educators can be a barrier and a facilitator to connecting with patients".

When clinical educators work closely with students, they can choose how to model care. I had not really considered the significant difference clinical educators can make to a student's placement experience. A clinical educator makes a choice as to the extent of their relationship with students. To conduct research, I had no choice but to allow students to tell their stories. I had to allow students to enter my own story. We had to experience the clinical placement together. This intentional and committed relationship heightened my understanding of student's experiences. These were mixed experiences. I shared their deeply meaningful ones. I also experience shame for my nursing profession.

Susan's Journal

A group of students told me, "you've got our backs". That's an interesting comment. When you've got a person's back it means if someone is about to stab them in the back, you're in the way and taking it for them and supporting them. It shouldn't be like that on clinical placement. But it has

been. Even in the way that I communicate with the ward staff when they are complaining,

"oh, the students are not doing well - we expect a minimum standard of knowledge of skills when they arrive".

I can choose to "take students to task" and demand improvement. Or I can explain to the RN that what the students need is to experience a relationship to see them blossom. It is like that with patients. Develop a relationship and it brings healing to the patient. After all, developing a therapeutic relationship is only part of the 2.2 competency. The other part of the sentence says, "*develop collaborative relationships"* (NMBA 2016 p.3).

This recorded conversation in Group Seven provides one perspective from students about the impact of the clinical educator on their placement experience.

Student, "Lots of things have [been helpful] because, we can share our feelings and…" Second student, "But if we have got some problems then we can say to you and you can talk to them [RNs]". First student, "yeah. With a facilitator from the Uni [not the hospital] like we can be more open. Like we can talk with you …" Third student, "and especially like we know you. You're from Flinders…and we can ask about issues, we discuss straight with you. We never say anything up there [in the ward]." Student two, "but we shared our feelings with you". Third student, "and that's I think very good support".

Students in this conversation communicate the value of a deeply caring relationship which is foundational to our role as advocates.

7.4.2 Thread 4: "RNs can be a barrier and facilitator to connecting with patients".

There is a gaping silence of the student's relationship with the RN in their written and oral stories. This could be interpreted in a number of ways and I concluded that an analysis could take up a separate study. In my own journal, evidence of the impact RN's made on the students' experience of clinical placement permeates the whole inquiry. The relationship between a student and an RN also appeared frequently during informal conversations. Similar to Mikkonen et al.'s (2016) study, students often reported feeling positive if the RN is supportive and not aggressive, throughout the placement. This student described the appreciation she felt when well supported.

> *2nd year student: "Although sometimes I face ups and downs when working in busy ward, we got good support from all the staff".*

In addition to journal notes this recorded conversation from Group Six is enlightening.

> *"If someone has MRSA[3] - requiring universal precautions[4] and they are calling, the RN will go in. They don't mind they are MRSA they will not stand outside and say, "I don't want to go in there". Another student agreed, "that's the thing that is really nice about them [in this ward], they don't differentiate". Another student, "and the communication is also really good with all the patients, they maintain really good communication and everything, they crack jokes. Yeah, I think that's really inspiring you know". Another student agreed, "Even if they have lot of paperwork, lot of work to do, every time they go to the patient, they will just crack some joke, make them smile".*

[3] MRSA - Methicillin-resistant Staphylococcus aureus is an infection caused by bacteria that has become resistant to many antibiotics

[4] Universal precautions aim to reduce the risk of pathogen exposure from the patient to the nurse. These may include donning gloves, impermeable gowns, plastic aprons, masks, face shields and eye protection

Another student, "they are also doing their work but at the same time they make patients smile and are listening to them". Another student, "that's the exciting thing, the quality I would like to learn it". Students murmured their agreement.

This discussion demonstrates these students' perceptions of how RNs connect with patients. They recognise this as a positive role model for themselves. Looking closer at the students' words the students appear to have separated the RNs 'real work' with the 'extra work' of connecting with patients. This perception fits with a study conducted by Chan and Lai (2016). A student in their study stated that, "*Nurses are so busy that they can't afford much time to talk with patients. We are still students, so we can spend more time chatting with patients on our placement"* (Chan & Lai 2016 p.5). Stories gathered throughout this narrative inquiry demonstrated the positive role model of RNs. However, aspects of these stories question what the RN is actually role modelling. Is it that engaging with patients is only peripheral and not central to nursing care?

My journal entries also identified that some students found working with some RNs highly stressful. Some students developed strategies to manage non-collaborative relationships from as early as their first placement. By third year, some students appeared to have accepted the situation as the norm.

Susan's Journal

First year student, "I have worked with a lot of RNs [in this ward], – some were ok, but because I did get to go to basically everyone, I knew who was actually nice as well as who was actually going to teach me stuff".

Second year student: "There was a new graduate RN, so I found that he can understand our situation. Every time I work with him, he helps me and he supports me".

> *Third year student, "we just have to listen to what the RN is saying because every nurse likes doing it differently. I'm literally doing something from the way one likes it, then whatever the next one says I will follow that. Whatever the next, I will follow that…Finally one said to me, do it your own way or you will lose your originality".*

Interactions with RNs such as these are often perceived by the nursing profession as acceptable. Strategies for managing difficult relationships are usually targeted at students. Resilience is a term discussed frequently in nurse education literature. Thomas and Asselin (2018) suggest that reflection and journaling may help to develop resilience in students' managing these challenges. Student's comments above demonstrate that they have developed their own ways to manage working with conflict. While student resilience is often discussed in the literature, addressing institutional contributors is less prolific. Nursing leaders and health care organisations have a responsibility to establish an environment which enhances care for students (Conroy 2018). There is a plethora of government legislations, organisational policy and procedures, and professional codes of conduct, to eliminate bullying in the workplace (South Australian Department of Health 2016; NMBA 2019; Flinders University 2019). The effectiveness of these policies to protect students is questionable. In a study by Tee et al. (2016), almost half of the 657 nursing students had experienced or witnessed violent behaviour during their clinical placement. In a larger study conducted by Birks et al. (2018), students described bullying during clinical placement in the *"forms of verbal, racial, physical and sexual abuse"* (p.45). Significant research has been undertaken in bullying in nursing, often colloquially known as *"nurses eat their young"* (Anderson & Morgan 2017). It is clear from this narrative inquiry that much work is yet to be done to address this unacceptable experience by students during clinical placement.

7.4.3 Thread 5: "Students from Culturally and Linguistic Diverse (CALD) backgrounds experience unique challenges. The impact on patient engagement is unclear."

Students from CALD backgrounds have described feelings of frustration, rejection, and sometimes blatant discrimination during clinical placement. This finding is consistent with research into the experience of international students in nurse education (Jeong et al. 2011). Stories told in this inquiry certainly reflect the misery some students experienced during placement. Some stories also reflect the personal strength with which students faced their experiences. Towards the end of one shift I met with a second-year student who was teary. She explained:

> *"I was allocated the procedure room but the RN wouldn't let me do anything. She was abrupt all day. Then an Australian born student came in and the RN went to her and introduced herself and showed her around. It was totally different to me".*

According to Mikkonen et al. (2016) as CALD students become familiar with their environment, routines, and expectations, their confidence and self-esteem develops. Some stories in this inquiry reflected a similar finding, expanding the concept to include student's overall cultural confidence.

> *Second year student, "I have been living in Australia since last two years and enjoying the study. I'm very optimistic and following my dreams to be a nurse. I was very nervous before placement but now I'm more comfortable being around persons and knowing their story and journey in hospital".*

It is important not to discount students' unfolding experience as they become accustomed to placement. Sometimes students are not afforded the opportunity to settle in before being criticised.

Susan's Journal

It's been difficult for these students on their first week [second placement]. On the third day the RN manager expressed annoyance, "when we ask them to do something, I have to repeat a few times. They just look around as if they don't know what to do". I feel quite frustrated because the staff were just expecting so much from the first couple of shifts. Then I spoke to a nurse who had actually worked with them over a shift. His feedback was concerning. He said that students are not necessarily treated with the respect that they could be. "Well there's impatience, they get given half an instruction and the instruction trails off. Staff speak very quickly, and the students are left without direction".

While this is their second placement hardly anyone has their first placement in a hospital; many in aged care venues. So, the first week is really about getting to the shift, working out where to go, what to do, the rhythm of the shift.

According to Jeong et al. (2011), culture can influence students' experience as much as language. In some cultures, it is taboo to question elders (Jeong et al. 2011). If students are unclear how to respond to a question, some prefer to stay quiet rather than lose face (Mikkonen et al. 2016). Unfortunately, in such situation's students can be labelled as unmotivated, or lacking in basic knowledge (Mikkonen et al. 2016). My journal describes such a conversation between a nurse manager and myself:

Susan's Journal

Nurse manager, "I go up to them and say, "well how are you doing, what are you doing?" "Oh, I'm just doing a blood pressure". "Well can you tell me why you are doing it?" Then the student just shrugs and says nothing". I'd like to explore that a bit further. The assumption by the nurse manager is that the student doesn't know what they are doing. It's hard to get a word in.

Clinical staff sometimes question the university sectors' choice to admit students with a low level of English (Jeong et al. 2011). It can be suggested that such negative staff opinions may inadvertently be transmitted to students. Instead of individuals, there is the risk that international students can be viewed as an institutional mistake. Stories in this inquiry provided me with some insight into what being an international student was like for the individual. In a voice recording a second-year student shares;

> *"My parents - mum and dad and my brother and sister are back in my home country. I really miss them a lot. Sometimes I wish I could go back where I was before"*

In an exercise asking students to write a letter (pseudo) to a patient this student wrote,

> *"Dear X,*
>
> *I feel like I'm looking after my own grandmother. When I first introduced myself to you and you said, "it must be very hard to do all this study, work long shifts, managing finances, when you come to a totally different land and need to adjust according to people's thoughts and cultural environment. You must be missing your mum and dad the most. I felt so touched because no patient that I have looked after or any staff have ever said that to me. I felt the warmness, the kindness in your saying, exactly like my grandmother still says. I felt like I have met my grandmother in you. Later when you said that "I had a heart attack on my birthday". I felt so bad. You would have been planning for your birthday bash, would have invited guests and would be very excited to meet your family especially your grandkids. When you said this heart-attack surprised me on my birthday I felt so sad and touched. At that time, I wished I could take a pic with you and show that to my grandmom".*

Students have said that working with other nurses from international backgrounds may or may not be helpful. This one student described his experience.

“If we work with a migrant nurse, the relationship is different. They can understand you, whether they migrated from the UK, from Ireland, from Germany, anywhere, or like countries we are all from. And I feel like because we come from a different environment, we think differently. But suppose a local person from here haven’t experienced another environment, they don’t know that feeling. I mean they haven’t seen beyond that wall. Then how can they understand us when they don’t know? But the person who came from outside of that wall he knows what's – what's there and what's here. Environment is a big factor”.

8 Chapter Eight: Touchstones 8-12

8.1 Touchstone 8: Representing narratives of experience in ways that show temporality, sociality, and place

In this inquiry I aimed to view each story within their three-dimensional context. There were imbalances in one dimension or other at times, and these may indicate *"disruptions, fragmentations or silences in participants' and our own lives"* (Clandinin & Caine 2012 p.173). The ethics limitations on interviewing participants inhibited coming to know them beyond the context of the placement. My joint role of educator and inquirer required a degree of professional restraint in sharing aspects of myself. Some clinical placements were short, restricting the amount of time to come to know students. Apart from these restrictions' students' stories were written and told in the midst of their placement experience. They reflect the complexities they encountered throughout that time. Clinical placement is meant to influence students' future career as RNs. Their experience shapes the way in which they engage with patients, present and future. This narrative inquiry drew "*attention to the difficult places, times … [and] contexts in which [students' work]"* (Clandinin & Caine 2012 p.185). Drawing attention to placement complexities aimed to highlight potential factors impacting students' caring practice.

8.2 Touchstone 9: Relational response communities

As narrative inquiries unfold, they reveal the unexpected. Inquirers require support and accountability to ensure the research path remains connected to the research puzzle (Clandinin & Caine 2012). The most likely environment for this was

the academic setting. However, as I continued to live my life, whether as a nurse, a clinical educator, or within personal-social contexts, I shared my story of the research. People's feedback kept me grounded in the question of *"why and how am I doing what I'm doing?"* The most profound support came spontaneously from the students in Group Seven who were not intended to be part of the research. This Group demonstrated interest in the research project and agreed to a recorded group discussion. Interwoven throughout the presentation of narrative findings are excerpts confirming research threads.

8.3 Touchstone 10: Three Justifications

All researchers must demonstrate why their research matters. Clandinin and Caine (2012) explain "*We need to be able to justify the research through responding to the questions of "so what?" and "who cares?"* (p.184). This is also known as showing personal, practical, and social justification. Researchers are generally motivated to "*tap into a timely issue and / or to right a moral wrong"* (Leavy 2018 p.802). While the paradigm of arts-based research is widely used "*across the disciplines during any or all phases of research…"* (Leavy 2018 p.4), some academics still question its validity. According to Clandinin and Connolly (2000), initially "*reviewers and editors did not see the social significance of the work … [and] labelled it as 'idiosyncratic and narcissistic'"* (Clandinin & Connolly 2000 p.121). This motivates us as narrative inquirers to maintain clarity about the personal, practical, and social justification of our research (Clandinin 2016, p.36).

8.3.1 Personal Justification

Looking backwards and retelling my story helps me to uncover knowledge gained through the inquiry (Clandinin & Caine 2012). In my autobiographical narrative, I see myself on the edge of an inquiry about student- patient relationships. I had no idea that this view was *"too simplistic… too much about the Other, the participants whom we are researching"* (Clandinin 2016 p 82). Without continually re-examining my own justification for being in the midst, the research was at risk of being "*too technical or too certain"* (Clandinin 2016 p 82). Without becoming "*fully involved in the experience studied… [I couldn't] truly understand the lives explored"* (Clandinin & Connolly 2000 p.81). My personal investment caused me to not only receive insight into a changing puzzle, but to influence the change. Evidence in my journals demonstrate that the evolving inquiry extended beyond nursing student-patient relationships. This shifting inquiry called me "*to relive and retell [my] autobiographical stories, and to inquire more deeply into the knowing…"* (Clandinin & Cane 2012 p.184). Students allowed me to see how their life story beyond placement impacted their placement experience. Evidence of the effect of the students' relationships with RNs has disturbed me. These are the stories that students often pushed to the background during clinical education sessions. Instead, what surprised me was their enthusiasm to tell stories about their encounters with patients. I discovered the influence of RNs on students' experience through observing and participating in interactions. Conversations with RNs revealed diverse perspectives on mentoring students. My journal shows the internal and external dilemmas I faced as a "go between". In the beginning, I had no idea all the participants would be from CALD backgrounds. This opened up another series of questions and insights about their story of clinical placement.

I was unprepared for the students' transparency and trust in sharing stories of heart break and celebration. I pay tribute to the genre of narrative arts-based learning, in opening the possibilities for students' deep reflections on meaningful moments. I thought I knew the tensions I would face between my role as clinical educator and researcher. What I did not expect was the depth of care for the students I felt as a clinical educator. Just like my role as a narrative inquirer, I *"fell in love"* with my participants. Clandinin and Connolly (2000) describe *"composing and reading field texts allowed me…to slip out of intimacy for a time…allowing cool observation…"* (p.81-82). I was able to maintain personal and professional boundaries by continual assessment and reassessment of the research goals.

The student and clinical educator relationship are an important model for the student-patient relationship (Ekebergh 2011). In Watson's (2008) theory, caring moments are "*the moment- to-moment human encounters between…the care giver and the…recipient of care"* (p.81). These are the moments I experienced with students. This approach to patient care is one that underpins the nursing theory of care (Watson 2008). I look back and I realise how little insight I had of the power of myself, both as an individual and a clinical educator to facilitate learning moments.

8.3.2 Practical Justification

In order for this inquiry to be of practical significance, it must influence clinical practice. This inquiry uncovered areas of change required to improve nursing students' caring practice. These included deficits in nursing student and RN relationships. I found the stories of experience by CALD students disturbing and worthy of further research. The relationship between the nursing student and clinical educator has unexplored potential to facilitate learning to care. The possibilities of developing

students' reflective capacity through arts-based learning are on the cutting edge of clinical education. The International Council of Nurses (ICN) (2018) requires nurses to be "*active in developing a core of research-based professional knowledge that supports evidence-based practice"* (p.3). This research has uncovered professional knowledge applicable to develop nursing student-patient caring relationships.

8.3.3 Social Justification

Narrative inquiry is a relatively new methodology. Demonstrating its validity and applicability beyond this inquiry is an important responsibility (Clandinin & Cain 2012; Clandinin & Huber 2010). Narrative inquiries have become widespread in nursing (Haydon et al. 2018; Lindsay & Schwind 2016; Schwind et al. 2015; Wang & Geale, 2015). This narrative inquiry can add to nursing knowledge about the experience of using the methodology. Narrative inquirers also have a social responsibility to add to the social and political conversation in which they are situated (Clandinin & Caine 2012). Inquiries often highlight the "*complexities, contradictions, and inconsistencies … [in] policies"* (Clandinin & Caine 2012 p.185). Clandinin and Connelly (2000) began their inquiries with students, then widening to teachers, schools, and eventually educational policies. While this narrative inquiry began with nursing students and patients, it has highlighted the broader relevance to RNs, academics, institutions and policies.

Watson's (2008) view is that caring goes beyond individuals and influences change in the world we live in. According to the International Code of Ethics for Nurses (2018) (NMBA 2018), nurses share in society's *"responsibility for initiating and supporting action to meet…health and social needs…in particular…vulnerable populations"* (p.2).

Patients and nursing students encounter each other in the midst of their life experience. These encounters have a ripple effect extending beyond that moment, influencing the patients' social circumstance. Returning to my autobiographical narrative, I reflect on the parent and child who did not experience care in their health encounter. A vulnerable family, they required even more attentiveness from nurses. This inquiry hoped to explore the caring relationship between nursing students and individual patients. It raised questions about nurse-patient encounters and the wider institutional narrative.

8.4 Touchstone 11: Attentive to audience

Implicit in using arts-based narrative inquiry is creativity in presenting and disseminating the texts. The diversity of field texts allows for a number of options for presenting research texts (Clandinin & Connolly 2000). Creative forms may include *"textual, visual, and audible"* (Clandinin & Caine 2012 p.185). Crimmins (2019) asks, *"now that I have that data, what is the best form for which to communicate and engage an audience with this?"* (Transcript 141). Searching for form is of itself something that "*narrative inquirers do"* (Clandinin & Connolly 2000 p.153). This narrative inquiry is presented here as a mixture of a traditional and creative thesis. In order to engage with a broader audience, the thesis must later be recreated into a more appealing form. Crimmins (2019) describes how "*my authentic voice, and my way of knowing is represented and is intertextually enmeshed with the data that I engage with and that I have uncovered in my research inquiry"* (Episode 141). How I as a narrative inquirer present this master story will influence what happens to students' stories. The stories are meant to challenge academics and RNs in the way we engage with our students. They provoke reflection on our own practice (Clandinin & Caine 2012). They make us

ask ourselves and our colleagues, *"what role do we play in being an obstacle or an opportunity on student's caring practice?"* The stories also provide students with a voice. They provide us with genuine insights into the strengths and difficulties they experience in relation to clinical placement. Most importantly, they provide new knowledge with which to improve patients' health care experience.

To disseminate this narrative inquiry, an audio format such as an audiobook or oral history project could be an appropriate medium. An excerpt of a storytelling session is included here as an opportunity for you, the reader, to 'be with' the students in this inquiry. The excerpt reflects the power of storytelling through even a small segment of one session. Some of the stories told in this thesis will be recognized in the recording. The section provides evidence of all five narrative themes discussed in chapter seven. The recording demonstrates students concentrating wholly on the session. Students describe moments which show mutual respect between themselves and patients. Stories produce insight into how I can support students as a clinical educator. Two different descriptions of RN's role modelling reflect the diversity which students encounter. English was not the student's first language and the recording provides some insight into how this impacts their placement experience. I encourage the 'audience' to listen to the recordings here before continuing. A transcript appears below.

8.4.1 Audio Group Six:

https://www.dropbox.com/s/wnt60hp1b56bjjm/Chandra%20and%20Anusha.mp3?dl=0

Chandra:

"I saw one lady, but like she had lost any hopes of living. Err because she had to go frequently to the hospital in xxx. So, at that time the doctor didn't

tell her that she had heart failure, problem. And when the err new doctor came in and she, they told her, like doctor told her that you have heart problems you need to go here to xxx [a different hospital]. She was shocked because she went three times to xxx hospital and they didn't tell anything about that one. And when she came here suddenly, she found that she had heart failure. And she said that you know I had lost any hope of living, it's better if I die. And she is –like she's, like she don't eat anything. So, whenever I go, you know, you don't eat anything, so you won't be like that before, like before if you don't eat anything and she was very independent like so she used to cook by herself her meals.

And she's from [another country] so she likes different kind of err food. And err, once I bring her [unclear] she don't like it. She told me like I like only Weetabix. And I [unclear] one Weetabix and she [unclear]. Oh, it's good it's good that you did bring this. I really appreciate it but I don't have any hope left. And whenever I go, I just wish her, please drink something. Just [unclear], whenever I come, she will put just like orange juice in front of her. Look I finish this one. And she doesn't, she had one. Okay you finish this one I will come a bit later. And she said err yeah, I will do it don't worry. [Unclear] not eating much but she, and I give her one bread and she ate. I feel like at least she is eating something. But I have never seen such person because she has no, she like, she don't, she don't have any hope.

Like she said I don't, I don't have hope to be better. I know I will not get better. I've not been like that before. It's better my heart it don't give me life support. It's better I die. She was like that and at that moment [unclear]. What should I tell her? Because I can't tell her I understand her problem? I don't, like, like she do. I'm not expert in anything that one. I said that, you can be some more better; everyone has some problem. But have a drink and we can try walking if you like. And she said no! Look at me. I'm just, I'm using pan and pan [unclear] bed wet and she was feeling really guilty and shame. And I said but it's okay. It's even normal nurse we can't hold our

bladder for long time and you have been into angio[5] then maybe this and you did that well for that time. It's okay I will take the damp sheets.

I'm really feeling err guilty because I'm not supposed to do that. I'm not - look at me how I became like, I was independent, now look at me. I better die. She tells me every time. And that's so so bad. Like, no one should be like that. She had no hope left. Even the thing like [unclear] but she, inside she said you don't know how I feel. I know how I feel it's really bad. I don't want to feel like that.

So, it was really hard, it was really hard caring for her. So, I need to think I need to think, what I will tell that I can make her happy, so she will not talk about like that. But even I make her happy, like use some sense of humour. But err eventually she will ended that note. Like, I don't want to go on living like this. So, it's really stressful.

Anusha:

It happens in old people when they are changing. like, I was, I was caring one of the patient and she was a fashion designer. And she likes dressing up really good. Like she really loved clothing and thing like that. And she just had a breakdown when she was looking at her gown. She just breakout like why I am wearing this gown? Just. I imagine of my previous days what I used to be and now what I am right now. She, she says like that. She means that, umm what she's right now so. Yeah, you know I really love dressing. I was a fashion designer, I used to dress myself. I used to silk cloth. I really love yellow, red. Like that, she says, just look at me now what I am wearing. I just looked in the mirror and that was just a breaking point for me. And, just look at my hair…

Chandra: Yeah.

Chandra: I haven't…

Anusha: [unclear] do things like that.

[5] Angiogram is medical imaging technique used to visualize the inside of blood vessels

Chandra: She was also [unclear] before, she told me. I was [unclear] and look at me now. She tends to compare…

Anusha:Yeah.

Chandra: …before and after. Even she hadn't [unclear] it will die eventually because she is again comparing and [unclear].

Anusha:Yeah.

Chandra:

Mainly because when she went frequently to that hospital and they didn't tell her anything. And she said that I'm [unclear] in that hospital I went so many times they don't tell me anything. And eventually they called her and said oh you have cardiac problem and you need to be admitted. So, it's my breaking point. I know my heart never be same as before.

Susan: Is it the same patient you're talking about?

Anusha:No.

Chandra: No.

Susan: Two different ones?

Anusha:Two different ones.

Susan: It's hard, isn't it?

Chandra: Yeah.

Susan: Because you feel powerless, what can you say?

Chandra and Anusha together: Yeah.

Chandra: Yeah.

Anusha:Yeah.

Susan: You can't really say anything.

Chandra: Even when I said I have nothing to say. I want to tell her, like comfort her.

Chandra and Anusha: Yeah.

Anusha:Yeah.

Chandra: But I had no words to say to her, what should I say? It will be okay. I can't say that because with heart problem it will not be ok, it will be hard, but you have to work with it. But I honestly can't say that I understand your problem because I don't. I can't feel like her. I'm not the one experiencing that one. So, I feel powerless. It's like I can't do anything for her.

Susan: But you can, what you've done is listen.

Chandra and Anusha: Yeah.

Susan: And not, not everyone listens.

Chandra and Anusha: Yeah.

Chandra: [unclear].

Anusha: Yeah, someone experiencing and sharing those problems if we are going to - it's better to not to give ideas and suggestions, you know. When we listen to them and just listen and listen. Say yes, no or more, [unclear] ask them then what you did? Then, what was the experience? Then, what did you feel that time? They will be like, you know, they will be more encouraging and telling you everything. At the end of that they will feel quite relaxed. So, I think yeah, just giving suggestions and things is [unclear] that really works. She suggested to me to just dress beautifully when you are young. I was so happy. Just do everything when you are young, you know. She was like that. ***End of recording***

8.5 Touchstone 12: Commitment to understanding lives in motion

As this narrative inquiry draws to a close, it is important to recall the temporality of the research. The participants and I entered the inquiry in the midst of our own personal and professional lives. Our lives are continuously evolving. In narrative inquiry "*there is no final telling, no final story, and no one singular story we can tell"* (Clandinin & Caine 2012 p.186). I conclude the research in the midst of my life. My

experience influences the experience of my future students. I trust the narrative inquiry will also influence the participants' experience of becoming a registered nurse.

9 Chapter Nine: Summary and conclusion

9.1 Return to the Research Puzzle.

This narrative inquiry explored two related questions.

"What role does storytelling play in helping students to reflect on caring practice?"

"Do stories identify obstacles and opportunities students encounter to engage with patients?"

The first question related to the value of arts-based pedagogy through storytelling, during clinical education. The evidence in this inquiry demonstrates that storytelling prompted deep reflective sharing. Students lived their experience. Through creative writing and oral narratives, they told the stories of their experiences. Their reflections encouraged them to "go back" and relive and so learn from their patient encounters. Peers actively listened and provided encouragement and empathy to each other. The themes of the stories varied. Some were stories of interactions with patients, others about their placement experience. While a long-term goal of storytelling is to enhance caring practice, this inquiry could only ever examine a steppingstone. Caring within nursing practice is a broad topic and is the subject of much research. This narrative inquiry has demonstrated that a dynamic and promising relationship between arts-based learning and caring practice does exit. Further exploration within the field of caring research could uncover exciting prospects for nurse education.

The second part of the puzzle focused less on arts-based learning and more on arts-based research. The methodology of arts-based research, through stories, revealed multiple and unexpected complexities. Obstacles and opportunities to engage with patients cannot be truly delineated because they often intersect. Students

raised some of these issues unconsciously through their creative writing and oral stories. Others I experienced for myself as I came alongside, living the student's clinical placement with them. I retold these experiences through written and oral stories, recorded in my research journal. Within the blurring of "positive" and "negative" influencers, two particularly strong threads emerged. The first is the power relationship between RNs and nursing students. Their support, or lack thereof, dominated students' experience of placement. Unpacking the layers of complexity within this finding has been attempted in others' research. It clearly remains a concern. Secondly, students from CALD backgrounds faced additional and complex needs which require urgent and close attention.

9.2 Reflexivity

I recorded my experience of each storytelling session as soon as practical. I wrote the account in my journal or recorded my voice. These records demonstrate an immediacy of thoughts, feelings and observations of the session (Goldstein 2017). They enhanced the material which I gathered from the students' stories, often affirming and deepening my understanding of the narrative threads. Interestingly, this personal material also filled in the gaps in the students' audio recordings. The significant findings of the impact of RNs on students, and particularly on CALD students, were not explicit in many of the student recordings. Without the documented evidence of my own reflections these findings may not have been less easy to identify. The twelve touchstones of narrative inquiry (Clandinin and Caine 2012) guided me throughout the research. Working closely within this framework resulted in cohesive and transparent management of field texts.

9.3 Recommendations

Reflecting on the story of this narrative inquiry, several recommendations have emerged. Robust discussions between nursing leaders in clinical practice, education, and research could improve collaborative, caring relationships between RNs and nursing students. Students' experiences of feeling uncared for, bullied, harassed, or discriminated by nursing staff should be taken seriously at all levels of the nursing profession. Research into the educational, social, cultural, and health and well-being needs of CALD nursing students should be a high priority. Further research into the relationship between arts-based pedagogy during clinical placement and caring practice is warranted. The value of clinical educators in facilitating learning to care should be acknowledged by providing professional development and opportunities for further research. Professional development can also include collaboration with artists.

Retelling the story of this inquiry through an artefact such as an audiobook or oral history project will provide the students with a voice to tell their story. Retelling the stories in their entirety will provide others with the opportunity to know, and to contribute, to a new story. Retelling the story of this inquiry through an artefact such as an audiobook or oral history project will provide the students with a voice to tell their story. Retelling the stories in their entirety will provide others with the opportunity to know, and to contribute to, a new story.

9.4 Group Six: Final chapter

This thesis concludes in the same way as it commenced, with a story. In the following audio recording and associated transcript, students in Group Six tell their final story. It is their last day of placement. We will never meet as a group again.

Students may or may not stay in touch with each other and I may or may not come across the students at the University. It's unlikely that students will return to the placement venue. Relationships developed with nursing staff and patients have already faded. The *"temporality"* of life, and narrative inquiry, is never so poignant as at these final sessions. Before we say goodbye to the *"place"* that bound us together, we need to reflect on the *"personal-social"* conditions which shaped us during our time together. In this brief recording students discuss the power of storytelling to reflect on their own experience of learning to care. In order to evaluate the student's experience of storytelling, I finish the storytelling session with one final question. This is the recorded response from Group Six. The students are Anusha, Chandra, Benita and Dashita.

Group Six: Final Audio recording

https://www.dropbox.com/s/p6tio5jiye2jm32/Group%20Six%20Concluding%20Story.mp3?dl=0

Susan: "… ask you one more question about how you found the writing exercises. Do you think - I mean this was a trial to see whether this is something umm that, can be helpful.

Chandra: Yeah, I think like, like whenever we write, like, if I have something like err like stress, it will help to relieve it, because whenever I'm writing, I'm writing good things and remembering good things. So, it's it's eventually making me err think good things and positive and makes the stress a little low.

Susan: Yeah

Chandra: So, it should be done like, everyone will share something. Then, we like, she share something, I learn something,

Susan: Yes

Benita: Yeah

Chandra: and when she tell about the good things like, we are like, “Oh!” (laughs gently).

Susan and All: Yeah

Susan Yeah, it encourages everyone

Chandra: It transfers to everyone. Everyone can connect with it.

Susan and All: Yeah

Chandra: It should be like continued so it would be helpful for everyone.

Susan: Lovely, thank you

Students nodding, in thought.

Dashita: Even with the writing I think err like a whole picture comes in our mind. And then we err like we are like feeling like we are in the whole situation. Even though we are not present at the moment and err when someone sharing their feeling, or err their umm, or err that situation then we can feel like we are in that situation, same as.

Susan and All: yeah

Dashita: I think that's good.

Susan: So, you're learning from each other?

All: Yeah

Chandra: It’s like we are not present, but we are present at the same time. Like, we are seeing from their eyes, like something.

All: Yeah

Chandra: Like the one you told about the boy (laughs gently) when you are telling, we are imagining.

Benita: Yeah

Chandra You were, we were umm you are just showing us the picture of that one.

All: Yeah

Chandra: unclear

Chandra: Even so it's really helpful

All: Yeah

Susan: Lovely

Anusha: I think, umm, in university we learn about, all the medical terms and everything we need to do, there is some signs of doing that. We need to learn about the medications, its side effects, everything. But this exercise really helps us to be a good nurse for a patient. Like one of the umm staff in aged care she told me that there are two kinds of nurses, one is the clinical nurse and another one is the patient's nurse. So yeah, the clinical nurse only thinks about his, all the paperwork, and medications, and his conditions. But the patient's nurse sees his condition and try to change it according to his umm needs and condition and try to connect that. I think that, that is what she means with the patient nurse.

Susan: Mm

Anusha: And this exercise really helps us to bring that from us to be a patient's nurse; to observe them.

Susan: It makes you go back and think about it, doesn't it?

All: Yeah

Chandra: It's err, like it's not practical - practical is important lie, with evidence err like behind it. But there is also emotional thing…

Susan and All: Yeah

Chandra: That we need to connect. Because at the end we are all human

Benita: Yeah

Susan: Yeah

Chandra: It makes us more human

Susan: Yeah, it does

Anusha: Yeah, if we are only going to think about their diagnosis and their conditions and what doctor said, then I don't think we can really write this exercise that well.

Chandra: Yeah, like, err, like this is err helping us focus like on patient also, like not only his conditions, and not only his treatment. But focus on him, how they feel. What they want.

Susan: Mm

Chandra: We need to focus like what is good for them and what is bad.

Susan: Yeah.

Chandra: But at the same time, it helps us think about what is their wish, like.

Susan: To get to know the person?

All: Yeah.

Susan: Thank you so much for that! That was just so beautiful…" Recorder off.

END OF TRANSCRIPT

9.5 Conclusion: Return to my autobiography

This recording demonstrates the value nursing students place on storytelling during clinical facilitation. As I step out of the research, I carry the conviction that the simple tools of pen, paper and permission to write can facilitate students' learning to care. Devoid of arts-based pedagogy, clinical education has few tools to offer a new perspective on caring practice. The grand narrative of nurse education will continue to accept students' views of patients as nameless bed numbers clothed with nursing terminology. I return to my hope that if we infuse clinical education with story, colour, texture, and even movement and music we have the potential to change the story of clinical education. Arts-based pedagogy, through storytelling, has the power to prompt students to reflect on this critical question; "If you only knew the patient's story would you care?"

The End

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Appendix 1: Information Sheet

Susan Timpani
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RESEARCH INFORMATION SHEET

Title: Storytelling during Clinical Facilitation - An Arts-Informed Narrative Inquiry.

Researcher
Susan Timpani RN
Post Graduate Student: Master Clinical Education / Research
College of Nursing and Health Sciences, Flinders University
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Dr Nina Sivertsen	nina.sivertsen@flinders.edu.au	T: 8201 5098

Description of the study
This research project is being conducted as part of my studies within the Master of Clinical Education / Research. This inquiry will explore the experiences of undergraduate nursing students on Clinical Placement when they aim to explore their patient's life story, within the context of their illness.

Purpose of the study
As nurses we acknowledge that the patient's past, current or future life story may impact their illness experience. In order to deliver holistic nursing care, we understand how important it is to know as much as possible about our patient's story. While working as a Clinical Facilitator I have listened to students describe their experiences in trying to get to know their patient's story. This research aims to identify themes expressed by students during these encounters. This important information will help to develop teaching and learning strategies to support student skill development in exploring patient's stories during Clinical Placement and enhance their nursing care.

What will I be asked to do?
There are two main components to participate in this study. The first is provision of your reflective pieces you will have created during placement facilitation (these will be returned to you), and the second is a single individual interview. Throughout the facilitation process Susan has created Field Texts in the form of notes and observations from the facilitation sessions. You will be asked to consent that these be included as data and you will be able to review these if you would like to. A single individual interview will be audio recorded and transcribed and will be stored as a computer file according to Flinders University policy. The transcript of your own interview will be made available for you to review upon request.

What benefit will I gain from being involved in this study?
Critical reflection on experiences always holds the potential to improve clinical skills. You will also have the knowledge that you have provided an important role by contributing to research which aims to improve educational processes and patient care.

Will I be identifiable by being involved in this study?
The identity of each student in the facilitation group will be known by the principal researcher and other students in the group. However, the research participation will occur following the clinical placement and therefore your involvement will remain confidential. All participants' details will be kept confidential. All data collected will be de-identified before being shared with the other research team members. To promote your anonymity in the written outcomes of the study pseudonyms will be used. You can choose your own pseudonym if you wish. All of the information you provide will be stored on password protected computer systems. Upon completion of the research, all paper documents will be digitised and then shredded; electronic information will be kept in a confidential manner for 5 years at the university as required by law.

Are there any risks or discomforts if I am involved?
Creative reflection can result in deep personal insight, and at times participants might find themselves confronting unexpected emotions or feelings. Should you need or request further support this is available at the university's Health and Counselling service, Level 3, Student Services Centre next to the Sports Centre. They are open: 8:45am - 5pm, Monday – Friday. Tel: (08) 8201 2118. Alternatively, we would recommend you contacting a service such as Lifeline on 131114 or your local General Practitioner.

How do I agree to participate?
Participation is voluntary, you are under no obligation to participate in this study, and you are free to stop at any time. If you are willing to participate, please contact me at timp0010@flinders.edu.au or bring the consent form with you to our final facilitation meeting.

Thank you for taking the time to read this information sheet, and I'm sincerely hoping that you will consider participating. If you have any questions, please do not hesitate to contact me via email.

Susan Timpani

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number: 7938). For more information regarding ethical approval of the project only, the Executive Officer of the Committee can be contacted by telephone on (08) 8201 3116, by fax on (08) 8201 2035, or by email to human.researchethics@flinders.edu.au

Appendix 2: Consent Form

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(Focus Group Discussion)

Storytelling during Clinical Facilitation – An Arts-Based Narrative Inquiry

I_____, being over the age of 18 years hereby consent to participate as requested in the research project with the title listed above.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to participate in a Focus Group Discussion.
4. I agree to audio recording of my information and participation.
5. I agree to the researcher using Field Texts developed during the clinical facilitation sessions.
6. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
7. I understand that:
   - I may not directly benefit from taking part in this research.
   - Participation is entirely voluntary, and I am free to withdraw from the project at any time; and can decline to answer particular questions.
   - The information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   - Whether I participate or not, or withdraw after participating, will have no effect on my progress in my course of study, or results gained.
   - I may ask that the audio recording and association field texts be stopped at any time, and that I may withdraw at any time from any individual interview session without disadvantage.
   - Even though information provided will be treated with the strictest confidence by the researcher(s), as a mandated reporter, any disclosure of illegal activities will need to be reported by to the relevant authorities.
8. I agree/do not agree to the audio recording / transcript of the interview being made available to other researchers who are not members of this research team, but who are judged by the research team to be undertaking related research, on condition that my identity is not revealed.
9. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's name…….……..

Participant's signature……Date……...

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participate in the Interview component of the research.

Researcher's name……Susan Timpani

Researcher's signature…….... Date…….

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Item 8 as appropriate.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. Project number: 7938 For more information regarding ethical approval of the project please contact the Executive Officer on (08) 8201-3116 or human.researchethics@flinders.edu.au

Appendix 3: Ethics Approval

MODIFICATION (No.3) APPROVAL NOTICE

Project No.:	**7938**
Project Title:	Storytelling during Clinical Facilitation - An Arts-Informed Narrative Inquiry
Principal Researcher:	Ms Susan Timpani
Email:	timp0010@flinders.edu.au
Modification Approval Date:	18 November 2019
Ethics Approval Expiry Date:	**31 December 2020**

I am pleased to inform you that the modification request submitted for project 7938 on the 6 November 2019 has been reviewed and approved by the Chairperson of the Committee. A summary of the approved modifications are listed below. Any additional information that may be required from you will be listed in the second table shown below called 'Additional Information Required'.

Approved Modifications	
Extension of ethics approval expiry date	
Project title change	
Personnel change	
Research objectives change	
Research method change	
Participants – addition +/- change	
Consent process change	x