THE USE OF STORYTELLING IN NURSING EDUCATION

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A Dissertation

Submitted to the Graduate College of Bowling Green
State University in partial fulfillment
of the requirement for the degree of

Doctor of Philosophy

May 2010

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Abstract

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The purpose of this study was to explore the use of storytelling in the pedagogical process of nursing education wherein the emphasis on meaning construction by the nurse educator allows better lesson integration and facilitates a learner-centered construction of meaning by nursing students. This study explored how nurse educators use true stories to add authenticity to a learning objective. This inquiry employed the theory of phenomenology grounded in postmodern constructivism to consider how storytelling can be most effectively used in nursing education.

The nine nurse educators presented substantial evidence supporting the use of storytelling in classroom and clinical settings. They carefully considered the pedagogical issues of attending to specific student learning objectives, assessing student readiness, and considering student engagement. They evaluated storytelling as a teaching methodology by considering how intentionally they use stories, the appropriateness of various content to this method, and by thinking about class size and classroom layout. These educators strongly considered the learning they try to develop in students by engaging the affective domain to specifically provoke students’ feelings, attitudes and emotions.
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Chapter I: Statement Of The Problem

Changes in healthcare have caused healthcare educators to look critically at many processes used in education. Nurse educators are questioning whether current pedagogies are preparing students to successfully practice in today’s healthcare arenas. Nursing education is beginning to challenge long-held beliefs and traditions used to educate future nurses. The shift to managed healthcare, diminishing economic resources for higher education and research, and increasingly diverse student populations call for schools of nursing to rethink traditional approaches to educating nurses. Another complicating factor is the critical nationwide shortage of nurse educators. These challenges are precipitating a renewed interest among nurse educators in developing and using alternative pedagogies which may be more responsive to this changing learning environment.

Research in nursing and higher education demonstrates that generations of teacher-centered conventional pedagogies have led to learning climates that are competitive, confrontational, isolating, and anxiety-provoking. Conventional pedagogy is referred to in the nursing literature as outcome-based or competency-based education. In conventional teacher-centered pedagogies, experiences are predetermined in terms of objectives and evaluation of learning is linked to outcomes (Diekelmann, 2001; Williams, 2004). This is a well-supported idea in nursing education. Content is selected and placed within a particular course in a nursing curriculum. The learning experiences related to the content are pre-planned by the teacher to meet pre-selected outcome-based learning objectives. In problem-based learning, authentic nursing situations are used to stimulate and focus classroom learning. The ultimate goal is to prepare nursing students for the licensing examination as well as the complex and challenging roles in various healthcare arenas. This kind of learning experience focuses the attention on the
teacher and implies only the teacher can determine what counts as knowledge, what constitutes learning, and how it might or should be demonstrated (Ironside, 2001).

An assumption underlying conventional pedagogy is that learning is a rational, orderly, and sequential process leading to knowledge and acquisition of specific skills (Ironside, 2001). The teacher presenting information begins with simple concepts or ideas and proceeds to those more complex. Quantifiable learning objectives are prepared by the teacher to direct the student to the most important aspects of the course and provide measurable standards. This model reinforces the assumption that there is a single best way to obtain knowledge and truth; yet it is known there is never a single best way to handle any clinical situation. Each patient situation has a multitude of variables yet conventional classroom practices encourage students to reason in terms of a single possible outcome. Students are taught each clinical situation should be assessed individually and interventions chosen specific to the patient’s needs. However, classroom techniques do not always assist critical thought about unique and different alternatives to the same or similar health problems encountered. Rather than devoting so much effort to teaching students what to think, perhaps teachers need to do more to teach them how to think (Tsui, 2002). Most teachers are aware of these limitations of the conventional approaches to education but feel pushed by institutional guidelines and rules, the requirements of accrediting organizations, and state licensing boards to continue these practices.

This does not mean that conventional pedagogy has no place in nursing education. Major strengths of conventional pedagogy, particularly in light of the nurse educator shortage and faculty reductions, include the predetermined specification of desired educational outcomes, the process by which the student can achieve those outcomes, and the mechanisms by which student achievement can be evaluated. This makes the conventional approach to education well-suited to
large student-teacher ratios. Conventional pedagogies have served the nursing profession well and continue to be helpful in many situations. However, nurse educators are becoming increasingly aware of the limitations.

Teachers who have recognized the limitations and inadequacies of conventional pedagogy are exploring and developing pedagogies to combat these limitations. New pedagogies like critical pedagogy, feminist pedagogy, phenomenologic pedagogy, and others have arisen out of the challenging to conventional pedagogical assumptions. These approaches are often referred to as interpretive due to their concern with how teachers and students interpret what is taught and learned (Ironside, 2005).

Within alternative, interpretive pedagogies, there is a shift to critiquing, exploring, and deconstructing student experiences for the meaning and learning (Diekelmann, 2001). The focus is on exploring multiple ways of knowing, thinking, and interpreting; not on one best way. The focus is not the teacher but the students and their learning. Students are exposed to many different teaching approaches and offered opportunities to practice different ways of arriving at knowledge.

Researchers examined the efficacy of various classroom techniques in enhancing student learning. Terenzini, Springer, Pascarella and Nora’s 1995 study measured the critical thinking of college students in instructional experiences using the critical thinking module of the Collegiate Assessment of Academic Proficiency. These researchers found critical thinking was significantly and positively related to only a few classroom and instructional experiences; namely, the discussion of content with faculty members, role-playing, and individual sharing of student interpretations of content (termed, for these purposes, storytelling). After controlling for a general pre-college level of critical thinking, however, only hours per week spent studying
remained statistically significant. Much more research about the effect of classroom strategies on student learning must be done.

Further research on classroom strategies was done by McLaughlin, Freed, and Tadych. In 2006, they studied classroom teaching methods known as action methods designed to increase student interaction. They felt that if educators were to help nursing students with role development, they needed an approach engaging them at the intellectual, emotional, and experiential level. In action method classrooms, students are encouraged to “act” or “show” rather than merely “talk” or “tell” about their experiences (p. 2). The originator of action methods, Moreno (1953), developed several kinds of teaching methods. Each method provides opportunities for students to take on roles (explore new roles), play roles (practice the roles of different participants), and create roles (expand their understanding of roles) (McLaughlin et al., 2006). These skills not only allow students to learn multiple sides of a story, but also to actually experience the various conceptions.

In 1995, Barr and Tagg presented a similar learning theory to these action methods. They wrote that the “instructional paradigm,” the educational paradigm dominating undergraduate education for years, was in the process of shifting toward a “learning paradigm” (p. 13). They believed higher education institutions existed to produce learning rather than provide instruction. The college was no longer a place where teaching activities were primarily the delivery of 50-minute lectures. They believed the mission of colleges was to produce learning within every student by whatever means worked best, transforming students from passive listeners into active learners. This was a significant shift in how higher education viewed its responsibilities. Today, the “instructional paradigm” is still in heavy use but the concept of the “learning paradigm” presents a very appealing alternative (p. 16).
A specific learning method reflecting this paradigm was coined as “narrative pedagogy” by Diekelmann (2001). After studying the common experiences of teacher, students and clinicians in schools of nursing, she found one method used to explore these was through the telling of stories. Teachers and students gathered at various times throughout the year to share stories about learning. In the clinical area, stories centered on students’ interactions with patients or their interactions with other nurses, physicians, and other healthcare professionals. In the classroom, time was allotted for students to interact with other students and the teachers. Each clinical and classroom interaction became a story helping the student better integrate nursing information.

This phenomenologic pedagogy entitled narrative pedagogy is unique to nursing research. It was not researched externally and incorporated into nursing, but instead developed through the study of the lived experiences of nursing teachers, students, and clinicians. Researchers have since included narrative pedagogy within the broader category of phenomenologic pedagogy (Diekelmann, 2001; Ironside, 2001; van Manen, 2000). Ironside (2001) described phenomenologic pedagogy as a way to understand and explore the common experiences of teachers and students through the “gathering of students and teachers into reflective dialogue” (p. 81). Phenomenologic pedagogy is not a specific strategy, but rather it creates a place for conversation among students and between students and teachers (Ironside, 2001). Narrative pedagogy specifically examines practices in the educational setting where teachers and students share and interpret stories of their “lived experiences” (p. 81). An important result of this sharing of stories is that students and teachers begin to understand their common concerns. Students often fear being questioned in class, yet teachers use this technique to encourage group interaction and facilitate deeper discussion of the material. When teachers
and students share their side of this story, each grows in understanding and a deeper sense of community develops. Teachers learn direct questions are very intimidating to students and students recognize that teachers use this method to more fully engage students into the content. Thus, storytelling is a specific strategy which can introduce phenomenologic ideas into a conventional curriculum.

Van Manen (2000) described phenomenologic pedagogy as a way of attending to and being with students. The day-to-day interactions with students are often the most instructive periods of time. The strength of phenomenologic pedagogies is not in creating theory or generating knowledge but in understanding and exploring the common experiences of teachers and students (Diekelmann, 2001). Phenomenologic pedagogies help reveal the experiences students use to make connections between theory and practice as well as those experiences making those connections more confusing (Ironside, 2001).

One of the most powerful nursing education tools used to make these connections is the intensely personal, highly emotional, and often brutal stories of everyday life lived by patients and witnessed by nurses. Within these stories is the essence of nursing. Stories help make nursing practice visible (Koch, 1998). With so much in healthcare based on numbers and dollars, each discipline is forced to prove its worth in the overall care of the patient. For example, doctors must admit patients to acute care facilities and manage them within a prescribed number of days. Technicians provide testing and diagnostic services. Support clinicians assist with specific service needs. Nurses, however, hold the entire picture together and much of what they do is considered most important to the patients; listening to their stories and simply caring.
Healthcare has not always succeeded in demonstrating care and empathy for hospitalized patients and nurses are as guilty as any other player. This researcher’s practice is filled with examples of nurses, physicians, and other healthcare team members who do not listen to patients’ stories. Arthur Frank describes a hospital experience with a less than positive impact, saying

After the ultrasound a physician said, “This will have to be investigated.” Hearing this phrase I was both relieved and offended. The relief was that someone was assuming part of the burden of worrying about what was happening to me. But I was also offended by his language, which made my body into medicine’s field of investigation. To get medicine’s help, I had to cede the territory of my body to the investigation of doctors who were as yet anonymous. I had to be colonized.

One day I returned to my room and found a new sign below my name on the door. It said “Lymphoma,” a form of cancer I was suspected of having. No one had told me this diagnosis. Finding it written there was like a joke about a guy who learned he has been fired when he finds someone else’s name on his door. (1991, p. 51)

This story points to the importance of listening and attending to patients’ feelings. Nursing brings this unique gift to the healthcare table. No other healthcare profession spends as much time with the patient. Nurses, therefore, must listen to the stories of their patients. Thus, it is logical to posit that if student nurses are to learn to listen to patients’ stories, they must be exposed to the concept of stories. The use of stories in the classroom provides students with a similar, practical model.

Storytelling is described as a way to discover knowledge, uncover the knowledge embedded in nursing practice, and recover the art of nursing (Boykin & Schoenhofer, 1991). Students enter the classroom with life stories providing meaning to their past as well as a basis for developing future nursing stories. If time is allotted in the classroom to share lived experiences, teachers and students grow to appreciate these shared experiences (Koenig & Zorn, 2002). By analyzing these stories of experience in the classroom, practical nursing knowledge is both taught and learned (Benner, 1991).
The narratives within which individuals live, or their personal stories, are not just a way to describe lives. They are the means to bring order to or organize experiences (Bruner, 1990). This process helps establish meaning in experience. As stories are told, order is created from disordered lives and meaning established from what might be considered meaningless experiences. In learning to derive meaning, students are asked to adopt a pattern of lifelong learning. Learning can be seen as sense-making; a social process linking context to cognition (Reissner, 2005). Storytelling provides the context for this content.

As students hear or write stories, they become familiar with the process of sequencing, analyzing, and synthesizing data (Koenig & Zorn, 2002). Stories help them think critically and keep thoughts organized. They begin to see the strengths and limitations of the story’s subjects. They focus on important data and learn which data are less meaningful to their interpretation of the nursing situation. Students also develop their imaginations through storytelling or listening to stories (Koenig & Zorn, 2002). They learn to visualize situations and characters that help contextualize learning and enhance memory. This assists information recall when faced with similar situations with other patients. As students listen to stories, they become more familiar with the rhythms of language and develop a better understanding of the new and complex language of healthcare. Students are able to actually improve their speaking skills. In both listening to and telling stories, active engagement is required. Stories promote active listening and encourage conversation, both of which are essential to student learning (Koenig & Zorn, 2002). In sum, creating a community of continual interaction is essential to the learning process and storytelling helps develop relationships and make connections.

It is essential that faculty members who choose stories as a way to help students learn consider both learning theories and their own educational philosophies. Learning theories focus
on how people learn while educational philosophies focus on identifying methods allowing students to reach learning objectives. Each educator’s learning beliefs provide the basis for the approaches used in their teaching. Both new and experienced faculty members are challenged to choose theories which best support the institutional philosophy at the same time as complementing their individual teaching preferences. If the emphasis is truly shifting from teaching to learning, appropriate strategies must be employed.

Billings and Halstead (2009) point out that “psychologists have developed two principal types of learning theory – behavioral and cognitive – to explain how people learn” (p. 193). A discussion of teaching methodologies best fits within the cognitive learning theories. In the early 1900s, psychologists emphasized that perception and learning was interpreted in terms of perception organization (Billings & Halstead, 2009). Insight, often referred to as the “aha” phenomenon (Billings & Halstead, 2009, p. 194), was another important concept to this early work on cognitive learning. Insight is defined as a trial and error process resulting in a solution or pattern of thinking.

Memory is another important component to cognitive learning theory. Memory selects the sensory data to be processed and transforms it into meaningful information before storing it for later use (Billings & Halstead, 2009). Graff (2003) contended that memorization reflects only recall and not how students think about or make sense of the content. The problem in nursing education occurs when memorization is rewarded in the didactic portion of the class and the related expected knowledge is not applied in the clinical setting. Specific teaching strategies must be employed to help students learn didactic material and apply the consequential knowledge to new situations in the clinical arena. Storytelling is one such strategy.
In the literature, stories and case studies are used synonymously. As shown in Table 1, case studies emphasize the many parts comprising any patient situation whereas stories are most helpful in capturing the essence of the relationship between nurse and patient. Case studies can certainly paint a complete picture of a patient’s diagnosis by including diagnostic details and therapeutic alternatives from a multidisciplinary perspective. Diamantes and Ovington (2003) found case studies to be more useful to students learning school administration. They felt case studies could be “held still for repeated examination,” whereas stories could not (p. 465). Stories, on the other hand, with the strong emphasis on relationship development, better assist the student nurse focus on nursing issues.

In years past, nursing education concentrated on the medical, psychological, epidemiological, and sociological features of illness (Boykin & Schoenhofer, 1991). This includes issues specific to medicine, physical therapy, psychology, and several other disciplines, thus making it difficult to articulate the content of nursing. Case studies generally include pathophysiology, diagnostics, pharmacology, histology, nutrition, and therapeutic treatments, providing all aspects of care in the clinical picture. Nursing students often have a difficult time deciphering which parts of the case study are specific to nursing. Using stories to portray nursing situations helps put emphasis on nursing and not medicine or other disciplines. Stories help nursing students better understand their role in the health and care of patients and clarify the contribution of nursing to general healthcare. The goal of this study is to fill the gap in research regarding the use of storytelling by nurse educators to help nursing students understand content.
Table 1

The Pedagogical Differences Between Case Studies and Stories in Nursing

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<th>Case Study</th>
<th>Story</th>
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<td>A situation including a patient, nurse, and other healthcare professionals which explores a particular health problem</td>
<td>A true, lived experience including a patient and nurse focusing on the interactions between the two</td>
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<tr>
<td>Includes pathophysiology, diagnostics, pharmacology, histology, and nutrition</td>
<td>Includes all situational details that emphasize nursing concepts and require nursing actions</td>
</tr>
<tr>
<td>Can be based on actual events but is generally significantly modified to meet the specific learning need</td>
<td>An actual lived nursing experience filled with emotion and drama illustrating a specific nursing learning concept</td>
</tr>
<tr>
<td>Emphasis on interrelationship of concepts from several healthcare disciplines</td>
<td>Emphasis on relationship between nurse and patient</td>
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**Purpose of Study**

The purpose of this study is to explore the use of storytelling in the pedagogical process of nursing education wherein the emphasis on meaning construction by the nurse educator allows better lesson integration and facilitates a learner-centered construction of meaning by nursing students. This study explores how nurse educators use true stories to add authenticity to a learning objective. This inquiry employs the theory of phenomenology grounded in postmodern constructivism to consider how storytelling can be most effectively used in nursing education.
Research Questions

1. How do nurse educators use storytelling in the classroom?
2. What content is best suited to storytelling?
3. How do nurse educators develop stories to advance the pedagogical process in the classroom?
4. How do nurse educators assess the learning outcomes achieved through storytelling?
5. How do nurse educators find students react to the use of stories within the classroom?

Definitions

The term pedagogy, when used in its broadest sense, includes “what is taught, how it is taught and how it is learned, and the nature of knowledge and learning” (Ironside, 2001, p. 73). Chinn (1989) described pedagogy as the “action we take in the learning environment, the materials we use, how we use them, and the attitudes we convey” (p. 9). Although the term pedagogy is often used synonymously with teaching, the two definitions above refer to it not as merely teaching but also a way of thinking about and dealing with education. It is in this sense that the term pedagogy is used in this research.

The words story and narrative are often used interchangeably in the literature. The word narrative suggests a structure that underpins the story (Frank, 2000). This might include the characters, setting, staging of the characters, and so on. The word story includes these structural components but, more importantly, involves the storyteller. Stories create a relationship within which the story is told. People do not tell narratives, they tell stories. Storytelling, then, is the process of creating a relationship around which the details and facts of the story are woven. Richardson (1990) provided a broad definition of storytelling, but instead used the term
narrative, writing that “narrative displays the goals and intentions of human actors; it makes individuals, cultures, societies and historical epochs comprehensible as wholes, it humanizes time, and allows us to contemplate the effects of our actions and to alter the directions of our lives” (p. 200).

A story is not something made-up. It is not a fictitious group of ideas designed to make a bad situation appear good. A story is an account that is deeply true and so engaging that listeners feel they have a stake in it (Ibarra & Lineback, 2005). People live stories and as they tell their stories they reaffirm them, change them, and create new stories. Koch (1998) wrote that “stories when well crafted, are spurs to the imagination, and through our imaginative participation in the created works, empathetic forms of understanding are advanced” (p. 1183). Teaching nursing students empathy is always a challenge. Stories create a sense of empathy for the characters which help students practice empathy in the clinical setting. This is the concept of story examined in this study.
Chapter II: Literature Review

Human beings are both understood and shaped by the stories of their lives. Stories are told about endeavors with a language rich in hopes, needs, and fears (Severtsen & Evans, 2000). Learning largely occurs within the context of the story in part because, through the hearing of a story, its facts and realities are lived and, therefore, become known and understood. The term narrative has been conceptualized as a way to both transform knowing into telling as well as learn from the hearing of the story. Both the storyteller and those listening enter into a relationship of discovery.

If all human beings are storytellers and their stories are texts to be interpreted, then every patient encounter is a rich opportunity to listen and interpret their health experiences. Boykin and Schoenhofer (1991) suggested that all nursing takes place in “lived experience in which the caring between the nurse and client promotes well-being” (p. 246). The details of the stories shared in these nursing situations then become invaluable sources of information to the nurse.

Storytelling has been used for many centuries as a powerful vehicle for communication. Before the written word, stories were a vital way of preserving historical information, tradition, and culture (Flaming, 2003). Telling a story allows the listener to enter an environment that provides context to the story’s words. Both learning and teaching are driven by context (Berns & Erickson, 2001). Learning does not occur in a vacuum; instead, knowledge is shaped and formed by the context within which it is placed. Stories help to create the context within which to seat the learning and enable recall of associated details (Davidhizar & Lonser, 2003). It is easier to remember facts woven into a story filled with drama and emotion. Stories have great appeal because they capture interest and bring facts to life by creating personal scenarios.
Mann (2002) wrote about a meeting of both Native American scholars and emerging scholars at Montana State University. Participants wrote stories and shared them in a contemporary storytelling session. Stories were told in the traditional verbal ways of the Native American people, enhanced with pictures and symbols using modern technology. This blending of old and new brought native storytelling into a new time and place. Mann (2002) believed that all experiences are history in progress and stories in the making. She spoke of the incredible journey through these stories and how the culture and language of the Native Americans were reverenced. This reverence for stories has great potential in healthcare, particularly in nursing education.

Storytelling is not a new concept for teaching others, as exemplified by Biblical parables and Native American folklore. For generations, stories have been relied on to teach values and expectations. Individuals tell stories about themselves. These stories help define the self. To know someone well is to know their story; the experiences that have shaped them and the trials that have tested them. When a person wants someone to know him or her, stories of childhood, family, political views, and so on are shared.

Silver (2001) used narrative techniques to teach traditional birth attendants in rural villages of Uganda about major killers of women in childbirth. He teaches:

- If their eyes are pale, and they’re feeling very weak,
  To the hospital, to the hospital;
- If their hips are small, and they’re looking pretty thin,
  To the hospital, to the hospital;
- If their fever’s high, and they’re having lots of chills,
  To the hospital, to the hospital.

This simple song helps birth attendants remember to look for the three major killers of childbearing women: anemia, pelvic structure too small for delivery, and malaria. Transporting women with these symptoms to hospital facilities can increase the likelihood of survival of both
mother and child. The oral narrative tradition already exists within this native population, so the
use of a song that tells a story was a logical technique to teach these birth attendants. This
simple story has lasting and widespread effect on the health of women in this country.

**Stories of Patients within Healthcare Settings**

Stories are important in the lives of children dealing with emotional issues. Counselors
often use stories to help children who have experienced the death of a loved one express grief in
a developmentally appropriate way. Telling one’s grief story is a part of mourning (Glazer &
Marcum, 2003). In support groups, the sharing of stories is a critical part of the healing process.
The telling of the story allows the individual to verbalize events and feelings. As patients share
stories, they name and shape the meanings of their unique experiences. Child psychologists
often combine art and storytelling to help children express emotions in familiar and safe ways
(Glazer & Marcum, 2003).

Other healthcare professionals use storytelling in a variety of ways. Archibald (2003)
studied nine patients recovering from hip fractures in order to reveal the participants’
experiences and gain insight into methods of improving their nursing care. The stories from the
patients revealed dissatisfaction with the comfort of the beds, the lack of respect shown them by
staff, and a need for increased speed in responding to their need for pain medication. The
qualitative results were revealed through the patients’ storytelling. The researchers found that
only through the individual stories did the true experiences unfold.

Storytelling was also used in cooperative team meetings in an acute psychiatric care
facility. Meetings were videotaped so the dynamics could be viewed and reviewed. Nurses,
physicians, patients, and family members spoke about the progress of the patient in the unit
(Vuokila-Oikkonen, Janhonen, Saarento, & Harri, 2003). Each was asked to tell their story from their perspective. Researchers found that physicians often monopolize the meetings and tend to impose their perspectives on the patients’ progress on everyone else in attendance. The study resulted in a change in meeting dynamics and an increase in the time the patient and family were given to speak about the illness.

Thomas, Reeve, Bingley, Brown, Payne, and Lynch examined patients in a palliative care setting (2008). These researchers used semi-structured interviews to learn about the experiences of terminally ill patients and their spouses. One patient was determined to die in an inpatient hospice setting and another to die at home. The reasons given were studied through the eyes of patients and their caregivers. Researchers followed these patients and their families through their death experiences and even interviewed the spouses after the patients’ deaths. The insight gained led to policy changes in the hospice unit as well as additional education of unit staff members.

Williams (2009) studied patients in Intensive Care Units (ICU). She found critically ill patients had difficulty pulling together stories of their life-threatening experiences. She believed life-threatening experiences need to be understood as stories if the threat is to be responded to effectively. Charts and other unit records were reviewed to collect facts of what occurred during the ICU stay of five patients. Many patients were either unconscious or semi-conscious so memories of events were scattered. Once events were gathered into a coherent sequence, Williams (2009) found patients were able to understand residual symptoms and handle their varying levels of ability. Knowledge of the lost events helped them make sense of the full effect of their life-threatening experience.
In another study, mothers caring for children with terminal illnesses were asked to share their stories. Lenha (1999) found these mothers to be very eager to share the stories of their children’s illnesses. She found that storytelling provided the mothers with insight into the functioning of their family. Each time they told their stories, they explored how they felt and perhaps assisted themselves in adjusting to the child’s illness and the subsequent changes within the family. Listening to these stories also helped the professionals understand each particular family’s journey and allowed nurses, physicians, and other healthcare professionals to better meet the individual needs of each family member.

Stories are also useful as an educational strategy for older adults with chronic illness. Storytelling can foster informal patient teaching sessions capitalizing on past experiences and assisting with the integration of new health behaviors (Cangelosi & Sorrell, 2008). Older adults with chronic illness often live with short-term memory loss, side effects of medications, and a host of other symptoms challenging the teaching-learning process. When encouraged to tell their stories, older adults often reveal detailed medical histories, long-held beliefs, and their own personal perspective on coping with aging and illness. By encouraging these stories and listening carefully, nurses can better understand how chronic illness affects a person’s daily life.

Communicating with dementia patients is often a significant challenge for healthcare professionals. Holm, Lepp, and Ringsberg (2005) studied how storytelling can be used as a caring intervention to stimulate patients with dementia to take part in conversation. These patients often experience a poor quality of life due to alienation from themselves and others. Holm et al found storytelling can trigger associative conversations in persons with dementia. Patients actually began to communicate with one another. This caring intervention was found to be of great benefit to patients with dementia.
Russell and Timmons (2009) also studied patients with dementia. They used open-ended interview techniques with five patients diagnosed with moderate dementia. Extensive review of the narratives revealed information that helped explain patients’ behaviors. Preoccupation with the activities of a son was better understood as remorse for perceived failure as a parent. Constant reference to a fall was better understood as expressions of fear for a repeated fall. Russell and Timmons (2009) found these significantly cognitively impaired patients could participate in this qualitative research and the methodology was an effective way to learn about their lived experiences.

Just as stories confer meaning to the lives of patients, they also attach meaning to the jumble of facts or figures in a patient chart. Nestor (2006) found stories breathed life into laboratory and imaging results. Radiographic images or numbers on a blood test result are just a set of facts, but the patient’s story gives them true meaning. Nestor (2006) felt obligated to synthesize a patient’s presentation and laboratory findings into a clear and convincing story for specialists, other healthcare professionals, and the patient.

**Stories with Nurses in Healthcare Settings**

Smeltzer and Vlasses (2004) used storytelling to impact the satisfaction of nurses in an acute care setting by listening to them as individuals, rather than as a group. They found these stories influenced and shaped the culture of the institution by making it more in tune with its clinicians. The clinicians then found they could focus more on the patients because they felt they were heard and respected.

Lunt (2000) found professionals helping clients recover from mental illness should direct focus toward the patient’s personal individual experience, which is affected by illness or
disability. Lunt (2000) also agreed that storytelling was an important skill all helpers need. The ability to tell as well as listen to a story is a vital skill. She articulates that “relating individual, personal, and unique stories, as well as the personal philosophies and visions embedded in these stories, is central to the helping process” (p. 43).

Stories were also used to explore the experience of cancer within the American Indian and Alaskan Native population. Pelusi and Krebs (2005) found American Indian and Alaskan Native people use stories to fully live their experiences of cancer as well as communicate those experiences to their families. The participants reported that having cancer means one becomes an elder no matter what the age and retelling their experiences helps them acquire wisdom and strength (Pelusi & Krebs, 2005). Storytelling was found to value the individual sharing the story and also encourage personal growth for those listening.

Operating room nurses discovered using stories about their surgical experiences was very helpful to nurses just beginning work in surgery (Ramsey, 2000). Surgery educators designed a series of stories based on their operating room experiences as new nurses. They found if they were a part of the stories, the new nurses found them to be more believable and realistic. Educators found the new practitioners were eager to develop their own stories to be used in teaching the next group of new nurses.

Professionals in the field of nurse retention and recruitment have looked at the use of storytelling to further understand the complex issues around finding and keeping good nursing staff. Patterson (2003), a nursing consultant, saw storytelling as a form of persuasion. She believes stories “fulfill a profound human need to grasp the patterns of living – not merely as an intellectual exercise, but within a very personal, emotional experience” (p. 298). She combines audiovisual technology such as PowerPoint presentations and stories to arouse energy in her
audiences. She employs stories to tell how and why life changes and to encourage dialogue between nurse managers and staff nurses.

Nurse leaders have learned storytelling can be a very effective tool in moving staff members in a certain direction or motivating them to continual improvement. Futch (2004) found storytelling to be one of the most important skills a nurse leader can possess. Stories relate past experiences and challenges and teach others methods to overcome such challenges and the growth benefits of mistakes and bad decisions. Healthcare organizations have become accustomed to functioning within times of financial strain and stories are used to define what is important in an organization. Futch (2004) found stories energized her staff for the work yet to come.

Weissman (2000) discovered stories were specifically effective in solving conflicts. Nurses at a home-based hospice agency were having difficulty obtaining pain medication prescriptions adequate enough to keep the patient comfortable in the home. Nurses found physicians were often distant and impatient with issues of pain control. They would often not call back in a timely manner or refused to increase the dosage. Physicians were frustrated with the frequent calls and expressed concern over the effect of very high dosages on respiratory depression. When nurses and physicians were questioned about this issue, very different stories emerged. Nurses felt they were letting their patients down by not succeeding in getting the physician to order enough medication to control the pain. Physicians felt frustrated by their inadequate training in pain management, the high dosages of pain medication, and the inadequate pain assessment provided by the nurses. When each side told their stories, protocols emerged to guide the nurses in making changes to medication doses based on good assessment. When the
emotion of the situation was expressed in the individual stories, a mutually acceptable solution to the problem became clear. Thus, emotions and stories are closely connected.

Studies have also been done on new nurse graduates and how they think critically in their new roles. It is essential that nurses recognize early symptoms of potential health complications and initiate prompt treatment. Szafarski and Stotts (2009) found new graduates lacked integrated knowledge of diverse patient experiences and were unaccustomed to problem solving in clinical situations. Acute care hospitals need to assist new graduates improve their critical thinking skills in order to assure the provision of safe patient care. Problem-based learning, a method using problems as a starting point for learning and integrating new knowledge (Barrows, 1980), helps new nurses reflect on real patient cases to identify clinical problems and devise interventions. Szafarski and Stotts (2009) found using stories about authentic patient situations where seasoned nurses shared how they managed the complexities helped new graduates think through experiences they may not have yet had. Nurses then reflected and commented on the important features of the story and their impressions. This was found to improve communication skills as well as help the nurses trust their instincts.

**Stories in Nursing Education**

Storytelling is a valuable tool used in nursing education to develop skills in clinical settings. Davidhizar and Lonser (2003) reported that stories assist nursing students in listening and collecting data for cultural assessment. Baccalaureate nursing students caring for residents in a long-term care facility learned to listen to the beliefs and values of the storyteller in a nonjudgmental, contextual way. This helped them better understand the residents’ motivations and identify strategies to move them toward better health.
The simplicity of storytelling and immediate gratification associated with reaching a story’s end are powerful tools in contextualizing and humanizing nursing knowledge. Bowles (1995) found using stories in the classroom and clinical arena facilitate a deeper understanding of oneself and others within ethical and cultural contexts. Students are able to make connections between their patients’ cultural beliefs and ethical practice in nursing.

Schwartz and Abbott (2007) examined patients in community settings. Faculty and students met with people in homeless shelters, senior centers, and other community agencies. They designed semi-structured interviews and encouraged participants to tell their stories. Themes of listening, partnership, reciprocity, and solidarity emerged (Schwartz & Abbott, 2007). The nurses and students found they learned much more about the clients’ needs if they simply listened rather than asked specific questions or conducted examinations. They felt they developed partnerships with the patients in which they were all equal members. Both students and faculty found they gained insight into their own strengths and limitations, including biases. All developed a sense of solidarity and unity with the patients due to the integral involvement in the health issues. Students and faculty learned that listening to patients’ stories is a simple technique resulting in rich information about the patients’ tangled lives.

There has been significant research into how nursing students learn to care as nurses. Gilligan (1982), for example, found that women and men learn to care differently. She described that women learn to care from their interactions with others. She found they enter into a story relationship with teachers, family members, friends, and other students and, through this process, develop a sense of caring. Patterson and Crawford (1994) believed teachers who model caring for students end up teaching the elements of caring, though they admit this is largely untested. Patterson, Crawford, Saydak, Venkatesh, Tschikota, and Aronowitz (1995) examined male
baccalaureate nursing students and discovered that learning about caring in nursing is an evolutionary process in which the student’s natural caring traits are refined and enhanced. A major technique used in this study was the listening to and sharing of stories. Students were clearly able to identify uncaring behaviors and gain an understanding of caring behavior from the behaviors of their teachers, other nurses, and other healthcare professionals.

Educators are always looking for creative ways to engage students in teaching materials. Dupain and Maguire (2007) required nursing students create a digital story about a health topic using digital video equipment and the acting of their fellow students. The process of creating a realistic scene incorporating knowledge from textbooks and classroom teaching methods is an active learning method which helps students better understand and recall learned information. Research has shown that regardless of subject matter, students working in small groups tend to learn more and retain material longer than when it is presented using other instructional strategies (Dupain & Maguire, 2007).

Leight (2002) found stories to be useful in informing aesthetic knowledge in nursing. She believes there are two major epistemological domains in nursing education: scientifically derived knowledge called empirics and expressive, creative, intuitive knowledge entitled aesthetics. Nursing education focuses much of its efforts on the empirical knowledge. Leight (2002) believes stories are a good way to gain aesthetic knowledge and, since practice in nursing is the ultimate goal, stories should be part of nursing education.

Furthermore, Smith (1992) described aesthetic knowing as the moment of insight or “enlightenment” (p. 53) arising from the act of creating a structure which reflects clarity and completeness and extends beyond chaos and the “grim realities of life” (p. 53). The aesthetic
sense of an audience listening to a story is a stated goal and an important consideration when using stories.

The experiences of a graduate student assisting with the teaching of an online undergraduate nursing research course was chronicled using a story approach by Cangelosi and Whitt (2006). The graduate student kept a journal of her practicum experience as she interacted with students, graded assignments, and managed an online discussion forum. She initially had misgivings about the level of learning that could be accomplished in an online format but discovered that just as she learned from the stories shared with her instructor, using stories online helped her communicate with the students.

On the contrary, research exists which has failed to demonstrate that narrative pedagogy, chiefly the use of stories, makes a difference in the cognitive and ethical maturity of nursing students. Evans and Bendel (2004) studied the performance of baccalaureate nursing students on the Measure of Intellectual Development (MID) and the California Critical Thinking Disposition Inventory (CCTDI). The MID and CCTDI were administered to students prior to class participation using narrative pedagogy. The students self-selected to take the class, which was designed to use narrative pedagogy to help students understand and use caring in nursing practice. The post-class measures of the MID and CCTDI showed no significant difference in scores between students who took the course and those who did not (Evans & Bendel, 2004). While this study did not pinpoint narrative pedagogy as the best practice in nursing education, it does not mean the educational strategy is ineffective, only that in this study its worth could not be demonstrated.

Others have argued against an over-critical appraisal of stories saying the dissection of lived experience reduces the impact and meaning of those experiences. Cole (1989) believed
continual reflection on and study of a person’s lived experience diminishes the importance of the experience to the individual. External appraisal of one’s story may lessen its value and importance to the individual.

**Learner-Centered Learning**

For storytelling to be considered a teaching method, one must examine the research on student learning in nursing. Carper (1978) named four fundamental patterns of knowing that nurses use in practice: empirics, aesthetics, ethical, and personal. Empirical knowing is the science of nursing, borrowing concepts from medicine, physical therapy, and other disciplines (Carper, 1978). Aesthetic knowledge includes the creative, intuitive, and expressive application of knowledge and is sometimes called the art of nursing (Carper, 1978). Ethical knowledge addresses the duties, rights, and responsibilities of the nurse while personal knowing involves self-awareness and integrity in the personal relationships a nurse has with patients (Carper, 1978). Carper (1978) believed each of these domains of knowing is vital to the safe and effective practice of nursing. Nursing education practices focus strongly on empirical knowing with the use of lectures, assigned textbook readings, and seminars. Stories can engage the remaining three domains of knowing by helping nursing student develop relationships with patients, listen to their stories, and focus on their lived health experiences.

Children experiencing emotional and behavioral learning difficulties were studied by White (2000). She found narrative exploration was very beneficial with these children. Narrative therapy has been defined as a “respectful, nonblaming approach … which centers people as the experts in their own lives” (Morgan, 2000, p. 2). Problems are viewed as separate from people and people are thought to have skills and abilities to assist them in reducing the influence of
problems in their lives. Bennett (2008) saw this as a postmodern view where reality or truth is socially constructed through dialogue with others and selves. From this postmodern perspective, reality can be organized and supported through stories. These stories shape individual identity and may either disable or make lives better. Bennett stated that “one of the primary goals of the narrative approach is to increase individuals’ awareness of the dominant stories shaping their lives” (2008, p. 14). Therefore, this research supports the use of stories in enhancing learning and particularizing an individual’s meaning of learned events.

The development of critical thinking skills in nursing students is a goal in every nursing program. The ability to analyze evidence in clinical situations and respond quickly is necessary to the development of good nursing practice (Greenwood, 2000). Anderson (1985) discussed reasoning as a process by which people move from past to new knowledge. Nurses know infected wounds ooze pus, so when a wound oozes pus the nurse can reason it is infected. Other issues also accompany infections, so the nurse can infer the wound will be painful, the white cell count elevated, and the patient may have a temperature. This kind of reasoning is used by nurses everyday and is a skill that grows with each clinical experience. Several models exist of nursing clinical reasoning or learning.

One such model is the information processing theory which grew out of Broadbent’s 1960s work on human performance (Anderson, 1985). Information processing theory views mental activities as reflecting a flow of information. Data are received through sight, smell, and touch and interpreted with the help of stored memory. Interpretations are made with the goal of a specific response. The goal is realized when the appropriate action is taken. The elicited action is the feedback by which the process is monitored. Both conscious and unconscious information processing occurs and the more knowledge people possess, the more they can process
unconsciously (Anderson, 1985). Much of the study of the information processing theory used case studies and this has presented a challenge to the findings (Anderson, 1985). The theory does, however, help nurse educators better understand how to develop clinical reasoning in students. Scenarios or stories can help students use previously learned knowledge to interpret new knowledge for the goal of sound clinical reasoning.

The Dreyfus Model, a skills acquisition theory developed in the 1970s, includes five levels of skill: novice, advanced beginner, competent, proficient, and expert (Greenwood, 2000). In the first three levels, a significant analysis of facts and reliance on rules is used to make decisions. In the last two levels, however, there is much more intuitive thinking. The Dreyfus Model significantly informed Benner’s (1984) important work on the nature of expertise, which is used to describe levels of nursing performance today.

Another clinical reasoning model posits that human cognitive functioning places ideas or concepts into stored categories for retrieval at any time (Greenwood, 2000). This natural tendency helps organize thoughts and memories in a logical manner and provides the basis of schema theory. Concepts, objects, events, sensations, and their interrelationships are progressively grouped together in highly organized categories and are accessed simultaneously as required (Greenwood, 2000). This theory holds that objects and events in the world, although different, are treated in thought as conceptual categories (Greenwood, 2000). Table, for instance, is a mental group of objects that may be individually different but tend to share common properties such as a flat top and at least four legs of equal length. Each person knows an enormous number of schemata or categories to guide and interpret a wide variety of situations. Without such, individuals could neither behave appropriately nor predict the behavior of others. Teaching strategies that help students to group concepts into categories help them achieve higher
levels of clinical reasoning. Stories are a tool to help students create the schemata or categories in their memories.

Williams (2009) explored the mental process of constructing a story from a specific experience. The way a story is built from an experience helps make sense of the experience. When any event is experienced, individuals are confronted with significant sensory stimulation and must create meaningful personal significance from the data to understand it. The data must be organized, stored, and interpreted. Information is organized by linking similar events to form the basis of a story (Williams, 2009). Emotions are attached to these linked events through the interpretation process. Once this is complete, the person can reflect on the data until a meaningful story emerges (Williams, 2009). Once the story has coherence, it can be told in a variety of ways to suit the audience or the particular point being made (Williams, 2009). This cognitive process for each and every experience is the making of the story of that experience.

Williams (2009) also found a number of outcomes associated with “storying” (p. 283). One can create order out of fragments of memories and learn to cope with emotions related to the story’s events (Williams, 2009). Telling stories can reconstruct or stabilize one’s personal identity disrupted by life-threatening events (Williams, 2009). Future plans can be clarified and communicated with significant others (Williams, 2009). All of this makes it possible for the storyteller to interact in appropriate ways with the world and manage life more effectively.
Chapter III: Methodology

The purpose of this study is to explore the use of storytelling in the pedagogical process of nursing education, whereby meaning construction by the nurse educator permits better lesson integration and facilitates a learner-centered construction of meaning by nursing students. This study adds to the knowledge-base of nurse educator experiences helping to create constructed learning for their students through the teaching method of storytelling. A qualitative research method within a phenomenological framework is used. This section includes discussions about the assumptions of basic research, the assumptions of the researcher, and the perspectives on the nature of inquiry and phenomenology. A discussion of the participant selection, data collection, data analysis, and measures of quality follows.

Assumptions of Basic Research

This study, in the broadest sense, is basic research; that is, research for the sake of knowledge alone and to contribute to a fundamental knowledge base (Patton, 2002). The purpose of this study is to understand and explain the experiences of nurse educators related to storytelling. There are, however, significant assumptions about basic research that do not fit this study.

Patton (2002) outlined the purpose, goals, and key assumptions of basic research. First, the purpose of basic research is to answer questions deemed important by one’s discipline or one’s own personal intellectual interest. This study does fit this criterion. The education of future nurses is highly important to all nurses. The methods used to accomplish this are of equal importance. Nurse educators are very interested in studying and using teaching methodologies that are sound and beneficial to student learning. Secondly, a key ontological assumption of
basic research is that the world is patterned, explainable, and knowable; researchers have but to learn and describe the realities. This ontological belief holds in this study. There are important reasons to use storytelling in nursing education and it is believed that expert nurse educators use this method on a daily basis. Third, the publication mode for basic research is usually scholarly journals or books. The hope is the findings of this research study will contribute to the field of nursing education such that nurse educators will want to read it. Fourth, contribution to theory and knowledge base is the main goal of basic research. No claim is made that this research is intended to build theory. However, it does support existing theory which promotes the use of a more descriptive, learner-centered approach to helping students construct meaning. Fifth, the generalizability of findings across time and space is a goal of basic research. This research study is not generalized to any wider populations than those individuals participating. Lastly, the rigor of basic research is typically tested through the universality and verifiability of the theories utilized or created during the research process. The choice of a qualitative method for this study is justified in the following pages.

Since qualitative methodologies are well accepted as legitimate modes of inquiry (Guba & Lincoln, 1985, Patton, 2002), researchers have many framework choices. Further, each researcher brings a theoretical approach to each project, designs the framework to complement the main research question, and constructs the study by combining all considerations (Patton, 2002). There are a number of possible qualitative approaches which can shed light on nurse educators’ experiences with storytelling. The remainder of this chapter will address the following: the theoretical framework and rationale for the research questions, a description of the rationale behind the qualitative methodology, and an explanation of the methods and design including the steps taken to assure quality and rigor.
Assumptions of the Researcher

The researcher is essential to the study framework and design. To best serve the study as well as assure its quality and integrity, a researcher must be upfront and forthright with thoughts about how the study is framed and the resulting data analyzed (Patton, 2002). The framework and direction of this study, as well as the research questions themselves, reveal something about the researcher. Questions were constructed from my classroom teaching experiences, specifically the use of storytelling in the clinical arena to help students make connections between classroom theory and clinical realities. Students are encouraged to listen carefully to their patients’ stories so they can use the history and reality of the patients’ lives in creating an appropriate plan of care. Several peer nurse educators have been observed using stories to help their students understand complex concepts. I began with the assumption that nurse educators do indeed use storytelling as they teach.

Interest in studying nurse educators is based on a recent change in my career direction. Having worked in higher education for 18 years, first as a nurse educator in a diploma program, then as a nurse educator in an associate degree program, in 1994 there was a change to a position in nursing continuing education, focusing more on providing ongoing educational opportunities to licensed nurses needing education or training in a specific field of nursing. As administrative responsibilities further removed me from the classroom and students, in 2002 I decided to return to educating nursing students. Since then, I have been teaching medical-surgical nursing concepts to baccalaureate nursing students both in the classroom and the clinical setting. Upon return to the classroom, the diversity of students has changed and the lecture method used in the early 90s does not seem to fit this new student. Lecturing in a room of 175 students does not seem comfortable anymore. As a result of pursuing of a doctoral degree in higher education
administration, a literature search was initiated to find new ways to help students learn. After reading about storytelling, it became immediately clear that this was an area deserving more attention.

Nurse educators in baccalaureate education are chosen as the focus population because of a strong belief that baccalaureate education should be the minimum basic preparation for all professional nurses. The leadership and management concepts part of the baccalaureate curriculum are essential to the role of the registered nurse and the more technical preparation of an associate degree program cannot prepare a registered nurse for all the complex challenges nurses face daily.

Coursework at the doctoral level included several courses on research methodologies including quantitative and qualitative approaches as well as statistics and applied research. However, I have only conducted qualitative research as a classroom assignment. At the master’s level I have experience in several quantitative studies related to patient satisfaction, family understanding of treatment regimens, and patient follow-through with treatment plans. Several case studies were written for registered nurses and student groups to help apply classroom or textbook information in a new or different patient population.

Finding voice and telling one’s story are key concepts in qualitative research (Patton, 2002), which fits ideally in a study of storytelling. Through the process of data gathering and analysis, common themes and experiences about storytelling have emerged that may interest and prove helpful to other nurse educators. Meaning-making was also made central to this study by not focusing solely on the experiences of the nurse educators with storytelling, but also on the meaning these educators give those experiences. Phenomenology is defined as the study of phenomena. It is the experience of the issue being studied, not the issue itself (Cohen, Kahn, &
Steeves, 2000). The meaning of the experience of storytelling among nurse educators is the object of this study.

**Perspectives on the Nature of Inquiry**

In general, early nurse researchers were trained to do quantitative research but, in the last 20 years, nurse researchers have recognized that some phenomena cannot be captured or understood using quantitative methods (Hill, Bailey & Tilley, 2002). Nurses now look at research strategies using an alternative paradigm where meaning rather than truth is the legitimate end-product. Kuhn (1970) defined a paradigm as a worldview; a way of looking at reality and making meaning from experiences. The paradigm held and maintained throughout this study is a constructivist paradigm, perhaps most prominently described by Guba and Lincoln (1989). The use of qualitative narrative methods of data collection shifts the role of the researcher from a knowledge-privileged investigator to a more reflective, passive participant (Jones, 2003). The researcher emerges later in the process through the retelling of the subjects’ stories. Qualitative methods challenge the quantitative researcher’s ideas of “a single, transcendent meaning of reality and the importance of the search for empirical patterns that correspond to and represent ultimate meaning of [truth]” (Reed, 1995, p. 71). Qualitative constructivist research is based on the premise that reality is not only subjective in nature but is constructed by individuals as they interact with their social environment (Hill, Bailey & Tilley, 2002). One form of meaning construction frequently identified in qualitative literature is the story.

The constructivist paradigm holds several assumptions. First, it asserts a relativist ontology; meaning there are multiple socially constructed realities, or truths, of any given
phenomena (Guba & Lincoln, 1985). There is more than one single reality. This study of nurse educators necessarily demonstrates realities that are as different as the participants. Truth is defined as the best-informed construction of the data. The underlying premise of constructivist inquiry is the belief that individuals make sense of their world most effectively through storytelling (Hill, Bailey & Tilley, 2002). Thus, the use of qualitative storytelling as a method of collecting data related to the use of stories in the classroom is most appropriate.

The second assumption held by the constructivist paradigm is that of a subjectivist epistemology (Guba & Lincoln, 1985). Since a constructivist believes there are many realities, it is logical to posit that only through interaction can a researcher construct the reality of the data. The researcher cannot be detached from the participants of the study nor can personal values be separated. The raw data, the words and experiences of the participants, are combined with the researcher’s beliefs, values, and assumptions. It is therefore important to document and follow the flow of these beliefs, values, and assumptions throughout the study and maintain quality field notes.

The third assumption held in constructivist paradigm is that hermeneutic and dialectic methodology is most appropriate for eliciting the constructions outlined above (Guba & Lincoln, 1985). Guba and Lincoln wrote that “the process is hermeneutic in that it is aimed toward developing improved joint constructions, a meaning closely associated with the more traditional use of the term to denote the process of evolving successively more sophisticated interpretations” (p. 90). According to Miller (2000), an objective hermeneutic method proceeds on a “step by step basis” with each interpretation by the researcher immediately evaluated against interview transcript material (p. 131). This process is important as any material produced has been generated with the subjects’ own perceptions of their experiences as well as the research with
which they are involved. Guba and Lincoln explained “it is dialectic in that it involves the juxtaposition of conflicting ideas, forcing reconsideration of previous positions” (1985, p. 90). Having a continuous dialogue with the data is important to arriving at an accurate interpretation. A full understanding of the experiences of the nurse educators interviewed involves continuous review of the information shared as well as interview comparison. The goal is to understand the concepts of storytelling through the understanding of individual experiences with storytelling. Ultimately, with these three assumptions, the purpose of constructivist research is to reach greater understanding about the phenomenon from an emic, or insider perspective, rather than an etic, or outsider perspective (Guba & Lincoln, 1985).

Qualitative methods are used in this study and Patton (2002) states that qualitative findings come from three kinds of data collection. First, there are in-depth, open-ended interviews. Second, there is direct observation. Lastly, there are written documents. From interviews, the researcher gets direct quotes from people about their experiences, opinions, feelings, and knowledge. From observations, the researcher can create descriptions of activities, behaviors, and actions. Document analysis includes a review of course syllabi and faculty notes in preparation for classes. Each of these methods of data collection is used to fully understand the topic of storytelling in nursing education. Using these methods requires “discipline, knowledge, training, practice, creativity, and hard work” (Patton, 2002, p. 5). Data are collected systematically using field logs and audio-taped interviews to ensure accuracy. In qualitative research, the quality of the study depends on the “methodological skill, sensitivity, and integrity of the researcher” (p. 5). Purpose drives methodology and choosing a qualitative approach is the most appropriate course of action for the goals of this study.
Participants are asked questions permitting them to tell of their experience with storytelling and to express the meanings associated with those experiences. They are also asked how their experiences with storytelling relate to them as educators and how it affects their lives inside and outside the classroom. Interviews are conducted in the participants’ work environment, so that the real setting of their experiences with storytelling can also be observed. Patton (2002) describes qualitative inquiry as naturalistic, insofar as the research takes place in real-world settings, and warns the researcher must not manipulate the setting or phenomenon under examination. Guba and Lincoln (1989) describe naturalistic research as both a discovery-oriented approach minimizing researcher manipulation and also a design and approach to inquiry which places no prior constraints on the outcomes of the study. Care is taken to not lead the interview participants in any particular direction or judge one subject’s comments against that of another.

While it was hoped the educators could be observed teaching using stories, scheduling conflicts prohibited this. The nurse educators are, however, observed interacting with students and other educators before and after the formal interviews. Though this observation is not the kind Patton (2002) describes, it does provide information about participants’ interaction styles and relationships with students and other educators.

This research fills a literature gap on nurse educator experiences using storytelling to help students learn nursing. Patton (2002) says there are some questions that simply lend themselves better to qualitative design and analysis. Since the goal is to understand the experiences of the participants with the phenomenon of stories, this study lends itself best to the qualitative approach. Open-ended questions are used to facilitate purpose-driven conversations and elicit responses concerning thoughts, feelings, and making sense of experiences.
Guba and Lincoln (1989) stated the design of a naturalistic study cannot be given entirely in advance. Conventional researchers begin research knowing what they do not know, but constructivists (or naturalists) typically begin by “not knowing what it is they don’t know” (p. 175). Due to this uncertainty, a highly adaptable instrument is best. This research is entered without previously set notions about the results. Emerging data are allowed to lead the participants. As they speak about their experiences through storytelling in their own work environments, the researcher partners in the creative process of making meaning of their experiences. An emergent, constructivist design, such as naturalistic or qualitative inquiry, proves most appropriate for this study.

In both quantitative and qualitative research, positionality of the researcher is important. In quantitative studies, researchers usually remove themselves from the study; sitting at a distance, observing, and perhaps manipulating variables to disprove a null hypothesis (Patton, 2002). In qualitative studies, however, the researcher becomes a partner in the creative process of storytelling and meaning-making. The researcher is the instrument and, as such, the “skill, competence, and rigor of the person doing the fieldwork-as well as things going on in the person’s life, might prove a distraction” (p. 14). In this study, care is taken to document in a field log the researcher’s feelings and opinions as they emerge so they can be taken into account during data examination.

There is a difference of opinion between depth and breadth when comparing quantitative and qualitative research. In quantitative research, it is possible to measure the reactions of a large number of people to a limited set of questions (Patton, 2002). This allows the researcher to generalize the findings to other like-groups. Qualitative research, though, permits the researcher to study one topic in depth using fewer participants but the depth of understanding of these fewer
cases reduces the generalizability of the findings (Patton, 2002). This trade-off is acceptable to me since generalizability is not a goal of this study. No claims are made that the experiences of these nurse educators are the experiences of all nurse educators. However, common themes did surface and other nurse educators should be interested in the findings.

**About Phenomenology**

This study was developed using a phenomenological approach. Phenomenology emphasizes the interpretation of experience (Patton, 2002). Phenomenological methodology, which tries to understand another’s experience, is ideally suited to the study of the experience of nurse educators with storytelling. Nursing theorists all recognize the necessity of understanding patients’ perceived needs in order to effectively meet them (Cohen, Kahn & Steeves, 2000). This same approach is applied to nursing students and their perceived needs relating to learning. Cohen et al (2000) state that nurses can help only if they accurately understand the patients’ perspectives and needs. It is similarly believed that nurse educators can only help students learn if they truly understand their needs. Interacting with students through stories is one way of ascertaining those needs. This research demonstrates common themes among nurse educators which may alert other nurse educators to issues students simply allude to rather than make clear or direct in discussions. Patton (2000) describes that “phenomenologists focus on how we put together the phenomena we experience in such a way as to make sense of the world, and in so doing, develop a worldview” (p. 106). A phenomenologic study, then, attempts to uncover the true meaning of shared experience. A basic premise of the phenomenological method states the driving force of humans is to make sense of their experiences. People try to reach this understanding by interpreting their lives as they occur and treating experiences as stories.
unfolding (Cohen, Kahn, & Steeves, 2000). Therefore, the meaning people make of their life experiences is usually contained in the stories they tell. This study helps nurse educators tell their stories about their experiences with storytelling as a teaching technique.

**Participant Selection**

Qualitative inquiry generally focuses in-depth on relatively small, purposefully selected samples (Patton, 2002). Purposive sampling enables the inquirer to select information-rich participants from whom a deep understanding of the phenomena can be gained (Erlandson, Harris, Skipper, & Allen, 1993). This means only those individuals who possess data which will directly shed light on the studied phenomenon are selected for participation (Patton, 2002). The following strategies were used to select participants. First, expert nurse educators were asked by the researcher to identify faculty who used storytelling to teach nursing content. Then, these identified faculty members were contacted by e-mail or telephone and asked to participate. Once the first few participants were identified and interviewed, they were asked to identify other nurse educators who fit the selection criteria. Initially, four participants were selected and each of them identified one additional peer educator. Guba & Lincoln (1985) call this method of sampling “snowball sampling” (p. 233). The four additional nurse educators referred by the initial subjects all agreed to participate. After the eight participants were interviewed and the data became redundant, one additional subject was sought to ensure no new data could surface. Therefore, a total of nine nurse educators were interviewed for this study.

Since it is impossible for a researcher to know all the critical selection criteria in advance, it is important to note the selection criteria can change. Some practical considerations during participant selection are important to note. Due to the critical shortage of nurse educators,
locating willing participants proved a bit of a challenge. Most nurse educators facilitate two
clinical groups per week, often in different programs within the institution, and additionally
teach up to four classes. The time commitment was made very clear to the participants.

Nurse educators with at least some experience with storytelling were invited to participate. Subjects were recruited from higher education institutions offering a baccalaureate nursing program in Ohio and Indiana, within reasonable travel distance for the researcher. If initial contact with potential subjects revealed a willingness to participate, a formal letter of invitation was sent (Appendix A). The initial interview was then conducted and a personal relationship developed. Follow-up contact was made via e-mail and telephone to enter into their personal stories.

Ethics established by the Human Subjects Review Board at Bowling Green State University guided this study. An agreement containing full disclosure of the nature, purpose and requirements of participation in the study was initiated with each subject to establish confidentiality and informed consent (Appendix B). Information gained through interviews, observations, or document review thought to be personally identifiable, damaging, or considered private was removed to protect participant confidentiality. Risk to the health and well-being of the participants was minimal. Subjects were notified they were free to drop out of the study at any time with no loss to them. Study design and processes of data collection and analysis were fully disclosed to all participants.

**Data Collection**

In-person interviews comprised the primary data collection method and occurred in participants’ work environments. Interviews elicit a variety of data types through the kinds of
questions asked (Cohen, Kahn, & Steeves, 2000). The interviews (Appendix C) consist of open-ended, non-confirmatory questions to create an informal and interactive environment and encourage sharing and honesty (Patton, 2002). To elicit narrative data within a phenomenological framework, the researcher aimed for interviews that resembled conversation. This differs from tightly structured interviews which use a more directive style. The goal is to develop an “interactive interview” (Cohen et al., p. 61) where information is exchanged between participant and interviewer in both directions.

Each participant was initially interviewed once with follow-up interviews conducted by telephone, email, or in person. Initial interviews averaged three hours and follow-up interviews lasted 30 to 60 minutes. After each interview, a case report including the researcher’s constructions was created and shared with each participant. This allowed the participant to clarify the construction of the interview. Follow-up contact obtained verbal checks and approval of the information provided in the interviews.

All interviews and follow-ups were tape-recorded to ensure crucial data, including voice inflection, was captured. Follow-ups conducted by e-mail were archived. During the interviews, observations relating to settings, surroundings, facial expressions, and other body language were noted. Handwritten notes were also kept to ensure data were not lost due to equipment malfunction. All interviews were transcribed verbatim. Although the interview format permitted interactions between the researcher and participants, transcript analysis demonstrated the need for clarification or additional questioning. The transcripts were utilized as the primary data source.

Observations of participants were also utilized in the data collection process. Observation is used to describe participants, the work setting, and any other relevant information (Patton,
Data from observation provides vital additional information since the researcher sees things which may escape the participants’ awareness (Patton, 2002). One purpose of observation in this study is to describe the participants, their behavior during interviews, and their interactions with other faculty or students. Observation also provides data on the relationship between participant educator and student as well as any evidence of a developing relationship and mutual respect. As interviews were scheduled during the participant’s available time, there was no opportunity to observe the nurse educators engaged in sharing a story in the classroom.

Another means of data collection used was analysis of syllabi and instructor documents. These documents provide invaluable information about the storytelling environment. They are also a stimulus for generating questions (Patton, 2002). The analyzed documents included syllabi of the courses taught by the interviewed faculty and faculty notes for individual content when storytelling is used. Important data to note includes the purposeful use of stories, the presence or absence of a script, and any planned evaluation method regarding storytelling as a methodology. Access to these documents was negotiated with the participants. Confidentiality of all information was reinforced through the use of pseudonyms.

**Data Analysis**

Data analysis begins with data collection. The goal of analysis is a “thick description” that accurately captures and communicates the meaning of the participant’s lived experience (Guba & Lincoln, 1985, p. 333). A thick description captures the experience from the subject’s perspective in its fullest and richest complexities. Good description transports the reader into the described setting, often through rich quotations from the participants.
Description is the foundation of all qualitative reporting (Patton, 2002) and is separate from personal interpretation. Interpretation involves explaining findings, answering research study questions, attaching significance to particular results, and putting patterns into a framework. One goal in this study is to describe how stories take shape and emerge from the curriculum plan. The process of developing a story over time is examined and stories are told from the perspective of the participant from beginning to end.

Data analysis is closely tied to data collection. It is important to state that the human instrument, as used in this study, is capable of ongoing fine-tuning to generate the most appropriate data display (Erlandson, Harris, Skipper, & Allen, 1993). An effect of this continuous adjustment process is that as data were gathered, the analysis also began. This early data analysis often requires revision of the data collection procedures. For instance, some open-ended questions were not used in all interviews because participants took the discussion in other directions. These revisions revealed new data that would not have emerged if strict adherence to the questions was maintained. This process resulted in the effective collection of rich data that provided the basis for shared construction of what is real to the participants.

As data are collected, themes or categories are identified and, from these, data construction occurs. Glaser and Strauss (1967) explained this as a process of constant data comparison. As data are collected and coded, they are compared across other categories. The discovery of relationships began with the analysis of the researcher’s observations and interviews. Data analysis is a process of collection and interpretation. Each piece of information placed into a category is constantly compared with previous ideas, events, and classifications so that new interpretations are discovered.
Measures of Quality

The quality of any qualitative study is directly related to its particular methodology (Patton, 2002). Phenomenological research utilizes comparable quality measures to those in other qualitative methodologies (Guba & Lincoln, 1985; Patton, 2002). Credibility criteria are utilized throughout this study to ensure the plausibility of the data constructions. Credibility is demonstrated when findings and interpretations are approved by the study participants (Guba & Lincoln, 1985). During each interview, repeated verbal checks were made so the clarity and integrity of meanings were consistently upheld. Each participant also received a copy of her transcript and an overall description of the data construction to ensure accuracy. During that time, the subjects had the opportunity to strike material in the transcript and constructive narrative as part of a negotiation process with the researcher. The participants noted corrections, clarifications, and additions to the data and findings at that time.

The idea of interaction between data collection and analysis is one of the major features distinguishing naturalistic from traditional research. Steps are taken to ensure the data are respected and represented in a manner faithful to the intent of the participant. To ensure the trustworthiness of this study, several analytic methods are used. The first method is triangulation, which seeks out several different source types to provide insights into the concepts of storytelling (Erlandson, Harris, Skipper, & Allen, 1993; Guba & Lincoln, 1985). Triangulation can be achieved by the convergence of data from different sources or from a source using different methods (Ely, Anzul, Friedman, Garner, & Steinmetz, 2000). This convergence of at least two pieces of data, either from two different sources or the same source at two different points in time, was observed. The interview transcripts, setting observations, and document analysis helped create working hypotheses about storytelling. Careful analysis of all
interviews specifically looked for the same or similar points to emerge. These two methods of
data convergence achieved triangulation.

The second method used to ensure trustworthiness is the development of a working
hypothesis (Erlandson, Harris, Skipper, & Allen, 1993). The data were first sorted into logical
categories. This involved reviewing all collected data and developing categories that were
supported by the participants. Attempts were made to categorize all data into these sub-headings
to create a fuller and richer appreciation of the data. As pieces did not fit into one of the initial
categories, the material was reviewed again and the categories re-examined.

Thirdly, the tentative hypothesis is tested. This involves creating a data formation that is
shared with participants in a technique called member-checking (Guba & Lincoln, 1985). If the
participant validates the accuracy of the construction, the product of the analysis is valid and
trustworthy. Only one participant chose to change the construction and the feedback was
gratefully accepted. The researcher then reanalyzed the feedback and sent a revised construction
to the participant, which was approved.

Peer debriefing, another validity technique, is also used. This technique involves sharing
raw data and the construction with a peer educator. The peer reviews the data and construction
to validate that it is not somehow twisted through bias. The educator who completed the peer
debriefing concluded the participant’s ideas were faithfully represented.

Lastly, quality is ensured using the development and maintenance of an audit trail
(Erlandson, Harris, Skipper, & Allen, 1993). A complete audit trail of documents and related
materials collected during the study enhances its dependability (Guba & Lincoln, 1985).
Detailed notes on impressions and reflections as a researcher during data gathering, analysis, and
synthesis were kept. The audit trail included interview tapes and notes, transcripts, document analysis notes, and personal observations of the interview setting.

Summary

The purpose of this study is to explore the use of storytelling in the pedagogical process of nursing education, where emphasis on a construction of meaning by the nurse educator allows better lesson integration to facilitate a learner-centered construction of meaning by nursing students. An understanding of how participants construct and make meaning of the use of stories in the education of future nurses is gained. To ensure the fullest possible account of participants’ experiences, a phenomenological approach is employed in this study with the aim of constructing, through data analysis, the shared meanings, themes, and constructions of these experiences. Furthermore, while the findings of this study are not generalizable, it is nevertheless posited that the experiences of these participants are instructive and helpful to the professional practices of other nurse educators.
Chapter IV: Findings

The nine participants in this study brought a wealth of varied experiences to these constructions. All participants are white females, teaching in baccalaureate nursing programs in the Midwest. Their nursing education careers span four decades, with the newest educator in her second year of teaching. They are wives, mothers, nurses and nurse educators. The first section of this chapter presents an introduction to these participants. A short profile of each is provided in order to help the reader appreciate both the distinctive backgrounds of each as well as some of the common motivations that brought them to teaching as a profession and to the use stories as one of their teaching strategies. These profiles are followed by a discussion of the foremost themes derived from the participants’ descriptions.

Participant Profiles

The nine participants in this study were nurse educators from five different nursing programs in the Midwest. Participants were selected from schools that offer different nursing programs, with some from large multi-purpose institutions and some from small private institutions. Three of the institutions were sponsored by religious organizations, and two were large state universities.

Donna.

Donna is a full-time faculty member at a college in the Midwest owned by a neighboring medical center and sponsored by a church that is actively involved in a number of healthcare institutions in the area. This college offers programs of study in the arts, sciences, and allied health professions. Donna teaches in both the associate degree and the baccalaureate degree nursing programs.
Donna grew up wanting to be either a teacher or a nurse and to touch the lives of young people in a special way. Through high school Donna found herself drawn to the sciences. She registered for pre-nursing courses in college and earned a baccalaureate degree in science and nursing. She found her role as a staff nurse in neonatal intensive care (NICU) to be very rewarding but wanted to learn how to have a more positive impact on the health of her patients and their families. Donna was “a nurse educator … in the NICU (neonatal intensive care unit)”, but she began to feel that there was something more in store for her. Donna began working toward her graduate degree and applied for a research position. She very much enjoyed the research arena and remembered just how much she loved the sciences. By chance, she saw a flyer posted on the hospital bulletin board advertising for clinical nurse educators at an area college. Since she was working on her graduate degree, she was offered a position as an adjunct clinical instructor. Donna eagerly accepted the position as she viewed the extra hours as a way to help fund her graduate education. Her first few interactions with students were a bit frightening, but Donna soon decided that as a nurse educator, she could have a great impact on patient care by teaching future nurses how to be competent and compassionate nurses. She facilitated her groups of students through their pediatric rotations each semester. Soon Donna completed her graduate work and earned her master’s degree in nursing with a clinical focus in pediatrics. She successfully completed the certification exams and became a certified nurse practitioner in pediatrics. Donna shares a nurse practitioner practice with a colleague and teaches both classroom and clinical nursing. Donna finds great satisfaction in her role as a primary care provider, and uses her daily practice experiences as examples, or stories, in her classroom and clinical teaching.

Donna described her teaching style this way.
Aside from the [stories] that I know I’m going to use because I planned them, the others just seem to be off the cuff. And that’s pretty much the way life goes for me. I shoot from the hip and it doesn’t work for all. A lot of people have to be planned and down to the second, but I’m not that way. I [prefer] to discuss. This is what you need to know when you leave here today – what part of this do we need to talk about today?

**Sandy.**

Sandy teaches with Donna at a private college in the Midwest which is religiously sponsored. This college offers a variety of programs of study in the arts, sciences, and allied health professions. Sandy teaches in both the associate degree and the baccalaureate degree nursing programs.

Sandy began her nursing career as an associate degree graduate. She said, “I never thought that I would teach.” During the first semester of her associate degree program, Sandy encountered a nurse educator who changed her mind. This educator was the role model who encouraged Sandy to consider nursing education as a career. “I had a nursing instructor my first semester in nursing school who was a most valuable role model for me and I wanted to do what she did, because she did it so well.” Sandy found her to be “passionate… caring… she took students under her wing and showed them exactly what they should be doing and how to do it.” Sandy knew during this first semester of her nursing education that she was going to continue her education so that she could teach nursing. Now with a master’s degree in nursing Sandy is following in the footsteps of her teacher. That teacher “made a huge impact a huge difference, and I hope I am doing the same thing.” Sandy has found that using stories from her practice experience helped her to convey her passion for nursing, the passion that she felt so strongly from her own teachers.
When asked to describe her teaching style, Sandy talked about being very interactive with her students. She told a story about one of her teaching strategies to illustrate how she gets students actively involved in the process.

When I teach spiritual assessment that is a very difficult concept, uh, because students think that it all relates to religion, [which is such a personal thing]. So one way that I teach it, I go in and I become a person. I become Maggie. And I tell them a story about Maggie. She lives alone, her husband died… she is kind of ill right now…they’re allowed to each ask one question about Maggie related to spiritual nursing. They can ask anything. So I continue the story and I answer as if Maggie would answer their questions. They learn very quickly not to ask yes/no questions if you want to learn about [their] patient. So that’s one of the objectives…they’ll ask, well, do you believe in God? And Maggie answers yes. Their question is done. So after about the sixth or seventh person, they readjust their questions so they don’t ask yes/no questions. [They might ask] could you tell me about…then we talk about how to ask questions…I use a story kind of integrated through the whole class, and we spend probably 75 minutes on that. You have to have a little bit of everything [in your teaching strategies]…Lots of different techniques for different objectives.

Stella.

Stella teaches in a private single-purpose college in the Midwest. The college offers associate and baccalaureate degrees in nursing and certificate programs in a few allied health professions. The college is housed on the grounds of a large medical center offering its students great clinical learning opportunities.

Stella earned a baccalaureate degree in nursing and worked as a staff nurse for a number of years. She had one great longing – to teach nurses in another country. “I wanted to teach nursing in Africa- always wanted to go with the church and in the missions and go to another country where they don’t have a lot of nursing instructors…I wanted to be a witness to the Lord.” Stella’s great desire to teach met many roadblocks. “I started to apply to schools for teaching to get experience, and they would always ask me if I had any experience. When I said no, my application would be turned down.” In 1969 Stella was finally offered a clinical teaching position. After marrying a minister, Stella’s dream came true. Her husband was offered a
pastorate in Africa, and they moved there for three years. While in Africa, Stella taught nursing at one of the few nursing schools. She took groups of students to the primitive hospitals to teach them how to care for patients even when supplies are limited. She experienced many wonderful learning opportunities in Africa, and uses those experiences to teach her students about compassion and frugal use of scarce resources. Today these experiences have become the many stories that Stella uses in her classroom. “So when I’m teaching…I want to teach the content and then when I would come up to something that I definitely had an experience with…I would put that in there…and then it would come alive. The didactic information would come alive to them after telling the story.”

Stella has been teaching for many years and she talked about how her teaching style has changed over the years.

It’s really changes for me over the years that I have taught. I used to be concerned that [students] got every detail that I taught, you know, on a particular subject, and so I had pages and pages of notes…I used to stay to my notes, but I found that students get very bored with that and so I finally started to walk around and I am very at ease now in a classroom. I feel very connected with students now, and when I start stories the room just gets very quiet. I have noticed that. They get very quiet because they want to hear the details. Um, when…I use PowerPoint…or handouts…they think, well, I’ve got the PowerPoint and all that and I don’t have to listen very well. But when you come up with a story, then they have all eyes on you, especially if you get into it yourself, if you get into that feeling.

Monica.

Monica’s nursing career began in 1975. “In the 1970’s…nursing was one of the few options for women as a stable way to support yourself.” Monica worked as a staff nurse and a unit manager for a number of years. She left nursing for a period of time to pursue a Masters in Business Administration degree but she stayed connected to healthcare and worked in hospital strategic planning. Finding her way back to bedside nursing, Monica found what had first enticed her into nursing: helping people to take control of their own health. However, the
physical demands of nursing soon overwhelmed her. She was offered a clinical nurse educator position and continued to work as a staff nurse, as well as teaching student nurses in the clinical setting. “I just fell in love with education so I switched over” and she began to teach full time. Monica uses skills that she learned in the business world and applies them to her teaching.

A good manager is a good educator because you are always teaching and you are always translating, and playing scenarios with your staff if you’re going to help them understand how to do their jobs. So to me that was a natural skill that I brought to education….And I think it’s good if you have been a manager of large numbers of people because you have some skills of organizing people around a common goal that some educators do not have if they have not been managers.

Monica teaches a health policy course as well as nursing fundamentals in the baccalaureate program in a private, single-purpose, college in the Midwest. Monica uses stories in her classroom “because if you’re trying to make a point and you want to engage people in the meaning behind what message you’re sending, if you make it real with the story of a real person who has experienced something, they pay more attention than if you talk to them theoretically.”

When asked to describe her teaching style, Monica described her process of preparing her lesson plans. “When I’m designing my lesson plan, I lay out my teaching methods in 30-minute intervals, because people can’t follow a track more that 30 minutes. If a story fits into a 30-minute block then it gets put on my teaching plan.” Monica also talked about how she chooses her teaching strategy. “I’m [always] watching the reaction from my audience. I look to see if they are with me or not and if we’re getting discussion or if a story would work at this point. Then I pull [a story] out of my basket of tools and use it there.”

Jane.

Jane teaches in a state university in a large metropolitan city in the Midwest. This university has a number of different colleges and offers diverse programs from music and the arts to the hard sciences. Jane has a varied career background. She entered the healthcare field
as an emergency medical technician. “I started working in an ambulance on weekends. The first time that I lost four patients I said, ‘I have to be able to do more.’ So I enrolled in nursing school.” After working as a staff nurse for a few years, Jane decided that she needed to do more to affect her patients’ care so she went into nursing administration. “I was in administration for a while and I said, ‘you know if you’re going to be in administration you’re going to have to get your BSN.’ I got my BSN, and I said ‘I’m done with school.’ In August of the next year I started in a master’s program.” As a nurse manager, Jane knew she had great influence, but then decided, “…if I’m truly going to effect the profession in which I work then I have to do it through education. So that is why I went into nursing education, so I could have a larger effect on the profession.” Jane earned a Ph.D. in nursing and now directs graduate nursing education at a large mid-west university. She has worked in four major university colleges of nursing and now finds her work with graduate students to be fulfilling and satisfying. Jane uses stories in most of her classes, but particularly in her health policy class because “…[students] don’t seem to believe…that there really are problems with the healthcare system, and so I’ll tell stories of other students, and patients [who have had very difficulty experiences with the system].”

Jane talked at length about her teaching style, how she sees herself as a teacher, and about her philosophy of teaching.

I begin all my classes saying, I feel my role as an educator is to be a facilitator of the students’ learning experience…I am the facilitator. I am their guide on this journey of knowledge, and from my mouth to their ears in not the way that they learn. I make a pact with them. If they read the content, my job is to help them understand it and to put a face to it…my job is to help them to understand it. I’m not the imparter of knowledge. I am the facilitator to understanding … So to do that, that really facilitates telling stories because I put a face to it. I have a daughter with cerebral palsy. So they get the content from the book. My job is to put a face to it…through our lived experience, our story, I can put a face on it, so that they can have a broader understanding of what it means to have a child with a disability…I can’t replicate the experience for them, but I can give a face to the experience. And I think that’s what storytelling does.
Jane also talked about how she maintains a classroom.

I tend to roam the room. So if I see that they’re sleeping I going to go stand over by them. If I have to … I have stopped a class [because students are talking] and said if what you’re saying is more important than what I am [saying], then you can leave now because you’re interfering with the learning of others; and if everybody agrees that what I’m saying is not important then I’ll leave. Usually I only have to do that once. I don’t usually have to do it again.

Elaine.

Elaine teaches with Jane at a large public university in the Midwest. She teaches the fundamentals of nursing course. Elaine has been a bachelors-prepared, registered nurse in the mental health field in this university town in the mid-west for 18 years. She has 4 young children and was approached by a nurse educator at a large university to teach a clinical course in the nursing program. She did not particularly want to teach at that point. She was approached by the educator who observed her nursing practice in the mental health setting who wanted to have her as an expert nurse teaching nursing students in her program. Elaine entered into teaching education by facilitating groups of students through their mental health nursing clinical course. She also works with groups of students at a neighboring small university teaching their mental health nursing course. Elaine found that sharing stories from her experiences helped her students to care for patients in a mental health hospital unit. Sharing her experiences helps her students to be less fearful of patient with mental illness. She feels that sharing stories has helped her grow as well. “I love the idea that I am very much gaining something from my students and their life experiences…some of the questions that they ask stimulate my thought processes as well.”

Elaine talked about using stories only in the clinical setting since she is relatively new to classroom teaching. She has found that there are appropriate times to share stories with her students and there are times when stories just don’t work.
I think [stories] work better off the clinical floor, not while things are in action, not while they’re focused on something else, but when they can be somewhat relaxed…I think they need a certain level of comfort and relaxation and ability to listen … [At the beginning of the shift] they’re thinking about what they’re going to do in their day. Oh, my instructor is going to quiz me. They are going over the facts in their head; where am I supposed to be, what is my unit going to be like, what is my patient going to be like. So there’s some apprehension and some anxiety going on and I don’t think that is the [best time for a story].

Margaret.

Margaret works at a large public university in the Midwest, which offers a large number of degree programs from associate degree to doctoral studies. She graduated from a baccalaureate nursing program and began working as a staff nurse on the evening shift. This nursing program was located within college offering degrees in medicine, occupational therapy, physical therapy, and other allied health programs. In 2000, federal money was offered to students interested in pursuing a master’s degree in nursing on a full-time basis. Margaret grabbed opportunity to get a graduate degree at no cost, and focused her study on the care of older adults. Once she had the master’s degree, Margaret decided to begin teaching in a nursing program. She taught medical-surgical nursing to baccalaureate nursing students for about 10 years and feels that she learned so much about herself and the profession that she loved. She continued her education to a doctoral degree. Margaret’s grandmother was a nurse, and she loved her grandmother very much. She never had to ponder what her career would be – it would be nursing. “I believe that my career path has been God inspired. Opportunities arose and I took them, and here I am now.” Margaret has found that stories help students to learn to

…sit down and listen to people and value people. And when I’m telling my stories…the passion shows. I think that’s important….What I’m trying to do with my storytelling is invoke knowledge, but more than knowledge, to change attitudes, to bring about appreciation for the need for communication, the need for acceptance of people.
When Margaret left bedside nursing to become an educator, she took a cut in pay. “I needed another job to supplement my income and I read an add in the newspaper for a contingency nurse position at hospice and I have been doing that ever since. I truly believe that this practice has enhanced my teaching.” Margaret uses her experiences with her patients in hospice to help her students to understand pain, family interactions, and the dying process. She regularly shares the stories of her hospice patients with her students, who are excited to hear every detail.

When asked about her teaching style, Margaret described her behavior in the classroom. Usually when I’m teaching I am behind [the desk], I’m with the computer most of the time. I’m not a wandering type of teacher. And I’ll tell you why: because I have to follow my notes or I really get off track, really easy. It’s like the whole class could be a story, so I have to stay there and follow my outline. But when I tell stories I move. I move out from behind that podium…I tend to move over here and I stand scanning the audience.

Nancy.

Nancy teaches with Margaret at a large public university in the Midwest, which offers many different kinds of programs, including nursing: associate, baccalaureate, master’s, and doctor of nursing practice degrees. Nancy grew up in central Ohio and began her journey into the nursing profession in the mid 1980’s. She studied nursing at a university, which had an exciting campus life. Nancy’s life goals included marriage, motherhood and a career, so nursing seemed to be a good option, since most nurses’ work schedules can be tailored to their lifestyle. Nancy worked as a nurse in the intensive care setting, but the challenges of the unit soon became overwhelming.

After two years of hanging drips, monitoring intracranial pressure, and keeping people alive, I realized something was missing from my education. I didn’t know how to help patients and their families emotionally. What does one say to a parent when they’ve been told that their 18 year old will never walk again?
Nancy decided that a graduate education would help her with these issues, and she completed her master’s degree with a focus in mental health nursing.

Nancy began to work as a Clinical Nurse Specialist at an area hospital and found that a major part of that role was to teach practicing nurses. She found that sharing her experience in caring for patients in ICU helped other nurses to understand critical care nursing issues. Nancy soon realized that using stories about her experiences also helps her students learn.

Nancy talked about how her teaching style has changed over the years. “My first lecture, I had every single word that I said on paper, including the whole story, if I used one. Now I just write my side notes as far as definitions or things that I don’t want to forget to tell them.” Nancy relies heavily on lecture format, but finds that stories help to engage students and get them actively involved in the material. “I like to come out from behind the computer…I’m more animated when I’m storytelling because I don’t have to think so hard. When you lecture you have to be thinking all the time on what you’re going to say next and when you’re telling a story, you know, it just flows.”

Connie.

Connie works at a large public university in the Midwest and teaches in a baccalaureate nursing program. Through her own nursing education program, Connie thought that teaching would be a good fit, and she even visualized herself obtaining her doctoral degree in nursing. She began her nursing practice in the ICU setting, and found herself drawn to staff education. She developed expertise with several technically difficult procedures and noticed that other staff nurses would seek her out to learn from her expertise. Since teaching others to understand complex procedures seemed to come easily to her, Connie took on a more formal staff education role. As a result of her expertise in the ICU setting, she was asked to teach clinically for the
nursing program that was affiliated with the hospital. Her role as staff educator grew and Connie found herself teaching staff nurses, medical residents, and other health professionals. The burdens of the responsibilities for all of these professionals became overwhelming and Connie began to realize that her teaching skills might be better used furthering the nursing profession that she had grown to love. She took a position as a full-time nurse educator but she uses all of her patient care experience and all of her staff education experience to help her nursing students to better understand nursing. Telling stories about her experiences has helped her students to learn. “Now myself as a student, I love to hear stories. That’s when I could put my pen down and I could listen and learn and hear somebody’s personal experience…I just sucked those up.”

When talking about her teaching style, Connie mentioned that she feels pressured to provide all of the essential content in a given lecture to her students. “I feel compelled to give [all of the content for that day] because we’re preparing them for the licensure exam.” Because of this concern, Connie said that she tends to stay very close to her notes. She does like to call on students and get them involved in the class by asking them to share a clinical experience that they have had.

The nine participants in this study have different backgrounds and different experiences in nursing. Some came to nursing education from a staff education position and some simply followed their hearts to this profession. Each of them expressed that nursing was not merely a job but a calling, and that teaching allowed them to have the greatest impact on this profession that they love so much. Each of these nurse educators uses stories in the classroom and/or clinical setting to help students to better understand the role of the nurse, and they share how and why they use stories.
Pedagogical Issues Themes

From this research, three major themes emerged. The first theme that emerged is that stories are a part of the pedagogical process in nursing education for these nine educators. There emerged several common pedagogical issues that seemed to affect these educators’ desire to use stories.

Each of the nine participants in this research study use stories as they teach nursing students, and each of them believed that there is learning value in stories. They talked about nursing content being very difficult for novice nursing students to understand and that stories help in the learning. They talked about how difficult it is to use stories as a pedagogical tool without having significant nursing experiences from which to draw. Connecting stories to their learning objectives was important to them and not all stories work with all groups of students – there is a readiness to learn from stories that they considered. Finally they talked about how using stories in their classrooms was a good model for student, who need to learn to listen to the stories of the patients for whom they provide care. The salient points about these pedagogical issues related to stories that emerged from this study will be discussed in more detail.

Difficulty of Nursing Content.

Complex content can be difficult to learn if the learner has no real frame of reference within which to place the content. Some of the participants found nursing content could be difficult to make clear and real for students. If content is put into a context that is familiar, the participants found that learning could be facilitated.

Elaine commented about the complexity of nursing content and how stories can make topics much easier for students to understand. “I really think that stories are a neat thing for nursing educators, because our content is so complex. It isn’t like learning a set of rules... there
is so much more to what we do as nurses.” Elaine shared a story that she uses with her novice students to help them to learn. This story demonstrates how Elaine used a personal situation that she experienced to help students to see the difficult responsibility that they will be entrusted with as registered nurses. She uses an experience of a medication error to demonstrate the level of responsibility that nurses assume every day.

I talk to students about how I know that it is intimidating for them … feeling that they are just a lowly student nurse … they tend to be unsure of themselves, lack confidence in their ability to figure out what is right and wrong … And so I tell them a story about, not a student, but a nurse who floated to a pediatric unit … [A physician] wrote a PRN [means as needed] order for medication for agitation where doses were inappropriately large, too much for the child. [The nurse] questioned in her head about wasn’t that an inappropriate dose, but instead of speaking up she went ahead and gave the child the dose and the kid experienced … over sedation … It was an eight year old child and he ended up wetting himself which was probably a humiliating experience for him… was just overly sedated. But then we talk about other things that she could have done: call the pharmacy, talk to another nurse. But she was embarrassed because she should have been able to make nursing decisions for herself. So what I try to encourage with students is get over your embarrassment because it’s not about you. It’s about the patient that we serve.

This story demonstrates how Elaine makes a difficult issue in nursing more understandable through the telling of her clinical experiences. The story helps students to see that there are a number of ways that situations like this can be avoided, and that there are resources available.

Jane also talked about how she felt that nursing content is very difficult and complex and how she felt stories could make content more clear. Jane uses analogies to commonly understood household equipment to help patients and students to understand complex medical health issues.

There are certain contents … the more philosophical, the more theoretical, the more fuzzy it is, and you have to clear it up for the students. Real conceptual things, they have a hard time understanding. So when doing education with patients, too, my mind works [toward] making it down into its simplest form. So like when I’m talking about … doing a community education program, and we talk about hyperlipidemia, I talk about plumbing. Most patients know nothing about hyperlipidemia, but they know what clogged pipes look like … So you make it a picture that they can see… And it makes it real to them … If you use the jargon of medicine, they have no idea what it is. When I
talk about urinary systems, I talk about plumbing. When I talk about [neurological] symptoms, I talk about electrical wiring. Because you have a shared experience and then take a complex concept and put it in relationship to that shared experience and they can get to a higher level of understanding.

Like Jane, Nancy also talked about helping students understand new content within a context that is familiar to them.

Especially for a new student, if you don’t put [material] in context, if it doesn’t make sense to a student, then it’s just a bunch of garbled facts ... All the alphabet language we have. Everything is a series of initials. If we don’t put that in a perspective for students, into a context, then nothing makes sense. You’re putting the whole thing into a context that makes sense for them. You know, you’re making a story into something that, OK, now I have an experience I can draw from that makes sense to me.

Donna, too, talked about how she uses stories in her classroom because she experienced that her own personal learning of complex material was enhanced by her teachers’ use of stories in her graduate program. Again, difficult content can be made easier to learn and remember through the use of a story.

My instructor often told stories of certain patients and how she dealt with things and that kind of helped things stick a little better with me. [Another instructor] happened to teach nursing theory and policy which are very difficult subjects to really wrap your mind around and be interested in, but by her telling how they fit into her practice, it helped make more interest in those topics, that would have otherwise probably been very dry. I do [tell stories] on a regular basis. You can read everything you want in a textbook, but to translate how to do that with a patient is much more difficult … It helps the students to realize what this career is all about.

Connie found that her own personal learning was enhanced by the stories that her teachers told, because they helped to make connections in her mind that made sense to her.

I love to hear stories. That’s when I could put my pen down and I could listen and learn … from somebody’s personal experience. [Stories are] very positive [learning opportunities] for me … because then I remember content better. I can make links [between] my experience and the pathophysiology, the nursing interventions, the psychosocial implications.

These nurse educators help to explain the first pedagogical issue that emerged from this research. They felt that nursing content can be very difficult for students to understand because
of the large amount of multidisciplinary material that is required, the new language that is involved, and the multiple acronyms and abbreviations that are used. They believed that stories can help make these difficult topics more interesting and help students to make links to concepts that they have already mastered.

Need for Clinical or Classroom Experience to Tell Stories.

There was a common feeling among five of the participants that using stories in the classroom or clinical setting is more difficult for an educator who has limited nursing or educational practice experience; less experience as a nurse or a nurse educator means fewer stories from which to draw. Margaret felt that her stories arose from her personal experience with the content of the story.

Most of the stories I tell are related to, um, the education I do in gerontology and especially in the hospice and palliative care elective, because I have that clinical experience. You can’t tell stories without having the experience. I can read the textbook and I understand it and I can put it down into a lecture format, but my heart’s not in it. There’s no enthusiasm that shows, and I really think that experience in the setting helps and it helps with the stories … Most of the stories I use …it’s from experiences that I’ve had in my practice even back to when I was 16 years old working in a long term care facility taking care of 12 patients by myself. You know there are things I’ll never forget. I talk really passionately about people in long term care, um, and the potential for dehydration. Because my Grandma is 101 and, you know, every time I go visit her, here is this tiny cup of water half full beside her. And, you know, with the lack of total body fluids and the decreased thirst … so I have somebody in that setting.

Margaret felt that stories have to come from something that the educator has actually experienced, not simply from reading a textbook or hearing something second-hand from someone else.

Stella also believed that telling stories in the classroom is easier when the instructor has more experience. “I think I’ve used [stories] all along, but I think when I’m teaching … and I first started teaching in fundamentals and in the classroom, I don’t remember using so many stories because I didn’t have a lot of nursing experiences then.”
Connie commented that she finds that she can only tell a story to a group of students if she has some practice experience with the story content.

I can tell you when I gave the lecture on … immune disorders; I don’t have a lot of practice experience with it. Um, so I couldn’t tell a lot of stories about it. I have had some family members with some personal experience that I could highlight, but not the practical experience myself as caring for those types of patients. So, [if I have practice experience, I can] rely on stories to help students put the picture together in terms of application.

Nancy said that the script of a lecture provided her with a level of comfort in the classroom and that deviating from that script by using a story caused her some discomfort, which dissipated with more teaching experience. Nancy did not talk about experience as a nurse as being important, but instead talked about experience and comfort as a teacher.

In a sense, I think, you know, telling a story about … a mistake you’ve made [can make you concerned about the student] thinking you’re a bad nurse. But now I’m confident enough that, guess what, everybody makes mistakes. You might as well learn from mine … You get a little bit more comfortable with that as you’re more experienced. Now that I’m more comfortable in front of the group, um, a lot of the times the story will just pop up as I’m talking.

Only one participant, Elaine talked about using stories only in the clinical setting and not at all in the classroom. Elaine cites the reason for this choice to be inexperience and discomfort in the classroom setting, again supporting the notion that comfort and ease in the classroom facilitates the use of stories by the teacher.

I use stories a lot. I use stories to provide information about safety do’s and don’ts really because we’re dealing with the mentally ill clients. I use stories to provide illustrations about, um, historical aspects of nursing … I use [stories] sometimes with faculty, um, this is how the program used to be and here’s how it’s helpful and not helpful, and historically here’s how it is today. I don’t really use them in the classroom because … I’m just too new and uncomfortable there. Um, the only time that I’m using stories is in my mental health clinic. So that might be in pre-conference or post-conference.

These five participants help to explain the second pedagogical issue that emerged from
the research: experience in nursing and in teaching make using stories in the classroom or clinical setting much easier. The other four participants did not talk about clinical experience or classroom experience as a factor that mattered in how they used stories.

**Story vs. Case Study.**

Seven of the participants made a differentiation between a story and a case study. The literature often blurs these two issues, and these educators had some differences in how they viewed these two similar teaching strategies. There is discussion of this differentiation in Chapter II of this research study. Sandy talked about how she had teachers in her own master’s program that made a difference in her own learning, and she explained how she defined case studies and stories.

The instructors who made connections shared their emotions as they were going through the story. You know, I was nervous about this, or I cried, or this upset me greatly. So that they put … they humanized it. Versus just stating you have this case study – this is what I did. There wasn’t any attachment to the story.

Although Sandy’s comments about how stories and case studies vary are a little different from the differentiation made in the literature, her idea that there is a difference is important.

Donna commented, “… stories that I use are my own experiences. I will use cases but I do use very personal stories.” She then went on to tell a story about a situation that was a very personal, emotional situation in her own practice. This story was a real event from Donna’s clinical practice and she summarized the facts of the story to make the point that her stories are real lived experiences.

There is a [story] that’s very close to me that I had personal experience with and talking about how you handle that as a nurse. Um, how do you deal with those things? When do you follow your gut? And how as a nurse do you deal with your feelings? And so I’ll sit down on the desk in front of them and, you know, just tell the story. Uh, this baby went home and a month later came in … with a brain bleed … supposedly fell off a couch…it was one month old and had been severely shaken. And how devastating that was to know that you had a sixth sense that something was gonna happen. You really didn’t want to
send that baby home and you were forced to send him home. But you documented everything you should have and that case came back. Um, to see that, it happened and that there are instructors that have been through that, I think puts a little more reality into what [the students] are going to be facing when they graduate. [When I tell this story, I use] a great deal more detail.

The emotion and feeling in this story was evident in the way Donna told it. Her tone was serious and almost angry about the injury that this child endured. Donna’s stories are consistently filled with strong emotion and intense facial expressions and hand gestures.

Elaine felt that stories were a better tool to help students to learn than case studies because case studies are “not part of something you’ve experienced. You don’t have the emotional connection to it.” Sandy believed that case studies were “just facts … A story is emotion, it’s human.” Both Sandy and Elaine talk about emotion as being an important part of storytelling, and Donna demonstrates this emotion in her telling of the stories.

Nancy said that case studies have their place in her classroom, but that she valued stories differently.

I see a case study as a made up set of facts to make a point: basically a lecture, a little mini lecture, sort of. And you tweak the facts to make the point you want to make … it’s my experience that makes the story … and you actually tell a story about something that struck you or else you wouldn’t remember it … I tell the story about the lady who had a cancer growth that was actually [growing] out of her uterus, like a big cauliflower. She decided to go all alternative medicine and not have surgery or any chemotherapy … just have pharmaceutical herbs, but she came in because it started bleeding. So I remember looking at the thing, never having seen anything like that … to visualize that, um, and to put a picture in the student’s head, this is what cancer could look like … You know, that is powerful.

Nancy carefully created a picture of cancer for her students not found in any textbook. In creating this picture, she used words instead of shapes and figures, or photographs and graphs, and the effect for the audience is a clear picture of what cancer can look like.

Connie explained her views of case studies.
I see case study as made up sets of facts, maybe it’s based on some experience in its essence, but you add or subtract things to the situation to make the point or to take the conversation in the direction you want it to go. It is overly scripted. And I would never call that a story myself.

Not all participants articulated a clear difference between their use of case studies and their use of stories. Monica described only subtle differentiation between her use of case studies and stories.

… If you’re trying to make a point and you want to engage people in the meaning behind what message you’re sending, if you make it real with the story of a real person who has experienced something they pay more attention than if you talk to them theoretically. Or about just a, um, possible scenario … you make ‘em up. And even when I write case studies, I’m thinking of a real person and writing the real story of that person, with a few embellishments … when I’m in the classroom and I want to make a point that’s very strong then I talk about a real person and the events that went around that scenario in the context of what transpired and have the students react to that.

Monica appears to be saying that her interpretation of the difference between stories and case studies is rather minimal, and that in both, she uses real situation and real occurrences.

Jane had a clear differentiation between case studies and stories, and she introduces the idea that passion is a vital part of storytelling. Two other participants talked about emotion as being an important part of a story, and now Jane used the word passion.

A story has passion involved in it. A case study is an intellectual adventure. That’s where I really see the difference … a story is an affective domain, intellectual experience. A case study can be a cognitive experience. It doesn’t get to the heart… I think it can if you insert passion. But I don’t think you can have affective domain without either instilling your passion or evoking the passion of your students. That’s what affective is, otherwise it’s a cognitive experience … [a story] takes it from an academic experience to … it moves it into the human. It puts it on the human side.

There were several important concepts that emerged as these seven participants differentiated between case studies and stories. Again we hear that stories come from the experience of the teacher and are very personal. It seems that emotion and passion are important to a story, and that stories are the retelling of the teachers’ real, human, lived, experiences. The
concept of stories being a tool to engage the affective domain also emerges here. The descriptors used for stories are strong words: emotion, passion, visually powerful, moving a student from the cognitive domain to the affective domain. It is clear that there is a place for both case studies and stories in the nursing classroom. Case studies offer an objectivity that can be useful in getting students to take charge of the analysis of the problem to be addresses. Stories, on the other hand, offer a higher level of ownership on the part of the teacher. The teacher is more emotionally invested and so the story can seem more authentic to the student.

**Stories Must Match Learning Objectives.**

Eight of the participants commented about how they connect the stories they use to their learning objectives for the day. Sandy said that her stories have to fit her objectives for the students learning for that class session. She felt that there was no content that she would avoid using a story for “… as long as it fit in … with their level of learning … and their learning outcomes.” Sandy also talked about how she introduces her stories.

… I just don’t go in and tell any story without prepping the students. For example, [I would not] go in to talk about therapeutic communication … or tell them about the enema story or I won’t tell them about Tom’s story. [I would not] just go in and tell any [story]. It has to have some type of direction.

Nancy mentioned that stories “… have to be very relevant to what you’re trying to teach.” Monica talked about the fit of her stories and used a story to demonstrate how she chooses which stories she uses in her classroom. She reviews the objectives for the content she is teaching and then decides if a story would fit.

Because I’m an avid reader and I clip everything that could possibly be used, I have big files of newspaper stories and other stories of other people besides the ones that are in my head. And, for instance, I have one that I can’t wait to use … about Parkinson’s disease. And this story tells the story of people who are doing exercise rehabilitation and they’re finding that the principles of neuroplasticity are kicking in. People’s tremors are reducing and they’re getting function back, some of the shuffling is reduced and the dopamine doses are being lowered. And so I will use that, the story of those people’s experiences
with this particular intervention, to drive home the pathophysiological concepts of neuroplasticity and then the nurse’s role as the rehabilitative and restorative support person … So I make the decision based on what is the, what am I trying to do. If I’m trying to demonstrate a role, a nursing role, or if I’m trying to demonstrate the art of nursing, kind of the aesthetic knowing kind of thing … or if I’m trying to demonstrate more empirical knowing with the story. It depends. That’s how I choose.

There is a definite sense of intention that Monica uses as she selects the stories she uses in her classroom, and her decision-making process is clearly articulated in her description.

Donna uses many stories with negative outcomes: the patient suffers serious injury or even dies. She explained that the patient outcome is not what determines the usefulness of the story. The learning objective or outcome is what drives her use of stories.

So the outcomes of the stories that I told you were not what you would like to ultimately see as patient outcomes, but the outcome for the student learning is a positive experience. So in looking at the story, it’s not the story itself. I’m looking at the learning outcome [for the student]. The stories that I use would be to generate a picture or a feeling to get to the learning outcomes for the student to take away from the situation.

Although Elaine uses stories only in the clinical setting, she gave an example of a story that she uses to help students to get ready to care for patients in a mental health clinic. Students in this setting are typically very unsure and fearful of what the patients might do in response to something they do or say. Elaine’s stated objective in using this story is to demonstrate the important rules and regulations in this health care setting - an important objective for students new to the psychiatric arena - in a way that will make an impression on the students so they will remember the rules.

I had been taking care of a man for several days in a row [in an inpatient psychiatric unit] … He seemed to be getting better. When he came in he was psychotic, easily agitated, very sexually preoccupied, flirtatious, inappropriate, hallucinating, the works. And he seemed like he was a rapid responder to medication, doing a lot better, seemed to be getting a lot more lucid. And kind of a routine we got into was that every morning I would come in and have a one-to-one conversation with him kind of to see where his goals were, see where he was, see what his thinking was like … so kind of an assessment but also to give him time to let me know where he was. And, um, I was in his room and he kind of started out being very calm, seemed rather lucid and the more we got into
conversation the more agitated and animated he became. Um, I was at the far point in his room, which I never should have been in the first place, but thought that I just could get away with it, I guess. I just wasn’t really thinking, wasn’t being aware, wasn’t doing some of the very basic things that you just do as a psych nurse and soon it ended up to the point where he was standing between me and the door. I ended up sort of being a hostage in the room. I was very frightened and I felt afraid physically. I basically had to do a lot of talking to talk my way out of the room. There were other things I could have done; maybe yelled for help, I carried a whistle. I was fearful that in doing that the patient really would hurt me … So this is the story that I share with students to say this is why it’s so important to be mindful, to be aware of your surroundings, and never take a chance, ever. No matter how much you think you know or can trust the situation, it’s too much left to happenstance … I started using that story because we have a list of rules, do’s and don’ts. And that’s how a story is brought into the [mental health] clinic.

Jane used a story to demonstrate how she chooses a story to fit a particular objective.

The story is about how one nurse can make a difference by speaking out and getting involved in the political arena. Jane uses this story in her nursing policy class, with the major objective of demonstrating that her single voice made a difference in a state legislative decision.

In [Midwest state] when I was working at the family medicine residency I had prescriptive authority … so as a faculty member and as my role with the residents in [Midwest state] they allow EPSDT screening which is for Medicaid. It’s, um, early childhood screening ... and Medicaid pays for it. In [Midwest state] a nurse can be a certified EPSDT screener and they can be reimbursed at the same rate as a physician for that. But, um, before nurses do it they have to be certified … [Midwest state] had proposed a bill to require a physical [examination] for all children entering school because we know that if you can identify problems very early in children they can affect their educational outcomes. So this was going to be a legislative piece. Now these are all paid for by Medicaid, but many insurances did not pay. So as a companion piece to this there was a piece of legislation that said insurance companies had to pay for it too. So they had to pay for preventive care. Medicaid always did, but the third party payers would have to pay for it because it was a requirement for school. So everybody agreed it was win/win all the way around. But because there was reimbursement involved in it, the chiropractors decided that they wanted to be reimbursed too. They wanted to be able to do these physicals because they were reimbursed at $65, which is a good hefty amount. Well [there is] a national curriculum for nursing – we all bundle in a little differently but it is a national curriculum for nursing. For physicians, MDs and DOs there’s a national curriculum too. There’s not a national curriculum for chiropractics. Each university or each school decides on their own [what is taught in the curriculum]. Also, growth and development is not a required curriculum piece. But you are asking people who do not have a background in growth and development to be able to do physicals on children and…it’s not even a part of their educational background. So I testified before the senate committee that this bill was being heard in. I testified as a certified EPSDT screening
nurse. I was the only nurse to testify. The legislators asked me why are you the only nurse. I said because I’m concerned about, I’m testifying as a licensed nurse in the state of [mid-west state], as a taxpaying consumer in the state and this is why I’m opposing the bill. There were a number of physicians, but I was the only nurse. So I went to my state nursing association and said why was no one there testifying against it. Well, that same time, the Nurse Practice Act was being opened because they wanted to have independent prescriptive authority…so it was a very trepidatious time to open up that Nurse Practice Act. People like to get in there and play. So they had created a political deal, they were not going to oppose the chiropractors on their bill and the chiropractors had agreed not to oppose nursing [and the amendments to the Nurse Practice Act]. Well, the good part of this story was the bill died in committee because there was enough opposition to it. The bad part of the story was I went to the state nursing association and said you know when you make deals with dogs, when you lie down with dogs, sometimes you get fleas. And ladies, you have fleas. I said, yes, I belong to my state nursing association because they make me aware of the legislation, but I don’t always agree with what they do. But this is an example of one voice in nursing did make a difference. I was able to protect those children because of my one voice…and you can make a difference with your one voice too.

Jane has clear objectives for sharing this story in her health policy class, and the story is one that invokes passion and emotion in Jane, and likely in her students as well. Listening to this story certainly increased my sense of interest in the outcome.

Sandy shared a story to demonstrate how she helps students to deal with their feelings of inadequacy or regret about the care they provide to patients, and she explained that one story could meet several different objectives. This story contains many different learning opportunities for novice students and Sandy explained how she used it.

When I was, um, teaching nursing in [a mid-west city] … two patients come in within two weeks of each other with Guillain-Barre Syndrome. [There was] a gentleman [who] came in; he was 52 [years old] and he was from my hometown. And, um, I was his primary nurse and we made a connection because he was the same age as my father. And I was working with him one night. He was in a progressive care unit. We knew [the paralysis] was still progressing. We just didn’t know when it was gonna stop. I went in and his respirations were 14. And went in a half hour later doing my routine check and everything was fine except his respirations were 10. I went in 10 minutes later and they were eight. So I had to call his wife to get permission to do the [tracheostomy], because he was, he was a basket case. And, um, so we got permission … intubated him, and his paralysis went all the way up to his lips. Well, we knew it was going to take a while with the [tracheostomy]. The progression stopped. We knew it was just a matter of time before it would reverse, hopefully. Well, I worked a lot with Tom and he would get so upset
with his legs. He had feeling in his legs because they don’t lose sensation they just lose movement. And so, his past-time I found out was golfing so I would take him golfing every night that I worked. I would do that by going on the back of his feet and I would go at the end of the bed and I would push his feet like he was walking. If he has a bad day we would do 36 holes. If it was a good day nine holes would do him, but it made his legs feel better. They got exercise, improved circulation, improved his mental status, he felt much better. It was a coping mechanism. There were all kinds of benefits … the problem with him was he got use of his legs a lot more quickly then he did his hands. And he had to, um, wear adaptors, devices on his hands. I always wondered if I had worked with his hands as much as I’d worked with his legs and feet, if that would have made a difference. And so, I talk to the students a little bit about the story and the attachments and things that so they always ask [lots of] questions. And I ask students questions … are you supposed to make those kinds of bonds with your patients? What if the nerves don’t grow back and what can they do? What is rehab versus hospital? So there are lots of different directions that they take and sometimes they take a different direction than I want to go, but it’s still learning … [My major learning goal is] to tell them about Guillain-Barre syndrome, how it affects patients and families … the effectiveness of interventions. And the other thing is that sometimes you think that you’re doing everything that you possibly can, but then you have regrets.

The participants in this study shared many different thoughts about how stories need to fit the objectives of the class. Monica scans the newspapers for current event stories that might illustrate a point in one of her classes, and how she uses those stories to help students to learn many different things related to just one newspaper article.

I do a lot of screening of the newspapers and we had an article in our Sunday paper this week about a tragic story of a family with two children born with a genetic disorder called epididamylisis balsa. What it means is when you touch their skin they break out in blisters and their skin sloughs off. These children have horrible experiences with pain, infection. They have to go to school with their arms and legs totally encased in gauze and sit on pillows. They can’t have any pressure on their skin at all. So we were trying to talk about technology and genetics and who should pay for what. So I read them the story out of the paper of this young couple with these two children, and what their life was like with this, and then kept pushing them to make decisions. What are you going to do? How as a nurse are you going to get into this? How prevalent is it? What would it be like to have children like this? What would it be like to be pregnant with a child like this? Who should pay for genetic testing? Just keep pushing them around the story of that family…try to drive home this is where the hard stuff happens. Here’s a picture of these darling children with their bandages in color. You’re policy makers, what are you going to do? … And for that particular session the objective was that they would understand, uh, one important concept and that there’s a limited amount of money and you can’t do everything.
Monica also used a story about a young, dying mother to illustrate a little different concept about stories and how they meet her learning objectives. Monica uses the same story to meet several different objectives for several different classes, and she explains how that works for her.

A young mother who had pancreatic cancer … in her 40’s and she was a single woman uninsured with a 12-year-old daughter. I was the palliative care nurse that day and got a call from ER that they needed to get her up to me right away, which meant that they did not want her to die on their watch. And so as is common, they came running and stampeding up the elevator and shove her into a room as fast as they can and then take off … and then within seconds the neighbor who came in with her was running out to tell me that she’s coughing and she needs help breathing. Her 12-year-old daughter is sitting on the floor outside her room playing Nintendo and totally alone and not aware of what’s happening on the other side of the wall where she’s resting her back. There lies her mother who is dying. I walked into the room and raised the head of the bed so the patient could breath and as I put my arm behind her, blood poured out of her mouth and down over the side of the bed. She took a deep breath. She aspirated all the blood that she had coughed up, because she has an esophageal varix, and she aspirated her own blood in my arms [and died]. And I remember then going out of that room and seeing that little girl who was still playing Nintendo and wondering how could this happen that there was not even any place for this child to go. The mother had never had anybody talk to her about arrangements for her child. How could nurses have intervened with this woman? How could nurses have helped her? See I turn it into a question. What could we have done differently? At what point in her diagnosis could a nurse have said – you have a child. We have to talk about hard decisions. Why did it get to this point? And how do we learn? What is the role of the nurse? At what point in the diagnosis does the nurse bring up this hard stuff? When the doctor’s still trying to do interventions, even when they’re futile, what is the role of the nurse as a patient advocate? How does the nurse decide how to approach this? How do you open up the discussion to let the C-word [cancer] get into the room and the H-word [hospice]? And how do you do it in such a way that it doesn’t take away hope and that supports the person’s goals for whatever life they have…I’ve used that same story in the health policy course, where I’m talking about the policy making and living wills, conflict of futility, quality of life, sanctity of life, and all the conflicts that comes from that. That story comes up wherever it works for me … The questions that you ask after you tell the story is what puts the spin on it.

Connie even talked about using a non-clinical story to help her students learn about communication. “If I’m talking about, you know, a communication issues it may be something, a personal communication issue that I’ve had with a neighbor. I mean even that to me is a teachable good story depending upon what you are teaching.”
Each of these participants added something to the pedagogical issues that stories be congruent with learning objectives. According to these participants, stories must have a direction and must meet the learning objectives for the class. Stories must demonstrate a concept that part of the planned learning, in either the classroom or clinical setting. Monica added that educators could put a “spin” on a story by asking leading questions that encourage student critical thinking. These post-story questions can give great direction to the story and can make it possible to use the same story to meet many different learning objectives.

**Stories and Student Readiness.**

Five of the participants explained that the stories that they select to use in their classrooms are carefully chosen to meet the students’ readiness to learn. A beginner student would not learn well from a story about advanced nursing skills or complicated medical diagnoses that they have never seen or heard about. Donna talked about stories fitting student’s level of learning.

I think that your stories have to be appropriate to the level and appropriate to the content … I will use stories that scare the poop out of students sometimes just to get the point across that this is serious. You need to pay attention to what you are doing … as a responsible nurse who could potentially cause life or death to occur; you need to think about what you’re doing. My students are getting ready to graduate the next semester and they need to be aware of that. I don’t know that I would do that with a baby student, you know, because then you’re setting them up for fear. You wouldn’t scare a one year old.

Connie used a story to explain that every story does not work with every level of student, and that some stories are beyond the understanding of beginning students.

I tell the story of my friend that was working in the middle of the night ... she was very bright … We used to draw up our own potassium boluses and put them in [IV] bags ourselves. [She was] tired, four AM … she draws up her potassium, takes it into the room, and almost gives it IV push … by the grace of God she didn’t do it … Being inexperienced is not going to be an excuse when you have to go to court for a mistake that you made. And they don’t know how much they don’t know sometimes at the level of a student. [I would not use that story with a very young student] because I don’t think they have enough experience to visually perceive the difficulty with having a patient with
multiple IVs [and medications] … Also it is their understanding of their responsibilities, it’s not there yet … readiness to learn is certainly part of it, but really realizing what you’re responsible for … [they] haven’t seen enough of it.

Sandy seemed to agree with Connie’s ideas that even a very good story with good learning objectives might not be right for every level of student.

The stories have to relate to [the students’] level, to their understanding, to the content. I couldn’t go in and tell my Guillain-Barre story to my foundations students. They would have no clue [about the disease] except they might connect with the nurse-patient relationship and the range of motion issues.

Elaine, who uses stories in the clinical setting only, talked about student readiness to learn from a little different perspective. She talked about the location and time of day that is best to share her stories with students during their shift on a mental health unit.

I think [a story] works better off the clinical floor, not while things are in action, not while they’re focused on something else, but when [students] can be somewhat relaxed … [So I tell stories] on orientation day which is the first day on campus where they’re receiving information from me about what to expect, and the other time [I use stories] is in post-conference, so they have the relief of being done with their day, done with practice, done with their quizzing … I think in my view they need to be ready to receive, ready to learn. I think it’s timing that’s all about comfort for the student, as much as possible, and so that would take timing, um, for when they’re ready to receive a story. So I think that they need to have a certain level of comfort and relaxation and ability to listen.

Nancy also commented about not using stories that are above the level of understanding of the students she teaches. She shared a story to illustrate what she meant.

I wouldn’t tell [students] stories that are over their head … I think some educators think that they sound smart if they talk over the student’s head. Big words. There’s another story that I tell about a neuro ICU patient that had an ICP and EVDS and he had just had a brain aneurysm clipping and things went bad … He ended up having a brain stem infarct, he herniated, and not a good outcome [he died] … but I tell that when I teach neuro because the one pupil blew and I started seeing the changes very early in the night…I’m not going to go into that whole story with the first year [student] because they don’t know what ICP is and they don’t know what an EVDS is and they just look at you like … duh … They don’t know ICU and all that equipment stuff so how meaningful is that gonna be anyway?
These five participants bring additional understanding to the pedagogical issues of student readiness and the use of stories. Stories that scare students are not seen as appropriate except in students ready to graduate if the goal is to make a point about nursing responsibilities. Students early in their nursing program do not have an understanding of the responsibilities of a nurse and have not seen or experienced enough for some stories to even make sense to them. Nancy thought that using medical jargon and sounding important by using complex words is not a useful teaching strategy. Stories that include complex medical problems or complex medical words may not be appropriate for students in the early stages of their programs of study.

**Stories Engage Students on an Emotional Level.**

During the interviews for this research, each of the participants talked about the importance of emotion to a story. Emotions that are evident in the lived experiences of these educators were very evident in their retelling of their many stories. Margaret shared a story to illustrate how she tries to connect to students on an emotional level. This story shows how Margaret teaches concepts like advocacy to nursing students, and how it is not a piece of knowledge to be memorized, but a lived experience that demonstrates this important affective concept. Margaret mentions that her stories often focus on issues that are not found in the students’ textbook. Concepts like how to care or how to advocate are often not found in the cold facts of a textbook.

A lot of my stories focus on … patient advocacy … My patient was a ‘no code’ and her IV came out. [The surgical resident] came in and was trying to get it back in. He left the room to get something and I literally blocked the door and would not let him back in. I yelled to another nurse to get the supervisor, and get the family on the phone. He was trying to put a needle in her neck. You can see that my voice changed right now … advocacy … this is important. [The students] can get the ‘knowledge’ later, but they have to learn to be the patient advocate - nobody else does it … So that is how I would end the story.
Monica also talked about touching students emotionally with stories. She has notices that when students experience an emotional story from their patients, that they retell that story in a very detailed and engaging manner.

I do my clinicals on the oncology unit, and I hear lots of stories coming there because we have lots of very tough decision points being made. There is lots of bad news being discussed. And when the student gets affected emotionally they are much more forthcoming in recognizing the patients’ situation. When the student takes me aside with tears and says ‘this is so sad and I don’t know what to say’ … we will work with that on the unit. When we get into the conference [at the end of the day] that’s the student that tells the best story, because they’ve been touched by it.

Sandy gave some examples of the kinds of topics that she covers by using stories. Again the topics she talks about are not nursing procedures, but are the topics that are more difficult to teach, and involve emotional topics. “[Topics like] issues with professional boundaries … what is appropriate nursing behavior … very effective. [Stories] give them more of the personal touch versus just content.”

**Stories as Models for Listening to Patient Stories.**

The participants in this study mentioned the importance of listening to patient stories, and talked about how they encouraged their students to listen to the stories of the patient for whom they provide care. Sandy explained that she has her students tell each other about what happened with their patients during their shift. During post-conference, Sandy explained that she would say to her students,

…”tell us a little bit about your patient and what happened today … Just tell us what happened today. In our documentation we tell [students] to write the story so that when we read it [we know what] exact things happened. So, stories are not just verbal. They can be written as well.

Sandy also talked about how students manage giving reports to each other related to their assigned patient in long term care.
When I teach in an extended care facility the patients are the same. So instead of doing report [which would be nearly the same each week] I will say, you tell a story about this patient that you took care of last week. So I actually use that phraseology. Tell us a story so that [this student] can go in and take care of that patient today. The second thing about the patient stories is when we talk about therapeutic communication we emphasize a lot that you have to listen to what the patient is saying to you. Patients will tell you stories. They will tell you things that you’re trying to find out in your physical assessment. For instance, today we had, um, return demonstrations on stomach and oxygen therapy. Students came in, they went to the nurses’ station, saw the doctor’s orders for their patient…they had a stomach issue and an oxygen issue. They gathered their supplies and they went into their patient’s room. We were the patients, the faculty, and they had to deal with the situations as the patient related to them … For example, the patient that I was today, I had to be taught about stoma care. I was two days post-op, my stoma was not functioning well, and teaching was to begin … I started saying, what’s this thing here? [Pointing to her abdomen]. So we do talk a lot about listening to what those [patient] stories are.

These activities demonstrate that the concept of stories is not simply a classroom activity, and that the example of using stories to help students learn can be a good example for students about how to listen more distinctly to learn their patient’s lived experience.

Connie also talked about using stories in the classroom that are actual situations that the students have experienced.

I use stories [in the classroom], um, that we encounter in the clinical setting that are relevant to the content [that I am teaching]. If I have a critical care student who I know went through a code, and I was talking about codes [in class], [I would] bring them in to talk about those experiences so they end up sharing their stories.

Connie seems to be using stories in the classroom and modeling the behavior that is expected of students when they care for patients. She asserts that “Stories are a good way for you to learn, and I want you to learn to listen to the stories of the patients for whom you provide care.”

Monica explained that because nursing is so focused on interactions with patients we serve, that modeling stories is a good way to help students to see how listening to a story can provide significant information about the patient. She even suggested that listening to patient stories be woven purposefully through all nursing curricula.
Stories are so important in my opinion in what nursing does; it’s that we look for and try to learn the life story from the person under our care … I think we need to find a better way to evaluate if that’s really happening with students. But I’m not always … comfortable that they get that’s what they’re supposed to be doing. And it seems like sometimes in nursing education we package courses and content in these little silos and the students go, well, when I’m taking care of the older adults I do story stuff, but when I leave that and go to acute care I stop that story stuff because that belongs to the older adult. And so, I’m not sure that we get that nursing, nurse’s soliciting the patient’s story from them as the powerful therapeutic dimension across all the courses in the curriculum; almost like a conceptual thread. I’m not sure we have that going on, although I think we should.

Monica also talked about how telling stories in the classroom encourages students to tell their own personal stories, and this allows them to get involved in the learning process and allows her to clarify any misunderstanding.

[Students] get stimulated to tell stories from their own lives and they become storytellers … [So when I tell a story], then [the students] will say ‘oh I know exactly what you’re talking about. My best friend’s roommate’s brother-in-law had the same experience.’ Then it gives me a chance to validate that, yes that is what we’re talking about. Clarifying.

In the clinical setting, Donna uses stories, but not her own stories. She uses the stories that arise as the students care for patients.

In the clinical setting though, I try to use the students’ stories as opposed to mine. I try to…pull from their experiences and ask them direct questions. Tell me a story about how this has impacted you, or could you tell me what happened today with your patient? And try to get them to internalize those stories and how that may impact their future judgment. [I think I model the importance of listening to patient stories] by listening to the students’ stories, by helping them to reflect. And I think a large part of learning is reflection. And by storytelling we can reflect on your learning experiences, uh, because often times you’ll see things later that you did not see in the initial occurrence of the story … So reflecting on, OK, well, if you had to do it again today, what would you have done differently?

Jane differentiated between the science and the art of nursing as she talked about how important it is to listen to the stories of patients.

The science of nursing is diagnosis and treating. The art of nursing is managing patients and their families and their diseases. And so I think you have to hear the patient’s story, the family’s story; to do the art of nursing … You have an elderly patient who is taking a
diuretic. Why shouldn’t we let him take that at night? Let’s put a face on this. He has to get up at night to go to the bathroom. He should take [the diuretic] in the morning … otherwise what’s gonna happen if they get up at night? Well, he’s gonna trip and fall … and break a hip.

Five participants in this study talked about the pedagogical issue of stories being a good role model for students who, they believe, should be learning to listen to the stories of the patients in their care. Sandy’s example of having students tell the patient story to the next student who is to care for the patient demonstrates that Sandy values the narrative concept of speaking from ones own construction or understanding of the patient’s situation. Connie asks students to talk about their clinical experiences in the classroom to reinforce the learning objectives of the day, and to help students to make connections between classroom learning and clinical practice. Monica so strongly believes that stories have value in strengthening student learning, that she would make stories a curriculum thread. Donna added a new concept of the importance of reflection to student learning. She uses the retelling of the student’s day, their patient’s story, as a way to reinforce learning and to critically think about possible alternate interventions that might have been used. Jane helps us to understand that the art of nursing is strongly connected to listening to patient stories, and helping them to deal with their diseases.

**Story Use Strategy Themes**

The second major theme that emerged from this study is that storytelling was used by each of the participants as a regular teaching strategy. There were several issues that came into play as the participants used this teaching strategy. Many of the educators used stories very intentionally and yet sometimes serendipitously too. There was definite content that was perceived to be appropriate and not appropriate to be taught through the telling of a story. The physical space in which the educators taught and the size of the class did seem to matter in how
and when they used stories. Most did not use any kind of audio or visual aid during stories, but relied on their own abilities to act out the lived experience. Finally most of the nurse educators did not include stories explicitly anywhere in the syllabi for their courses.

**Planned vs. Spontaneous Use of Storytelling.**

Each of the nine participants talked about using some stories in a very intentional way as well as in a rather serendipitous way. Donna explained that she uses some stories very planned because they fit the content in her lecture, but some stories just pop up.

I don’t always plan [stories] as part of my, um, classroom activities. I tend to be not so regimented a planner. I tend to go in and know what I need to cover. I tend to know and be able to have my notes and know, OK, we’ve got this much time. I need to get this content covered, but I will use the situation and I flex very much with where the students are going.

Donna talked about using stories about raising her children; potty training, allergies, and many other day-to-day stories that can help students to better understand pediatric health issues. “It’s really easy to use a personal story about how [allergies] have impacted [my family] … My two and a half year old recently was admitted into the asthma care unit for 36 hours and was in respiratory distress, so that’s an easy story to relay [how asthma affects a whole family].”

Jane also talked about both planned and spontaneous stories in her classroom.

Sometimes I plan [stories], sometimes I don’t. Most of the time I don’t. But I judge it by the students, by their understanding … by the questions that I ask them and by their responses. I ask for feedback constantly … and by the look on their face. You can tell if they are engaged or not, and you can tell if they’re understanding. If they are not understanding, I [say], let me give you an example.

Stella also talked about planned and unplanned stories in her classes, and she explained why she uses both kinds.

If I’m kind of covering a lot of material, I will just put in there at this point, tell the story. And then if I’m walking around the room and I get off my schedule and come back and notice it, I’ll say, oh yes, and there is this story I have to share with you. But most of the time it’s intuitive. This week when I was doing oral medications and injections, it was all
intuitive because I probably have seven words down on my notes, and it was more or less discussing. But as I talked about these things then it would bring stories in.

Margaret mentioned that most of her stories are unplanned stories. “I use storytelling with every level of student and in every class and clinical … [but] I don’t plan it. When students talk about their experiences sometimes it will trigger in me an experience that I’ve had. And then I share that experience.” Margaret gave an example of how she uses stories in her classes.

Something will pop in my mind. In the hospice and palliative care elective a huge portion of the class is symptom management. So I’ll just remember somebody that had that symptom and how it was treated and it’s not usually your average everyday patient that’s short of breath. It’s one of those standout cases. Somebody that I made a connection with and somebody that’s different so I can emphasize … I’m thinking with storytelling I’m putting a picture in their mind and I really thing it helps them remember the content better because it’s real. It’s not from a book, it’s real.

Connie said that she also does not specifically plan stories for her classes. “I don’t plan [stories]. And as I’m thinking as we talk about it, stories evolve.” The idea of evolution of storytelling was echoed by Nancy. She explained how her use of stories has changed over the years. “My first lecture I had every single word that I said on paper … But I find [stories] pop in my head now. Now that I’m more comfortable in front of the group … a lot of times the story will just pop up as I’m talking.”

One participant actually adds specific stories to her lesson plans.

Occasionally you’ll see where I’ll purposely have a story that really works … I taught a seminar on dying in America, and there were a lot of experiences from my palliative care nursing that really helped make the point. I would have that on the teaching plan as tell ‘so and so’ story or tell story about ‘such and such.’ But a lot of times it is, it’s very spontaneous because the student may ask a question or say something that then stimulates me to share a story or to make a point or to clarify a concept. So it can go either way with me, but I do sometimes plan them on purpose.

These participants talked about both intentional and spontaneous use of stories. When the stories were spontaneous, the reasons for using them were personal or patient care experience with a topic that comes up, assessment of lack of understanding from the students, or questions
from the students indicating need for clarification. Three participants talked about stories just ‘popping up’ during class as certain material is being covered. One participant even talked about stories coming to mind intuitively- the dynamics in the class indicate the need for a story.

**Content Appropriate for a Story.**

A number of participants commented about the content that they include as stories and the content that they feel is not appropriate for a story. Monica said that the only way that she would not use a story to help students learn would be

… if it doesn’t fit the learning objectives. I can’t remember [any content that I tried to teach in story format] that did not work … I use stories a lot in just about anything I teach. Even in our skills lab I tell stories … The students are collecting data and intervening and the instructors are talking them through it at the bedside. And so that’s another sort of story approach … and students these days really like that.

Monica also talked about using stories about conflict as a topic that works well in a story format.

Conflict at end of life between what the family wants and what the living will says … those are the kinds of scenarios that I think really are boosted with stories. It makes it real for the students. [Taking] the page of a book or an article and turning it into a human experience, I think, is what we’re trying to do in nursing.

Here Monica again makes a reference to stories being a vital part of role of the nurse. Nurses listen to what patients have to say and direct their care only after there is a solid understanding of the patients’ lived experience.

Monica also talked about a different kind of story format; watching film clips.

I use clips from movies that tell a story and it shows exactly the sequence of events that I want to address in my content. One of my favorites is the movie *Wit* with Emma Thompson. It shows the job the resident does of the interview when he is working her up for a possible admission. We watch that and then we talk about it: what would you do differently.

Monica admits that movie clips are not stories, but uses them in a similar way to stories. She has the students critique the clip and provide alternate endings that might be more appropriate.
When asked about using a story about difficult content like errors, or dealing with difficult patients, Connie provided several examples of some of the story content that she uses in her classroom.

[I tell stories about] dealing with some of the heavy emotion and anxiety of working in an ICU, and dealing with loss and death and grieving as a nurse … dealing with difficult physicians or how to communicate with physicians. When is the right time to call a physician, when can you, when do you need to gather more data. Um, dealing with a difficult family member because their emotions are so high.

Connie used a story to demonstrate the kind of story that she tells most frequently.

My favorite things to tell stories about are mistakes that I’ve made. And one in particular that I remember very intently is when I just started working in the surgical ICU recovering post-op open hearts … when patients would come back, like any operative procedure, they’re unstable. And the anesthesiologist had nypride running, something we use commonly post-operatively because patients can’t keep their blood pressure down. They would make from the OR one set of [IV] drips … we would make another set of drips because we were running them at different concentrations. Well, in that switch over on this patient … this patient was on a lot of drips … and we would just essentially take one manifold, get rid of it, all the anesthesiologist’s drips, and put our manifold on with all our drips ready to go. Well, somehow that nypride was hooked up in a different place and it was running into the patient wide open off the pump. Patient’s blood pressure is dropping, dropping, dropping. We had no idea why. I am too young and overwhelmed to really be calm at that time to process it, to really look at the medications and, you know, put two and two together and, I’m telling you, neither was anyone else. Finally an experienced nurse saw it but it wasn’t until after we pushed calcium, and the cardiac surgeon screaming at us, “What the hell’s going on.” It took all of us together to figure this simple thing out. You know, I just felt like that was a big turning point for me … I really realized my accountability and my responsibility with medication.

In this story, Connie honestly shares a story about a series of mistakes in a situation where the patient’s condition is deteriorating rapidly. It was clear by the tone in her voice during her telling of this story that this experience was one that shook her to her core and became a turning point in her practice. She was able to relate this story with great emotion and as sense of urgency as the details were unveiled. Connie uses her own early nursing practice experiences to show students just how vigilant they must be and that there will be situations that cause them to
unravel a bit. Clearly, sharing experiences that demonstrate poor judgment or fumbling inexperience is very appropriate in Connie’s eyes.

Nancy talked about the fact that stories about clinical situations are the types of stories that she uses most in her classroom.

I think in our nursing world that clinical stories are probably the most pertinent, because that’s where they’re gonna be ... I tell them a story about a person [with congestive heart failure]. So then you create a clinical picture of a patient, and then follow with what you did. I do tell a story about a CHF patient. She was breathing hard and I could hear this funny rattling and I had no idea what was going on and I was gonna call the doctor. Now my supervisor said, Nancy, do you know what her lung sounds are? Um, no. Have you looked at her EKG? Um, no. Do you have lasix ordered? I don’t know. Well these are the questions your doctor’s gonna ask, so you need to find that out before you call. [I would tell the students] that I was embarrassed because I didn’t know [those things]. So now when I see [a patient with those symptoms] I know that I better listen to their lungs, check a pulse, check their meds. I would tell students don’t make the same mistakes I did. Learn from this and get your information straight before you call that doctor.

In this story, Nancy shows that she too uses stories about her mistakes or less-than-flattering moments, to help students to learn from her mistakes.

Margaret talked about how the stories that she uses are experiences that were really meaningful to her as a nurse, patients whose experiences made a strong impression on her, both negatively and positively.

I have a Grandma in long term care so there are things that jump out at me ... when I talk about exercise in the older adult; I talk about Grandma … this woman, until she was 96 years old got into the pool and swam three times per week. She would drive 30 miles to the [YMCA], Monday, Wednesday and Friday. She had this routine. She got in [the pool] at 11 and got out at 11:30. And to watch her swim you’d think with every stroke she was going to drown, but at 96 years old the woman was swimming. So things like that pop out at me.

Having personal, daily experiences with a family member in a healthcare setting, can provide a lot of story material that can prove helpful to the learning of young students. Margaret shared another story to illustrate the kind of content that she feels is appropriate for a story.
I can remember a man with rectal cancer and he had developed lower extremity edema and it had moved up into his waist … and it was really uncomfortable for him to move around. His death event was he just threw blood clots, and that terrified look on his face in addition to the pain … that was the first person I had seen with terminal sedation, um, so that was huge for me. I also love to tell stories about caring for the first AIDS patients, and how sick they used to be, and now they’re not in the hospital at all … but I use [the story] to teach, to get the point across that you don’t have to be afraid of people with AIDS. You’re going to be caring for people with AIDS; you’re not going to know they’re HIV positive. They are in semi private rooms. So that gets back to, you know, universal precautions. So [this story] always fits somehow. And I get a chance to share my memories of those first AIDS patients and [wearing] three pairs of gloves and shoe covers and four gowns.

Stories that have a deep personal meaning, like her first death experience with a patient seem to be appropriate stories for Margaret to tell to her students. Margaret again emphasizes that the stories that she tells to her students are strongly personal experiences that have made a significant impression on her and have changed her nursing practice.

Although Stella talked about many different kinds of stories that she uses, a common theme in her stories is that those with negative outcomes provide good learning opportunities for students, unless she perceived them to frighten the students in some way.

When we were talking about [medication] errors, we talked about errors and … the characteristics of the nurse’s integrity … The right way, of course, would be the five rights, but … when I first came here I made a bad error. [I was used to working with seniors], and they had that certain way of doing the IV’s and each drawer of IV’s is … every patient has their own drawer. Well, here they don’t have that. Three other nurses looked at that bag and we hung the wrong IV. So I started using that story in post-conference about how you just cannot assume, never assume. I tell them some of my downfalls, and they look at me like I’m a real human being. I’m thinking of one situation about calling a doctor. I did have a doctor who just reamed me out and who put in big black letters on an [order sheet] DO NOT EVER LET THIS RN GIVE MEDICATIONS AGAIN. Now I don’t share that with students because that would scare them to death … So I share things that will help them to learn, rather than scare them away.

Donna also uses stories with less than positive outcomes. She also reinforced Stella’s ideas about stories being a way to better connect with students on a personal and emotional level.

When we talk about grief and death and dying, I’ll talk about the one case where a very dear friend of mine was a nurse and had twins, and I had to code one of the twins for an
hour. And when we finally called the code, I had to be the one to go tell her that I
couldn’t do anything to save the baby … in class I’m usually crying, and they see that …
and that’s OK. So we talk about emotions and we talk about how we as nurses can deal
with out emotions and grief and how it’s OK to cry with our patients, because that’s what
makes us human. And that’s what makes us nurses. Um, and to me it really helps solidify
the bond with the students, which allows them to see me as a person and someone they
can come to and ask questions.

Elaine talked about the kinds of stories she likes to tell and why.

[I like to tell] stories about mistakes or things I should have done or said differently. That
to me does several things. Number one, it shows them that I as their instructor am
fallible, and I’m human and vulnerable, just like they are and just like our patients are. So
that is a way to make things more human and personal.

Elaine went on to explain. “I’m not this all knowing being. You can certainly come to me with
questions and concerns and we’ll think them through, but just know that every day is a learning
opportunity for me as well. I think that’s a really neat model to present to a student.”

Elaine also talked about stories that she would not tell to students. “I wouldn’t spend
time on a story in which there was a situation where somebody acted unethically and didn’t have
a consequence … maybe an inappropriate relationship with a patient with no consequences for
the behavior.” In this situation Elaine would not share this kind of story because there is no real
learning value in that story.

Sandy said that she likes to tell stories about mistakes that she has made “… because they
can learn from my mistakes. I don’t think anything is off limits for a story.”

Jane used an example of a story that she uses to explain the content that is appropriate for
a story.

I have a daughter with cerebral palsy. So they get the content from the book of what
cerebral palsy is. My job is to put a face to it. So I tell them the story of my daughter and
our experiences … Through our lived experience, our story, I can put a face on it so that
they can have a broader understanding of what it means to have a child with a disability
… Hopefully, they’ll have a better understanding of what that means. Rather that just
looking at the disease, I want to put a face to it.
Each of these participants described content that she might present to students as a story. For most of them, there is no content that would not work as a story. Connie uses stories to help students to learn about how to handle the emotional aspects of working in an ICU setting. Nancy, Margaret, Stella, Donna, Elaine, and Sandy talked about how the stories that they use represent very meaningful events in their careers. Jane uses the story of her own daughter’s chronic illness to help students understand how entire families are affected. The major similarity in the content that these participants use as stories is that they are all deeply personal, and they strongly affected their professional practices, therefore are filled with emotion and generally great detail.

**Concerns about Using Stories.**

Donna talked about crying in front of students as she told touching or sad stories, and that she is comfortable doing this. Jane had a little different opinion. “I can get emotional very easily. I can’t do that in front of the students. I cry with students when they’re with a patient … but I can’t be effective if I can’t separate. I need to be effective so I can’t do that, because then it destroys my effectiveness with them.”

Nancy also talked about becoming very emotional during a story, and like Jane thought this was not appropriate in front of students.

I wouldn’t tell a story if I thought I was going to get too emotional. Like if it was something that hit too close to home … I don’t think [students] need to see a faculty sob … or get so emotional that they can’t get the story out. I don’t think that’s very effective in a lecture setting, so I wouldn’t go there.

Stella talked about crying in class during a story too.

As I tell [stories], my emotions come out … and you feel them … I know I’ve gotten teary a couple of times … I don’t break down in front of the class, but I know that I have welled up. I think [students] realize that even teachers who’ve been in nursing for a long time still have those feelings, so it’s really not a block [to telling stories] for me.
Donna, Nancy, Jane, and Stella all talked about becoming emotional in front of students, but Nancy and Jane were the only two who expressed concern about that. Donna and Stella seemed to be very comfortable crying in front of students as part of the story process. Each of these four participants was very animated and passionate during the telling of their stories and one can see how emotions and tears can become integral parts of their stories.

Stella did mention that there is a content area that she struggles with in her student population that presented a concern about using stories with her students. “We have a lot of Islamic students here. I tell the [story about spiritual despair] no matter what because they need to hear it and they can share on the level that is appropriate [within their faith tradition]. So that would be the only thing that I think I would consider a block [to telling stories].”

Elaine, who uses stories only in the clinical setting, talked about situations that hindered storytelling for her. “[Situations that would hinder using a story for me are] my own comfort level, if I’m tired, if there is distraction of some sort, a patient issue on the unit, if the students are distracted.” There are multiple things on a clinical unit that can distract the student and the faculty member from focusing on accurate and meaningful telling of a story, and Elaine has captured many of these issues.

Although Connie shares many stories about mistakes she has made, she did express some concern about the effect of those kinds of stories.

I do get concerned when I tell [students] about the mistakes and the potential for error, that they come away thinking negatively about nursing. But the purpose is to let them know that they are vulnerable human being and they are gonna be just as susceptible to make an error as any other nurse. There’s always enough time to do the right thing.

Nancy mentioned a concern about the number and length of stories in the classroom. “I think stories take a lot longer to get one point across. So if you would teach two hours worth of
content and tell a story about every point, you’d never get through your content. And I think they lose their effectiveness [if you tell too many].”

Sandy expressed a concern about getting sidetracked during stories. “[When I tell stories, it is easy for me to] get sidetracked by questions … going in a different direction [than I planned] … sometimes it’s better to go into that direction that they’re heading because that’s what they need at the time.”

Margaret expressed some concern about talking about the horrible side effects of some disease and not knowing if students in the audience actually have the disease.

I talk about the chronic long term effects of diabetes and they are pretty nasty. And I don’t know who the diabetics are. So I always say I am giving you the worst-case scenario … I think of people who have as grandparent or parents in hospice or have been through the experience and that’s difficult, because I’ll see some tears as I talk about that.

Because Jane uses the story of her daughter’s chronic illness to help students to learn, she had some concerns about getting too personal.

… There are a lot of things that I just wouldn’t share about my daughter. I’m putting a face on a disease entity. I’m not telling them the [daughter’s name] story, I’m telling them the story of CP … There are some areas I just can’t get into because then I’m mom. I’m not the educator; I’m just the mom. So I have to separate those out.

Seven participants expressed some level of concern about using stories. Those concerns included using spiritual stories in an audience of mixed faith traditions, the level of distraction in the setting (clinical or classroom), mistakes having the potential of leaving student feeling negatively about nursing, being easily distracted from the lesson plan, stories taking too long so there can be too many in any one class, not knowing if the audience is experiencing any of the diseases or healthcare processes in a story, and the fear of getting too personal and losing objectivity. Many of the stories that these educators shared contain content that fits into these
categories of concern. Most of them continue to tell the stories, but remain a bit concerned about the consequences of the use of the stories.

**Physical Space Appropriate for Storytelling.**

Participants were asked to talk about the physical layout of the classrooms in which they teach. There seems to be a definite feeling of preference for a certain room layout that the participants find to be more appropriate for stories. Margaret talked about one of the classes she teaches in which there about 90 students. The physical shape of the room makes connecting with each student difficult and Margaret has a specific plan to help connect with students.

[The classroom that I use for this group] is not like a tiered classroom. It’s a flat classroom that has a short wide seating arrangement. There’s a lot of surface area to cover … [During a story] I try to make eye contact with every student … I really try to think row by row and corner to corner to make eye contact with every student.

Connie teaches in two different types of classrooms and has found that telling stories is more effective in one room that the other.

I use one [classroom] that is tiered … auditorium style, and I feel I have some command of seeing all people. The other [classroom] is simply a long coffin as it were, and the dividers are opened to put all these students into one room. I might be standing at a podium three rooms away from some of the students … They can see me. They can see the screen on which the presentation is displayed, but I can’t see them at all. For me, the size and shape of the room makes a big difference in how a story works … [In the tiered classroom] I’m able to see if the students are awake and actively engaged … I can’t even see confusion in the coffin. The lighting is bad and the room is shallow and very, very wide, [so engaging the students is more difficult].

Having concerns about the layout of a large classroom in her institution, Monica simply moved chairs around to create a better environment for telling stories. She described a floor design that works for her, but still struggles with maintaining engagement with all of her students in a large class.

[There is a big classroom] actually two classrooms with a folding door in between them. It’s flat and seats about a hundred people. It had row after row after row of chairs all the way back to kingdom come. I went in one day and drug chairs around and created a
corridor all the way to the back of the room with four chairs in each row on each side-eight across. Now I’m never more that four away from the farthest student. I will go all the way back to the back of the room to engage [a student]. It’s hard sometimes to make the stories work because you want to assume the storytelling position, which is kind of one hip up on the desk and kind of casual – the ‘lets talk’ kind of posture. You can’t do it well with a class that big.

Sandy expressed a definite preference for a certain room on her campus. “I like the flat room where I can walk between tables. In the tiered room, the seats are nailed to the wall or floor … there is an uneven floor and you can’t really walk between them well. But for stories, I would prefer flat so I can walk.”

Four of the participants expressed a specific room layout that is preferred for storytelling. Each of the rooms had portable seating and was able to be arranged to meet the needs of the educator. A common criterion for an ideal room is the ability to engage with students in close proximity. The educators wanted to be able to get close to students and make significant eye contact with each student in the room. Monica even talked about a storytelling position that she likes to assume as she tells her stories.

**Optimal Class Size for Stories.**

Four of the participants talked about how the size of the class influences their choice of using a story. Some preferred small groups and some preferred large groups. Sandy said

I would say [telling a story] is easier with the bigger group because I have them, I know I have them. You look around and they are quiet and they are listening and you have them. In a smaller group they tend to interrupt the story and ask questions. And that can change the flow of the story …The bigger classes don’t tend to interrupt the story as a whole. They wait until I finish to ask all their questions.

A large class for Sandy is about 50 students. Sandy seems to like to have a quiet room during a story and not much talking from the audience. She seems to want the flow of the story to capture the student’s attention.

Nancy had a little different experience with stories told in small groups.
I sure like my small groups, and I think the 28 students it’s very easy to know if they’re with you. I get this sense whether it’s telling a story or lecturing on a piece of content you know if they’re with you. You know how many are engaged and how many aren’t. I enjoy telling a story to a smaller group because it feels more like a conversation … In the big [classes] I don’t get much feedback.

Although they prefer different sizes of classes, Nancy and Sandy both seems to prefer having the room quiet and their stories to be center stage.

Connie prefers to use stories with smaller groups, and like Nancy, she feels that she can assess the audience much more thoroughly in a small group.

I use [stories] in a much more limited way in big classes. In a group of 20, you can tell how students are experiencing a [story]. You can’t in a group of 200 … because there are so many people to look at. I can make eye contact with most people in a small group setting. In that small group setting I can tell people are actively engaged and are really cuing in and are enthusiastic about hearing a story. I can’t tell in a large class.

Margaret teaches in classes as large as 160 students and as small as 28 students, and she uses stories with both groups. She does not feel that the size of the class is a deterrent to using a story, but did talk about how the processing of the story is different between the two groups. “I think storytelling is useful for any type of group. It’s the outcome that is important. In a group of 160 students, how many would I really reach with a story? … Because of the lack of ability to have [individual] discussion afterwards. But I would still use them, just differently.” Margaret seems to like to have questions from students, and she feels that processing a story in a large group is too time burdensome. Processing a story in a small group can be easier and most if not all students can have the time to comment on the story.

Donna uses stories in all of her classes, large and small, but did not indicate a preferred class size for a story to be effective. Instead she looks at the way the class interacts as a whole. “There are some classes where there are 60 students but it’s a close class. Some classes where
there are 10 students and it’s not a close class. So it just depends on how the class as a whole is interacting [whether a story works or not].”

Each of these educators has experience with using stories in large and small groups. There was not clear consensus on whether stories work better with large or small groups, but it is clear that each of these educators has different expectations of their audience. Sandy and Nancy both prefer to keep the flow of the story going though they prefer different sizes of groups. Margaret and Donna seem less concerned about the size of the group and look instead at the group dynamics and the processing of the story as part of the learning process.

Use of Props or Audiovisual Aids During a Story.

Of the nine participants in this study, only three use some sort of audio or visual aid during the telling of their stories. Since most of the participants don’t plan stories but use them in response to student questions or to help make a concept clearer, there is not the forethought of preparing an audio or visual prop for the stories.

Donna shared an example of a prop she uses in the classroom. “I’ve got one story that I do have and x-ray of a child with a skull fracture. [I use it] when we talk about doing a thorough assessment. The skull fracture saved the child’s life because it allowed room for their ICP.” This visual prop sets the stage for showing how cases of potential abuse need very careful assessment, to include a thorough review of all test results.

Monica does not use physical props but uses music. “When I do my seminar on dying, I will play songs about death that people have written. I pass out the lyrics and that sets the stage for what we’re going to talk about that day. Then we’ll kind of move into discussion and then I’ll have a story to tell.” Monica said that these seminars are generally small groups, up to 20
students. Music can be a very powerful tool to set the stage for a particular discussion. Monica takes full advantage of this.

Sandy explained that she really likes to use props when ever if fits the content she is teaching.

When I’m teaching them how to give enemas, I fill up an enema bag. There’s a sink right in the classroom. And so I fill it up and I’m talking about it, then I tell a story about what happened to a student who was filling up an enema bag and after she took it from the sink, and tried to close it, she dropped it and water went everywhere. And they all laugh. And I said, I was standing right there and you know what I did? And they say no. What did you do? I walked out of the room and laughed for five minutes … and then went in and helped her clean it up.

This story demonstrates some practical, mechanical issues about an enema bag that should be learned before making a mistake in front of a patient. The outcome was laughter and an understanding of the importance of knowing how to properly handle equipment. These props in the classroom likely made the story come alive.

**Document Analysis.**

Each of the participants was asked to provide at least one syllabus from a class in which they use stories as a teaching strategy. Three of the participants provided two syllabi for review. A total of 12 syllabi were reviewed. The purpose of this review was to look for concrete evidence of the use of stories within the course. A careful review of each of the provided syllabi demonstrated that only one of the participants, Sandy referred to the use of stories anywhere in her syllabi.

Sandy provided a very detailed 69 page combined syllabus and course packet for a course that she teaches titled *Nursing Foundations*. In the method of instruction section of the syllabus for this course, Sandy used the following description. “Course material may be presented through the use of lecture, audiovisuals, role play, group projects, and discussions,
problem sharing/case studies, stories, multimedia, practice in on-campus and off-campus clinical sites, and self-directed and cooperative learning activities.” The teaching methodology of the telling of stories is clearly listed. Each of the units within this course is listed in the packet and includes student learning objectives, an outline of the content and assignments associated with the unit. Nowhere in the content outlines was there any reference to the use of any stories.

Sandy shared many stories during the interviews for this study, and related several of them to the Nursing Foundations course. However, her syllabus does not show any concrete evidence of the intentional use of those stories. Evidence of detailed content and specific methods of delivery, would be expected in the faculty members notes and outlines for each unit being presented.

This research study clearly demonstrated that the participants do use stories as a teaching strategy in their nursing courses. There is evidence to support that this teaching strategy is used both intentionally, and in response to the need for clarification or to more completely answer student questions. The participants felt that almost any content is appropriate to be taught through a story, even stories that demonstrate poor judgment or mistakes that led to negative patient outcomes. These educators were not afraid to share with students that they have made mistakes and they found that these kinds of stories made for intriguing classroom stories. There appears to be some difference of opinion related to the ideal size of class for the delivery of stories, but classroom set up was clearly an important consideration to ensure that students are fully engaged in the story. The use of audiovisual aids was not a common practice during a story, which may be explained by the fact that most of the participants did not plan a particular story in advance, so could not come prepared with any audiovisual aids. A thorough review of the syllabi provided by each participant showed no evidence of the use of stories in the classes. Only one syllabus had any evidence of stories being used as a teaching method, and was only
mentioned once. There was no specific reference to a particular story in any of the syllabi reviewed.

**Intended Outcomes of Stories and Assessment Themes**

The third theme that clearly presented in this research study is the concept of student learning that the participants intentionally took into consideration when they used stories in the classroom or clinical setting. There were several issues related to student learning that surfaced. The participants reported that students engage differently during stories, stories affect the affective learning domain, and that the effect of stories on students can be assessed in a number of different ways.

**Students Engage Differently During a Story.**

The participants in this study were asked to describe their perception of how students learn from their telling of stories. When describing her body position during the telling of a story, Margaret identifies a change in how students listen to stories. She also relates that her demeanor changes during stories and she becomes more passionate.

Usually when I’m teaching I am behind the computer most of the time. I’m not a wandering type of teacher … But when I tell stories I move. I move out from behind that podium … And we all know that students learn in different ways and if you have real auditory [students] … that’s the way they learn, then they really tune into that. You really see it. No matter where you are in the room, they’re like following you because they don’t want to miss a piece of the story. I think my passion comes through my voice. I use my hands and my tone of voice changes. Not that I try, it just happens. People can hear it. People have told me they can hear my passion and my love for this topic. They can hear it. I can see it.

It was easy to notice a change in Margaret’s demeanor as she told stories. Her facial expression became much more exaggerated, and she used her arms in a very pronounced, expressive manner. Her voice became soft during stories about pain or death, and loud and forceful during
stories about patient advocacy or justice. This change in her usual mannerisms may explain why she perceived that students listen differently during stories. It may be because she is behaving differently and they are intrigued and curious about what is to come.

Sandy also reinforced that stories have an emotional element. “A story is emotion, its human. There’s more of a lived experience.” Sandy used a story as an example. She talked about caring for a patient with Guillain-Barre Syndrome, and working extensively with his legs for weeks during his rehabilitation. As his disease improved he regained good use of his legs, but poor use of his upper extremities. Sandy talked about how she still regrets not exercising his arms and hands as much as she did his legs. “Sometimes you think that you’re doing everything that you possibly can, but then you have regrets … You always think of other things that you could have or should have done.” There was a definite sense of sadness in Sandy’s voice as she remembered her feelings about this patient. Her voice was soft and tender and her hand and body gestures conveyed a sense of regret and sorrow for not doing more to help this patient regain the use of his arms and hands. She said that this is one of her favorite stories to use with students. There was a change in Sandy’s demeanor as she told this story, which one could visibly see and hear. This change in her behavior may again explain why students listen differently during stories.

Nancy talked about where she stands in the classroom, and that she does not change her position much if she is lecturing or telling a story. But she does notice a change in students when she tells a story.

I still stay up front. But … I’m more animated when I’m storytelling because I don’t have to think so hard. When you think about it, when you lecture you really have to be thinking all the time on what you’re going to say next and when your telling a story, it just flows. And you have 100% confidence that you can tell that story. Whereas when you’re lecturing on the mechanics of ABG’s … you’re thinking, thinking, thinking. [Students] sort of stop and now pay attention in a different way … [As I tell a story with
extra animation], that emotion has got to touch them, so that they will remember what I’ve said. Also laughing or making a joke is another piece of a sense, another part of the brain that gets stimulated and then another connection is made.

Even though Nancy does not change her physical position during a story, she feels that her tone of voice and emotions are different. This may be a cue to students that a different kind of learning opportunity is coming. She also talks about stimulating various parts of the students’ brains so that connections can be made, and learning can occur.

Stella noticed that students seem to pay attention in a different way during stories. When I start a story the room just gets very quiet…they want to hear the details. When you’re using PowerPoint all the time, [students] can sit there passively and they don’t have to listen very well. But when you come up with a story, then you have all eyes on you, especially if you get into it yourself, if you get into that feeling.

Stella makes a connection between stories and active learning. She found that typical lecture methods encourage passive learning and that stories engage students in a different, more active way.

Donna provided many examples of stories that she uses in her classroom, and with each story, the emotion and energy in her voice was audible. After telling a story about a baby who suffered a skull fracture at the hands of her father, Donna defined how she thought a story was useful. “To me stories are something that really internally purposefully catches me. A story is just a way of helping me to realize [and understand] something that was a personal experience that I had.” Donna continued by explaining that she uses stories with students to help them to internalize an experience that she had. “[A story] does not always have to be something that brings tears to your eyes, or something that’s so emotionally profound that it shakes [students] at their core, but just something to help them internalize and understand the processes that they go through to be a better nurse.” Here Donna seems to connect emotion to learning, and stories with emotional elements seem to enhance learning.
Monica talked about emotions and how they enhance learning. Monica works with patients on a cancer unit and makes some interesting connections between emotions and learning.

Because I do my clinicals on the oncology unit, I hear lots of stories coming there because we have a lot of very tough decision points being made. There is lots of bad news being discussed. There is lots of that kind of thing affecting the students emotionally. And when they get affected emotionally they are much more able to recognize the patients’ situation. It’s interesting. When the student is on the unit and takes me aside with tears and says ‘this is so sad and I don’t know what to say’ we’ll work with that on the unit. When we get into the conference [after the clinical shift], that’s the student that tells the best story [about their patient], because they are touched by it.

Monica seems to reinforce the idea that emotion is connected to learning. She talks about helping students to deal with emotional patient situations, and notices that these emotional experiences help students to be more engaging when they talk about their patients in post-conference.

These six nurse educators each have a perspective on the learning that occurs when stories are used in the classroom. A common theme that emerged is that emotion and passion are important in the delivery of stories, and not only encourage students to listen intently to the stories, but are thought to enhance their learning.

**Stories Access the Affective Domain of Learning.**

Several of the participants talked about how stories can help to reach the affective domain of learning. There are three domains of learning that educators can access to maximize student learning. The cognitive domain reflects the learner’s ability to recall information, apply previously learned information to new situations, and break large pieces of information into smaller ones (Sorrell & Redmond, 2002). This domain is fairly easy for an educator to access, and most traditional teaching methodologies tap into this domain very successfully. The second domain is the psychomotor domain. The psychomotor domain refers to the types of physical
skills that the learner is required to demonstrate (Sorrell & Redmond, 2002). There are many skills that nursing students must master and most nursing programs provide significant, safe practice time with mannequins before any skill is performed on a patient. The affective domain is the most challenging domain to access as it deals with attitudes, values, and feelings (Sorrell & Redmond, 2002). Teaching a student to provide compassionate care is no easy task. Values clarification must occur and often long held attitudes must change for students to be able to interact in a truly caring manner. The participants of this study reported that stories help to access the affective domain.

Jane provided a reason for why she uses stories, and how effective stories can enhance learning. “The thing that I really use [stories] for is when I’m affecting the affective domain. I think that’s the key to learning. I mean you can teach psychomotor; I can teach the skills. But I can’t teach you in the affective domain unless I give you examples. And that is what stories really go into.”

Jane also connects learning to a process of internalizing the material. She differentiates between cognitive knowledge and affective knowledge, and believes that affective knowledge requires a process of internalization to be truly learned.

For true learning to occur there has to be that internalization of it. So there has to be that second process for it to really happen … There are some things that you would learn just from being presented to it, but the true learning, the higher level of learning is when you internalize it and apply it to the next situation … If it’s cognitive knowledge, they can learn that from the story as is. For affective knowledge they have to internalize it to help make it that way.

Jane connects affective learning to critical thinking – being able to apply previous learning to new situations. Forneris and Pender-McAlpine (2009), who studied the use of preceptors in the clinical learning of nursing students, reported that clinical learning should provide nursing students with the opportunity to discuss their experiences; not only to discuss what care was
provided, but to talk about what the student was thinking during the care. Forneris and Pender-McAlpine (2009) believed that this reflective dialogue could provide a structure for enhancing nursing student critical thinking in practice. This is the concept that Jane talks about; there must be a second process in the learning that allows students to reflect on what they have learned and to further develop that knowledge. Discussion and processing of stories may provide an opportunity to reflect on learning and to critically think about how the knowledge applies to other patient situations.

Donna offered some assessment of student learning when she uses stories. She related stories to the heart of nursing – interaction with patients. I seem personally to be able to get more information across to students when I use what I’m comfortable doing – telling stories. And I’m a very personal storyteller. I seem to be able to get my content across in that manner. I’ve noticed that [students] talk more. They are more interactive. They are more willing to share their stories in class. They are more willing to talk on a personal level, and nursing is so personal. [During stories, students] are internalizing or they are maybe pulling something out that they have experienced that makes it very much their own.

Again Donna connects the teaching methodology of storytelling to the very intimate nature of nursing – interacting with patients on a very personal level. Learning this personal interaction goes far beyond the didactic nursing content in any nursing course. This is where the affective domain can be harnessed. Donna also reinforces the concept of internalizing material through stories – students choose what makes sense to them and make it their own.

Margaret explained about how she uses stories not only to teach content about nursing but also to get at student attitudes. “What I’m trying to do with my storytelling is invoke knowledge, but more than knowledge to invoke passion … to change attitudes, to bring about appreciation for the need for communication and acceptance of people … A lot of [stories] get to
the affective.” Margaret told a story to explain how she uses stories to help students get in touch with their feelings especially about patients who are disadvantaged or different from them.

I’ll never forget a guy I took care of … he was in for community-acquired pneumonia. On his chart was written ‘cocaine addict.’ He was labeled. The student and I sat and talked with him, and we learned a lot about cocaine addiction, and that he had been clean for eight months. But he was still labeled. I talk about this experience and what I learned about [my biases], about cocaine, and about the power of ‘labeling’ patients. [I remind students to] sit down and listen to people, and value people. And when I’m telling my stories, like I am now, the passion shows. And I think that is important- that I get excited and the students see the passion.

Margaret once again expresses her emotion and passion for nursing and shows how she uses a story to encourage students to look at biases and to focus on open, honest communication with patients. Margaret’s story is a great role model for compassionate care, a part of the affective domain.

Connie talked about what her expectations are for student learning through the use of stories.

[Stories help students gain] … either a better understanding of the content, or a better understanding of themselves. Like dealing with the difficult people, dealing with difficult families, dealing with their own grief and suffering that you are exposed to every day as a nurse, that they can contain some sense of who they are in their core. They get rocked when they see their first death. It rocks people, shakes them off their blocks a little bit.

Once again Connie talks about the more difficult things that student nurses must learn – to be tolerant, patient, kind, forgiving and endlessly supportive. These are concepts that Connie felt can be learned through stories.

Stella talked about how stories help students to “see” a concept that is difficult to understand. She used a story to make her point.

I went into a home to give insulin to a woman who had visual problems when her daughter was out of town. Well, when I went in that morning it was the first time I had ever seen the woman. She was in her 60’s and African-American. I gave her the insulin but I did a head-to-toe assessment while I was there, and I asked her if I could check her feet. And I asked her if she did foot care and washed her feet daily, and she said “oh yes.”
When I took off her slippers she actually had maggots between her toes. Of course I was very surprised and I put on my gloves and I asked if I could wash her feet. I asked her son if he had anything I could use because I did not bring a basin with me. He gave me a turkey pan and I put her feet in the turkey pan and I washed them. I also made sure she did not put those slippers back on because I was sure that there were flies in those slippers. I went out and bought new slippers for her the next day. I wanted to let students know that even though they ask patients questions, they don’t always know what’s going on. She likely had neuropathy and did not even feel those maggots at all.

Stella’s story provides a vivid image to help students to understand neuropathy, and to remind students to be thorough in their assessment in spite of what the patient tells you. The image of the maggots is a good tool to create a picture in the minds of the students, to engage the affective domain, and to help them to better remember content.

**Assessment of a Story Success.**

Sandy talked at length about how she assesses the success or failure of a story in her classroom.

Sometimes I pass out a piece of paper that has thee questions: What are the three most important things you learned today, what did you like least, and what other questions do you have? And [after] the [Guillain-Barre] story, 75% write that as the most important, or ‘I learned a lot about Guillain-Barre syndrome.’ Verbally if I ask how did today go, I hear that the stories were great, helpful, things like that. There are test questions related or fill in the blank where [students] mention that story. But a lot of [my assessment of stories] is informal.

Monica has several ways in which she evaluates the usefulness of the stories that she uses in class. After telling a story about children who have a genetic skin condition causing severe blistering with any pressure, she conducts a debate within the class to discuss who should pay for expensive treatments for these children.

Making these kinds of decisions about where do we spend our money on technology, research, and who gets genetic testing, those are hard decisions. [The students] can’t sit there as citizens and say, ‘well THEY need to do something.’ So the objective was that they would internalize that, and through the conversation and debate in the class, I get a sense of how well they got that.
Monica also used objective examinations to evaluate the usefulness of her stories. “Then on their test, which is essay, they have to make statements about the concept but then they have to have an opinion and defend their opinion. So I start to see how they are forming their viewpoints. I can evaluate [classroom stories] in their tests.” Although course evaluations are standardized and very general, Monica often received emails from students expressing how a story has touched them. Monica also measures the success of her stories through the reflective journals that the students write. “Different students respond differently [to stories]. They generally sit quietly and listen, but some really take it to heart because it will come up in their reflective journals. This situation is just like what you talked about in class.” Reflective journals often provide opportunities for students to explore their feelings about how a patient care situation has affected them, and what they are feeling, part of the affective domain.

Margaret said that she does not formally assess the success or failure of the stories she tells. She admits that she tells stories during each class, and often several, but uses only multiple-choice exams that do not assess affective learning well. But Margaret admits that there are ways to tell if the story had its intended effect. “There is one way that I can tell if the story worked. It’s the silence in the room, and it’s the attention … it’s not attention to me, its attention that’s focused on the story. And I see it.”

Elaine also notices that there is a change in the students’ attention level during stories. Elaine said that she watches for “… non-verbals, their attention level, the questions that they ask, if they apply what I’ve been talking about. Also seeing students in action with patients is a good way to see if they ‘got it.’” Elaine watches students in the clinical setting and assesses if the objective of the story were understood by the way the student cares for the patient. Again there
is the reference to caring and emotion as being an important content area for which stories can be useful.

Nancy talked about telling students about a story of her first experience with a patient having a seizure and how many mistakes she made.

I took that scenario so that they could picture it and talked to them about seizure precautions. Here’s what I did right, and here’s what I did wrong … I know they connected with the story when they comment on it or they have questions. ‘Did he swallow his tongue? Did he stop breathing?’ I know they were engaged and listening and trying to make sense of the story.

Nancy used the story about the patient with seizures to help students to create a picture of a clinical situation that they had never seen, and to help the students to experience the emotions that she felt. Once again emotion emerges as an important part of student learning within the affective domain. “Another way that I know that a story was effective is when students tell me, ‘I was answering this question on the exam and that picture of that patient you told us about came to my head, so I knew to pick rales and not wheezes for the CHF patient.” When students can recall content of a story that assists them in choosing the correct answer on an exam, Nancy felt that this was an indication of a successful learning, and a positive assessment of the story itself.

Donna talked about how she assesses the success of her stories by providing an example of a story she uses. She told a story about a baby who had suffered physical abuse, and then talked about how she would handle that story. “I’m going to try to pull information out of them. If we are talking about abuse we may talk about the signs that you may have assessed when that baby came in. Or I may tell parts of the story and stop and ask questions along the way.” This technique of asking leading questions has been mentioned by many of the participants, and
seems like an effective way to assess the learning that occurred from the story itself. Donna also talked about connecting content learned from a story to an objective exam.

[When I use stories] they seem to be more receptive, more interactive. And the outcomes are more positive on exams in the content that’s reflected when I have a story versus when I don’t. Maybe it’s because we discuss it more. Maybe it’s more personal. It just appears that they’re getting a better grasp of that content.

Connie does not have a formal mechanism for assessing the success of her stories, but does have some cues from students that the stories are being positively received. “I sense that students receive stories very positively. They are engaged, looking at me. They sit back and they really listen.” Although this evidence is anecdotal, it is enough positive feedback for Connie to continue using stories in her classroom.

Over the years, Jane has sought feedback from students related to her teaching. A common classroom assessment technique that she uses is the mini paper after a class. “And so periodically I would at the end of the class say, take out a piece of paper … and write three things that helped you learn most effectively today … I continue to get students coming to me after class to tell me their story, and I encourage that too.” Students consistently write that the story that Jane told was very helpful to their learning. This feedback encourages Jane to continue using this teaching methodology.

Each of these participants has a way of evaluating the success of the stories she uses in her classroom. Two participants used the classroom assessment technique of having students write the three most important elements of the class that affected their learning and stories always appear on this assessment. Four of the participants assess the success of their stories by the number and quality of questions that the students ask after the story. These questions are seen as a way that students internalize the information and integrate the story into their learning. Three participants actually see evidence of how the story affects student learning in the students’
essay examinations. Though these assessment methods are different, they have provided the participants with enough positive reinforcement to continue to use stories to enhance student learning.

**Summary of Findings**

The nine participants in this study have contributed significant insight into the use of storytelling in nursing education. Three major themes emerged. The first theme that emerged is that stories are a part of the pedagogical process in nursing education for these nine educators. There emerged several common pedagogical issues that seemed to affect these educators’ desire to use stories. They talked about nursing content being very difficult for novice nursing students to understand and that stories help learning. They talked about how difficult it is to use stories as a pedagogical tool without having significant nursing experiences from which to draw. Stories were seen to be very personal patient care occurrence that the participants experiences, that became an important tool in how they thought about learning. Connecting stories to their learning objectives was important to them and not all stories work with all groups of students – there is a readiness to learn from stories that they considered. Very new nursing students have few nursing experiences so a story about an advanced nursing intervention, or complex piece of medical equipment only confused students instead of enhancing learning. Putting new learning into a context that is familiar to students can enhance learning and stories were seen to provide that needed context. During the interviews for this research, each of the participants talked about the importance of emotion to a story. Emotions that are evident in the lived experiences of these educators were very evident in their retelling of their many stories, and each of them commented on the importance of the emotion to student learning. Finally they talked about how using stories
in their classrooms was a good model for student, who need to learn to listen to the stories of the patients for whom they provide care.

The second major theme that emerged from this study is that storytelling was used by each of the nine participants as a regular teaching strategy. There is evidence to support that the storytelling teaching strategy is used both intentionally, and in response to the need for clarification or to more completely answer student questions. The participants felt that almost any content is appropriate to be taught through a story, even stories that demonstrate poor judgment or mistakes that led to negative patient outcomes. These educators were not afraid to share with students that they have made mistakes and they found that these kinds of stories made for intriguing classroom stories. There appears to be some difference of opinion related to the ideal size of class for the delivery of stories, but classroom set up was clearly an important consideration to ensure that students are fully engaged in the story. The use of audiovisual aids was not a common practice during a story, which may be explained by the fact that most of the participants did not plan a particular story in advance, so could not come prepared with any audiovisual aids. A thorough review of the syllabi provided by each participant, demonstrated almost a complete lack of evidence for the use of stories in the classes. Only one syllabus had any evidence of stories being used as a teaching strategy listed anywhere on the course syllabus.

The third theme that clearly presented in this research study is the concept of student learning that the participants intentionally took into consideration when they used stories in the classroom or clinical setting. There were several issues related to student learning that surfaced. The participants reported that students engage differently during stories. There is evidence indicating that the change in the tone of voice and demeanor of the teacher may have been a cue to students that something different was about to happen, leading to the noted change in student
behavior and attention during stories. Stories were found to affect the affective learning domain, to include feelings, values and attitudes. Students were believed to learn compassionate caring from stories, which is difficult to accomplish with other traditional teaching methods. The nine participants assessed the effect of stories on students in a number of different ways. Several participants used classroom assessment techniques, like the mini paper, as a way to obtain concrete, objective evaluation of the effect of stories. Several participants were able to assess stories through the essay questions that were used in examinations. Some participants found that students frequently shared their own personal stories after class, which may indicate that they are trying to incorporate the information from the story into their own reality, and make their own meaning of the story.

All of these faculty participants clearly valued storytelling as a viable tool to enhance student learning. Each of them have contributed to clearer understanding of strengths and limitations of this teaching methodology, and have provided a significant number of examples of how and why they use stories in their classrooms and clinical settings.
Chapter V: Discussion And Conclusions

This study explores the experiences of nurse educators with the use of storytelling in the pedagogical process of nursing education. There emerged an emphasis on a student construction of meaning allowing better lesson integration to facilitate a learner-centered meaning construction by nursing students. This study examines how nine nurse educators use stories in their classrooms to add to the authenticity of their learning objectives. Questions were asked to elicit the faculty members’ experiences, understandings, and feelings regarding the use of stories in their teaching practices. Additionally, general teaching practices were explored to further understand the nature and meaning of the nurse educators’ story experiences. Within the framework of the general themes that emerged, the results of this study, with key observations and references to related research, are discussed, contributing to a fuller understanding of how and why these educators use stories. The research questions are used to organize the discussion of the data. Lastly, resulting implications for nursing education and recommendations for further research are identified.

How Do Nurse Educators Use Storytelling in The Classroom?

The current research study explores how nine nurse educators use storytelling in their classrooms. Several key concepts surfaced as important considerations in their use of this teaching method. As these concepts were explored, it became clear that a practical guide emerged for nurse educators who use or would like to use stories as a teaching methodology.

Whether an educator uses stories intentionally or more serendipitously does not affect the choice to use them. Jane clearly articulated both planned and unplanned use of stories. Margaret admitted she rarely intends to use any particular stories. Monica reported very intentional use of
particular stories, explaining, “I taught a seminar on dying in America, and there were a lot of experiences from my palliative care nursing that really helped make the point. I would have that on the teaching plan as tell ‘so and so’ story.” Whether the educators intentionally planned to use specific stories or if the story emerged as a way to clarify issues for students, they were perceived as having merit as a teaching methodology. This is helpful information for a nurse educator seeking to try a new teaching method. A nurse educator using storytelling for the first time would want to carefully consider a specific story’s fit in a particular class.

To examine the question regarding how nurse educators use stories in the classroom, it is important to explore several pedagogical issues this study encountered. The decision to use stories was strongly linked to the educators’ pedagogical goals, including the planned learning outcomes for the students. Pedagogy is the entire process of preparing and delivering information and gives significant consideration to the way students learn. Various pedagogical processes informed these educators’ use of stories with their students. There were differences and similarities in both how they engaged students in the learning process and how stories fit their thoughts about learning. The complexity of nursing and the new and highly technical medical language were major contributing factors in the use of stories as a learning tool. Stories provide a context within which nursing students can understand the complex material through the creation of a familiar framework or a situation with familiar components.

Contextual learning is defined as “… a conception of teaching and learning that helps teachers relate subject matter content to real world situations and motivates students to make connections between knowledge and its applications to their lives as family members, citizens, and worker” (Berns & Erickson, 2001, p. 6). Chiarelott (2006) believed effective teachers understand and can articulate why certain behaviors work under certain conditions while others
do not. Simply put, they understand the contextual nature of the teaching profession. The participants in this study supported Berns and Erickson’s ideas about context as well as Chiarelott’s ideas regarding what makes a teacher effective.

Jane’s use of well-known concepts to help patients and students understand those more complex is a good example of the basic principle of contextual learning referenced by Berns and Erickson (2001). New nursing students struggle to make connections between textbook and lecture material because they have never seen or experienced the health issues being taught. They have no way to place the new content into their current repertoire of learned knowledge and make sense of it. A story about clogged pipes can help a student understand the concept of hyperlipidemia and its effect on the body. Stories help students learn to visualize situations and characters to help them contextualize learning and enhance memory (Koenig & Zorn, 2002).

Another issue explaining how nurse educators use storytelling in the classroom sees teaching experience and patient care experiences as necessary to effectively use stories. Nursing instructors without much patient care experience struggle using stories as they have little care experience from which to recall. The study participants reported that these instructors with limited experience, in order to try to provide the context necessary to learn complex material, use case studies. In the literature, stories and case studies are often used synonymously. Both case studies and stories paint a picture of a patient’s diagnosis, detailed symptoms, nursing interventions, and treatment options. Stories, however, help students identify the parts of the situation specific to the role of the nurse so they more clearly see their role in the health and care of the patient (Boykin & Schoenhofer, 1991). Some participants in this study supported Boykin and Schoenhofer’s (1991) differentiation. A strong differentiating component discovered between case studies and stories is the story’s generated emotional connection. Nancy described
using a graphic example of a tumor resembling a cauliflower. This story provided a picture of the cancer in a way textbooks do not. Nancy described her shock at the tumor’s appearance and how she was not emotionally prepared to handle it. The mental picture of that tumor is a powerful learning tool. This human, emotional factor is a key reason the educators in this study use stories to enhance student learning. It is also important to note that patient stories provide an opportunity for students to discuss the shock factor and emotions often experienced by nurses. This discussion helps the students make their own meanings of the story and teaches them to think critically.

Another identified importance of using stories is the manner in which the participants process the stories with the students. In Nancy’s example of the cauliflower-shaped tumor, she spoke with the students about the emotional effect of the experience and how ill-prepared she felt to care for this patient. The students were then given an opportunity to process their feelings about disfiguring tumors and identify ways they could prepare for these kinds of patient experiences. This story helped students contextualize an illness they had never seen and identify ways they could better prepare for such shocking experiences. This demonstrates a learner-centered approach to learning in which students make meaning of the experiences in the story.

There are three logistic environmental issues these nine nurse educators consider as they use stories in their classrooms: the physical room layout, the size of the audience, and the use of audiovisual aids. The preferred shape and layout of the classroom differed among the participants but a few key concepts remained consistent. It was important to each to be able to make eye contact with every student in the class, engage personally with each, and assess the understanding of the story. Another consistent environmental preference was a room with portable seating. Movable desks or tables allow students to see each other and faculty to see
each student, no matter the size of the group. Current published storytelling literature does not address the optimum environment to tell stories. Cangelosi and Whitt (2006) worked with graduate students teaching an online course. They spend considerable length in this study describing how they assess student learning in a traditional classroom, saying, for example, that frowns, head shaking, and lots of raised hands are evidence that students are lost. In an online class, these non-verbal behaviors are not available, so listening to students’ stories becomes essential.

Only three of the nine participants reported using any kind of audiovisual aids during a story. Diagnostic tools like x-rays, demonstration tools like enema bags, and music were the aids reportedly used during stories. The other six participants did not use any physical tools, likely because of the unplanned use of a story. Some of the educators mentioned a desire to use audiovisual aids but said it would require specific preparation and they do not intentionally plan to use specific stories. Educators who want to use specific stories in their classroom might consider incorporating audiovisual aides.

The discussion of how nurse educators use stories in their classrooms is important to fully understand why they use this teaching-learning technique. It is, however, simply a technique. Palmer noted that “technique is what teachers use until the real teacher arrives” (1998, p. 5). Offering tips or techniques to teach using stories is only part of this picture. As important as methods may be, the most practical thing teachers can achieve is insight into what motivates, engages, and moves students (Palmer, 1998). The nurse educators in this study demonstrate through their stories that teaching is more about being authentically and honestly themselves and less about any particular technique. The personality of each participant is evident and their passion for nursing and teaching was alive in their stories.
How Do Nurse Educators Develop Stories to Advance the Pedagogical Process in the Classroom?

A pedagogical issue which helps explain how nurse educators develop their stories is that stories are strongly connected to the faculty-identified student learning objectives. Monica described how she chose stories to use in her classroom, saying they are based on her specific class and learning objectives. Donna also discussed directing her choice of stories to her specific class objectives, articulating that “the outcomes of the stories that I told you were not what you would like to ultimately see as patient outcomes, but the outcome for the student learning is a positive experience. So in looking at the story, it’s not the story itself. I’m looking at the learning outcome.” It is clear the participants in this study did not use stories just to tell them, but were intentional about using ones which fit their learning objectives.

A second pedagogical issue that emerged regarding story development is that stories are carefully selected to meet the students’ readiness to learn. A beginning-nursing student may not learn well from a story about an advanced medical diagnosis or complex nursing skill, so it is important that the nurse educator choose stories appropriate to the students’ level of learning and readiness to learn. The participants demonstrated careful consideration of student readiness when choosing a story for classroom use.

The Dreyfus model (Greenwood, 2000) of skills acquisition theory posits five levels of skill that human performance can attain: novice, advanced beginner, competent, proficient, and expert. A student cannot move from one level to the next without a readiness to do so. Novices with little experience cannot move to advanced beginner without first gaining experience. The speed with which each student moves from level to level is based in part on their readiness to gain those experiences. The experiences of the nine participants in this study support Dreyfus’ theory (Greenwood, 2000) that advancing in skill is based in part on readiness. Sandy said she
would not tell students the Guillain-Barre story until they had some background in neurological function and physical rehabilitation needs as they would not be ready to incorporate the content. Nancy also explained that stories about Intensive Care settings and complex medication regimens would be inappropriate for novice students because they would not be prepared to interpret or understand those advanced concepts.

The third pedagogical issue demonstrated in this study is that stories engage students on an emotional level. The emotion found in so many lived experiences was found to be a key factor the participants considered as they thought about using stories. Concepts of advocacy and caring, vital learning outcomes for nursing students, are not pieces of content to be memorized but affective concepts that are difficult to learn from a textbook. Margaret shared a story about a patient situation in which the patient was vulnerable and without family support. The details of the stories, with the raw emotion Margaret experienced, provide rich opportunities for students to understand the concepts of advocacy and caring. Monica told stories about students’ experiences on a cancer unit and how the emotions experienced by the patients on the unit provided opportunities to talk about serious medical issues and the effects of life-threatening illnesses. This concept of the strength of emotional connections to the learning process will be further discussed in this chapter.

The fourth pedagogical issue addressing the question of how nurse educators develop stories is that the use of classroom stories is a model to help students listen to their patients’ stories. Patients bring stories to nurses at every interaction. They hope to tell them in a way that will help the nurse understand their lived experience (Cole, 1989). Effective communication with patients is story-like or narrative in structure (Sorrell & Redmond, 2002). Listening to those stories helps nurses understand the patients’ illness experience through their own eyes. It is
important that students learn to listen to those stories. Sorrell and Redmond (2002) described the busy shift of the nurse: rushing from one task to another and speaking to others without really listening. Many things obstruct true listening. Patient physical needs are great. Medications require time and diligent attention on the nurse’s part. Documentation must be completed and physician phone calls must be made. Coordination of tests, therapies, and treatments must be completed to best meet the needs of each individual patient under care. Stories require a special method of listening and modeling the use of stories in the classroom helps students learn to listen in a new and more acute way. Each of the nurse educators in this study provide data to support the findings of Sorrell and Redmond (2002) that patients’ lived experiences learned through listening to their stories provides information vital for the nurse to provide quality, personalized care.

Schwartz and Abbott (2006) found students who gained experience listening to stories in the classroom became better listeners in the clinical area. Faculty members modeled the behavior expected of students when they care for patients. Listening to the patient’s story assisted students in delivering quality care through the understanding of the individual’s traditions and the personal meaning of the illness. Leight (2002) found that listening to a patient’s story allows the nurse to attune to minute differences not necessarily casually observable. Attending to a patient and listening to their story is the unique contribution nursing makes to society and learning to do so helps nursing students gain these attending behaviors (Leight, 2002).
What Content is Best Suited to Storytelling?

Some content emerged as appropriate for the story method while some was thought to be less appropriate. Most participants agree that stories with less than favorable patient outcomes are good learning tools, indicating that a happy ending is not a requirement. In fact, most participants like using stories of their mistakes to help students learn through their situation processing. Providing perfect patient care is not a reality for any nurse and students must understand that errors and poor outcomes will occur with even the greatest of vigilance. There are no studies in the literature that address the content appropriate or inappropriate to be taught in story format, so the findings of this study truly initiate this topic’s body of knowledge.

The stories most cited in this research study are clinical situations where errors in judgment, inexperience, or simple lack of knowledge led to emotionally challenging patient situations. Again, the idea is put forth that emotional connections in stories help students learn. In general, the stories related events that were important learning opportunities for the educators, who believed that sharing them with students would also enhance their learning.

Only one nurse educator, Elaine, reported content inappropriate to include in a story. “I wouldn’t spend time on a story in which there was a situation where somebody acted unethically and did not have a consequence,” she articulated. Elaine would not use this kind of story because she felt there was no real learning value. Telling this kind of story with students does not provide opportunities for enhanced critical thinking.

All nurses have stories about patient care situations that were personally important learning events. Nurse educators looking to try storytelling as a teaching method have only to examine their memories to find rich learning opportunities. Stories with negative outcomes...
should not be eliminated as possible content areas and may actually provide some of the richest, most useful learning opportunities.

Although most participants agree that almost any content can be told as a story and be a good learning opportunity for students, there did emerge some concerns. Several educators talked about becoming visibly emotional while telling stories, but only two expressed concerns about this. Jane discussed using stories about her experiences with her chronically ill daughter. As an educator she can separate her comments about the disease and her daughter’s experiences but as a mom she gets tangled in her emotions. Jane reports she is very cautious about stories which touch her on a deep, emotional level as she fears the story looses its usefulness with too much emotion.

Nancy also related that becoming overly emotional could hinder the learning process, saying “I wouldn’t tell a story if I thought I was going to get too emotional. I don’t think students need to see a faculty sob, or get so emotional that they can’t get the story out…so I wouldn’t go there.” The concern about becoming too emotional seems to relate to potential loss of objectivity, rather than the vulnerable position emotions create for the storyteller.

Other participants talked about becoming emotional during a story as a positive thing. “I think [students] realize that even teachers who have been in nursing for a long time still have those feelings, so it’s really not a block [to telling stories] for me,” Stella advocates. Here she identifies that showing emotion in front of a students is a way of modeling connections to patients.

Connie shared stories with negative outcomes but was concerned about their effect. She felt stories about mistakes could paint a negative image of nursing and really frighten students about the possibility of making mistakes. Vulnerability is always a risky position to be in and
Connie admitted that appearing vulnerable to students is uncomfortable. However, she also described that it can demonstrate ways to handle mistakes through the possible alternate endings to the stories that she uses. Some discussion about human vulnerability could help student put stories with negative consequences into the proper perspective.

Other concerns about using stories included the use of spiritual stories in an audience of mixed faith traditions, being easily distracted from the lesson plan, stories of extended length, and not knowing if the audience is experiencing any of the discussed diseases or healthcare processes. Each of these expressed concerns may be significant enough to prevent a faculty member from using stories in their classroom. These concerns deserve thoughtful consideration on the part of the nurse educator, especially for educators with little storytelling experience. These concerns, although expressed, did not stop the participants in this study from continual use of stories in their classrooms. Current published literature does not address the content of stories or their perceived level of appropriateness to student learning. The findings of this study shed some light on this issue.

**How Do Nurse Educators Find Students React to the Use of Stories Within the Classroom?**

Several important concepts related to student reaction to stories emerged through participant discussion. Several nurse educators talked about how they see students engage differently when they tell stories. The educators reported that students’ eyes become fixed on them and follow them as they walk around the room. This kind of attention and eye contact was not a routine behavior the educators observed during other kinds of teaching/learning activities. As the stories were shared, the educators’ passion for the topics came alive and their voice quality, facial expressions, and hand gestures changed during the storytelling. These nurse
educators appeared to flip a switch and turn on whole new personas as they told many of their stories. Humor was added, detailed descriptions of patient situations were heard, and strong emotions appropriate to the situation was very evident. It was easy as a passive listener to become involved, and discussion of the story would enhance this even more.

These nurse educators reported that students were *different* when stories were told in the classroom and they felt it was because of the stories themselves. This change in the attention of the students may also be related to the change in the demeanor of the faculty member. Their changes in body movements, softening or amplification of the voice, and increased animation help serve as a cue to students that a different teaching method is about to be used.

It would be difficult to separate emotion and enhanced faculty animation from the story as most of the shared stories contained issues of justice, caring for the underserved, and advocacy for the vulnerable. The subjects of the shared stories often tugged at the heartstrings and evoked strong feelings of sadness, joy, powerlessness, or determination. The stories’ subjects were engaging but the narrative skills of the educators made the stories come to life. Good teachers possess a capacity for connectedness. They are able to weave a complex web of connections between themselves, the subject, and their students (Palmer, 1998). Palmer distinguishes that “bad teachers distance themselves from the subject they are teaching, and in the process, from their students. Good teachers join self and subject and students in the fabric of life” (1998, p. 11). This was observed as these nurse educators told their stories. They skillfully drew their audience in through body language, word choice, and their obvious love and passion for nursing.
How Do Nurse Educators Assess the Learning Outcomes Achieved Through Storytelling?

Another important concept from this research is that stories seem to engage students through the affective domain. There are three domains of learning educators access to help students learn: the cognitive domain, the psychomotor domain, and the affective domain. The cognitive domain reflects the learner’s ability to recall information, apply previously learned information to new situations, and break down large pieces of information (Sorrell & Redmond, 2002). Most traditional teaching methods like lecture, small group work, short papers, and others engage this domain very well. The psychomotor domain refers to the types of physical skills the learner is required to demonstrate (Sorrell & Redmond, 2002). Skills laboratories, demonstrations and return demonstrations, and clinical practice with patients help students master these skills. The affective domain, though, is the most challenging to engage as it deals with attitudes, values, and feelings (Sorrell & Redmond, 2002).

Palmer (1998) suggested that the human brain works best with information presented not in the form of isolated data but in patterns of meaningful connection. Patterning occurs when information is learned with the patient at the center because the story offers both internal and external connections. Facts about the patient are connected to concepts the student has already mastered and requires the student to both correlate and interpret the facts in the patient’s story and connect with them at a human level. This is not a purely cognitive process but involves the art of nursing (Palmer, 1998).

The participants of this study feel stories help students experience patient care situations filled with emotions like sadness, joy, or grief. The students learn about a health issue in a story and also hear how the faculty member dealt with the situation and all of its emotions. Jane explained it well, saying “what I really use [stories] for is when I’m affecting the affective
domain. I think that’s the key to learning. I mean you can teach psychomotor; I can teach the
skills. But I can’t teach you in the affective domain unless I give you examples. And that is what
stories really go into.”

Many of the nurse educators add another component to their storytelling. They use
reflections on the story through questions designed to encourage students to think critically about
the story and create their own meaning. Donna described this process as being interactive.
Students talk more about an issue if there is an actual patient or family involved in the
discussion, instead of simply a set of facts from a textbook. Donna also talked about how stories
help students engage in their own learning. She stated “[during stories students] are internalizing
or they are maybe pulling something out that they have experienced that makes it very much
their own learning.” Donna talked about student learning similarly to Forneris and Peden-
McAlpine (2009), who found preceptors modified their thoughts about critical thinking as they
used stories with their students in the clinical area. They moved from critical thinking as
prioritizing and organizing tasks to critical thinking as a dialogue sharing thinking and
understanding rationale. A number of the educators in this study discussed how stories affect the
critical thinking of their students.

Every student is biologically equipped to learn from experience (Caine & Caine, 2006).
Young children touch a hot stove and learn that repeating the activity will result in the same
burns. This kind of learning is making sense of one’s own experiences. From this learning
comes a series of decisions to be made: pass the stove and avoid a burn, touch it only lightly and
receive only minimal burns, or avoid previous learning and lay a hand on it to again receive a
burn. This simple example occurs constantly in a student’s mind. Students make decisions all
the time: study, come to class, play on the computer, hang out with friends, or participate in
sports. Sometimes these choices have profound effects on their learning. Caine and Caine (2006) believed that if students are to develop new knowledge, they must first ask relevant questions focusing on what matters to them. When the participants of this study provided time for students to reflect and ask relevant questions after hearing a story, they were helping students develop strong decision-making skills. As these skills are practiced, students become better critical thinkers and are able to better apply previous learning to a new patient situation. Williams (2009) was able to show that patients who use reflection about a life-threatening experience develop better coping strategies than those who do not reflect on these experiences. Reflection improves learning.

Another concept that emerged in this study is that evaluation of the effectiveness of stories is a difficult task which can be accomplished in a variety of ways. One nurse educator, Monica, set up a debate after telling a story about the cost of care for children with chronic illnesses. Students were told to debate who should pay for the expensive, life-long treatments these children would need in order to survive. Monica found the debate method encouraged active engagement and also provided a way for her to evaluate whether the students understood the issues presented in the story.

Margaret found assessing the effectiveness of a story to be challenging. Observing classroom activity during a story is certainly one method to evaluate the story’s effectiveness but it is a very subjective method. Donna was able to actually track the students’ retained knowledge from stories based on their performance on course examinations. Content taught only through a story can be assessed based on the students’ performance on an objective examination. Donna has done this kind of assessment of her stories with very positive outcomes. Her students
were able to answer objective question with some skill even though a story was the only teaching method used to convey the content.

Most participants in this study used observations of student behavior as a major method of evaluating a story’s effectiveness. Some ascertained what learning occurred by the type and depth of the questions students asked and the depth and breadth of their responses to faculty questions.

In conclusion, these nine nurse educators present substantial evidence supporting the use of storytelling in classroom and clinical settings. They carefully considered the pedagogical issues of attending to specific student learning objectives, assessing student readiness, and considering student engagement. They evaluated storytelling as a teaching methodology by considering how intentionally they use stories, the appropriateness of various content to this method, and by thinking about class size and classroom layout. Lastly, these educators strongly considered the learning they try to develop in students by engaging the affective domain to specifically provoke students’ feelings, attitudes and emotions. These nurse educators are united in their support and use of storytelling in the classroom and clinical setting.

**Recommendations for Nursing Education**

There are several implications for the practice of nursing education extending from the findings of this study. This research clearly supports the usefulness of telling stories as a way to help nursing students learn and a list of key issues related to this teaching method emerged. These concerns center on the pedagogical process, the teaching strategy itself, and the student learning expected to result.
As nurse educators consider their courses and how they expect students to learn and grow, several important issues must be considered. Nursing curricula contain complex concepts that are often very difficult for students to grasp. A story can be a tool to provide the context within which students can house the new learning concepts. Exploring patient situations containing mastered components and building more complex learning into these situations is a means of contextualizing complex learning. If difficult concepts are placed within a context students have already mastered, the new concepts can be more easily learned.

Any teaching or learning activity an educator plans must take several things into consideration: the learning objectives, students’ readiness to learn, and the educators’ preparedness to engage the learning activity. This is true of storytelling as well. Any activity taking place in the classroom or clinical area should only be used if it will facilitate a particular student learning objective. This ensures all classroom activities are directed toward student learning and not simply because they are enjoyable experiences. If stories are to be used, the educator must assure the content of the story has a clear connection to the expected student learning outcomes. The level of student readiness to learn should also be considered. Stories with advanced concepts or complex patient interventions may not be suitable learning opportunities for beginning nursing students. The educator’s clinical experience with patient care should also be considered. Nurse educators with limited patient care experience will have a smaller repertoire of stories from which to draw.

Any nurse educators with an interest in using stories in the classroom must consider these pedagogical issues. If there is continued interest, then several questions may come to mind before implementing this teaching methodology:

- Do I want to be very intentional and come prepared with a particular story?
• What content is appropriate to teach using a story?
• Are there skills I need to try to use a story in my class?
• Is the size of my class appropriate for this method?
• Is the layout of my classroom conducive to this teaching method?

Each of these questions are addressed in this study, however, the development of a manual or set of guidelines for an educator new to this technique is recommended and would provide a ready source of answers. Additionally, in-service training related to the development of this teaching method is highly recommended and would provide an additional resource to educators.

Another implication for nursing education is that student learning from stories needs further assessment to assure the method is achieving its intended goal. Methods of assessment that emerged from this study were subjective in nature. The educators used observation of student behavior during the story and observed the quality of the questions students asked after the story. Some educators asked leading questions to assist students in processing the story and helping the reflection about the learning that occurred. A few educators were actually able to track performance on objective examinations related to material taught through a story. These evaluation methods should be added to the guidelines discussed above and made available to interested educators.

Concepts nurse educators consistently have difficulty teaching are within the affective domain of learning. Intangibles like caring, values, feeling, and attitudes are not best taught using typical teaching methodologies. Stories provide the perfect avenue for exploration of these affective topics. Students can be taught to perform tasks fairly simply but cannot always be taught to care about patients. Stories evoke emotions in the storyteller which can demonstrate caring behaviors vital for nursing students to learn.
Nurse educators are nurses first. They come into nursing with a desire to help patients better manage their own health. The patient care sagas experienced by nurse educators make indelible marks in their hearts and memories. These memories can be brought forward as a story to include all of the experienced emotion. These emotions can be used to explore the experience from the perspective of the patient, family, nursing unit, or nurse educator. The passion and desire to assist the patient which the nurse educator felt during the patient care can access the affective domain of learning and have a very positive effect on student learning. This study demonstrates the power of emotions within stories and how that power translates into solid student learning.

**Implications for Further Research**

This research has forwarded additional questions which need to be addressed through future research. This study was completed in Midwest colleges and universities where students share similar demographics. Though programs were chosen from various kinds of institutions, the faculty was rather homogeneous. Conducting a similar study with nurse educators from the East or West coast may identify other issues and themes not discussed here. Interviewing nurse educators from different regions of the country may generate a more inclusive picture of the use of storytelling. Including more participants may also produce more data about these themes. More importantly, there is also a need for a more demographic mix. The inclusion of the male voice and more minority representation would expand the points of view on these themes. Additionally this study has some inherent bias in that only participants who have had positive results with storytelling were interviewed. A broader recruitment of participants with varying degrees of success with storytelling would be desired in further research.
A qualitative research method was chosen for this study because of the nature of the phenomenon under examination. Quantitative methods were thought to be inadequate in capturing the complex nature of this topic. Perhaps the use of themes from this study to develop a survey tool could generate more and, likely, different information about the use of storytelling in nursing education.

In subsequent interviews with the participants of this study, nurse educators were found to use stories more frequently and in more unique ways. The process of extensive discussion of this teaching methodology may have changed some of the educators’ practices. Interviewing the same participants over a period of time at different intervals might elicit differing perspectives or practices with stories. This could also yield invaluable data on the development of the practice of storytelling.

The great variety of teaching practices regarding the evaluation of student learning from stories discovered in this study point to the need for additional research by nurse educators on ways this teaching strategy helps students learn. The variety of subjective measures of student learning that are practiced by the educators in this study point to the need for more research on the best evaluation practices. The perspective of the student was not a goal of this study but would add to the body of knowledge related to storytelling. Examining the perceived learning from the student’s perspective would be critically important in measuring the full effect of storytelling in nursing education.

Conclusions

Learning to think like a nurse is a central goal in nursing education (Tanner, 2009). Thinking like a nurse demands developing and practicing many kinds of thinking. Evaluating
alternative choices, reflecting on one’s reasoning, self-correcting, hearing and understanding patient experiences, weighing alternative options, and modifying one’s approach based on patient response are only a few of the thought processes nurses use multiple times each day. Finding ways to encourage these processes in students is an important responsibility of nursing education. Stories and other similar educational methods have great promise in helping nursing students develop these “habits of thought” (Tanner, 2009, p. 300).

Ironside (2005) promoted narrative pedagogy, or stories, as a way to encourage students to think in the context of nursing practice. Many kinds of narrative pedagogy are found in the literature, including stories, debates, case studies, and simulations (Tanner, 2009). All these teaching methods meet a set of principles of best practice:

- Learners as active agents
- Opportunities to reflect on own thoughts and actions and how and why these actions achieve certain ends
- Collaboration among learners including students and faculty members
- Staged learning where complex learning is built upon basic concepts

This research study demonstrates that storytelling meets each of these principles of best practice.

In sum, the nine nurse educators in this study are convinced that the use of stories in the classroom and clinical area is a sound teaching methodology to help students to learn the science and art of nursing. Each is motivated by the passion they feel for the profession of nursing. Each closely holds their responsibility as gatekeeper to the profession of nursing and works tirelessly to instill the passion they feel into each student encountered. The passion each educator feels toward the profession of nursing is evident in each story shared and they each
hope to instill this gift of passion onto their students. Stories are one of the medium for this boundless passion, ultimately leading to student learning.

In closing, a story from a nursing collection is offered to demonstrate the power of listening to a story and the profound affect a nurse can have on a grieving patient (Ramos, 2006).

Monday morning, I had not worked the weekend, as had many of my co-workers. The shift began in the report room as the tape played information about each patient. The report of one patient played something like this: “Patient angry and critical of staff. Always coming to nurses’ station demanding something, yet doesn’t want to comply with treatment.” As I listened to this, I heard a deep sigh from the other nurses. I thought they had probably had a tough weekend and were not up to dealing with a complicated patient today. I volunteered to trade one of my patients for this patient if the charge nurse agreed. I went from room to room greeting and assessing my patients. Finally, I came to 306B and entered the room. Before I could introduce myself, 306B was telling me how bad the night shift has been to her, and the PM shift before them was just as bad. She said she could not get anyone to listen or help her. I stood there and let her tell me every negative thing she could come up with. When she stopped, I said “hello” and told her my name and that I would be her nurse today. I straightened up around her bed and bedside table as I talked to her about her pain, breathing, and so on. I asked her if she would mind sitting on the side of the bed so I could listen to her lungs. I could feel how tight she was holding herself. I asked her if it would be alright with her if I rubbed her back. She agreed. I got some lotion and began to massage her back. As I did this, she began to tell me about her mother. She said the last one to massage her back had been her mom, who had died within the last year. As she spoke, she cried, and as she cried she began to relax. She continued to tell me about her mom and the special things she has wanted to remember about her. I spent about twenty or thirty minutes rubbing her back. When I finished, she was in an entirely different state of mind. She said she felt so much better. I left the room. Sometime later, one of the other nurses said 306B had gone to the nurses’ station to apologize for being cranky and disagreeable. Later, her doctor asked, “What happened to 306B? She says she’s ready to go home.” I learned an important lesson that day from 306B. I learned that sometimes a bit of simple nursing can go a long way. Listening can sometimes be the best medicine you can give someone. Later that day, I found out that 306B’s mother had died in this hospital and on this same floor. It made sense to me that she was anxious and demanding without having the skills to explain why.
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Appendix A

Potential Participant Letter

Dear Nurse Educator:

I am a nurse educator and a doctoral student at Bowling Green State University, Bowling Green, Ohio and am looking for participants for a qualitative research study that I am conducting for my dissertation. You have been identified as someone who uses storytelling as a way of helping students to learn nursing content. The purpose of my study is to identify the experiences of nursing faculty with the development of stories and the use of storytelling in the classroom and in the clinical area. I consider a story to be an account that is based in your clinical experience, is deeply true, and is so engaging that listeners feel they have a stake in the story. For this study, storytelling is the process of creating a relationship around which the details and facts of a story are weaved in a way that the story comes alive. Research shows that this is a method that can increase understanding of complex material.

Though clearly voluntary, your participation in this study is very important and can help other nurse educators to better understand and utilize storytelling to help nursing students to fully comprehend the many complex topics in our field. I would like to interview you related to your use of storytelling. Participation in this study will require about 2-3 hours of your time for the initial interview, and there may be subsequent interviews requested to follow-up on any issues that were not clear to me after the first interview. These follow-ups will be brief, approximately 30 minutes, and can be accomplished by phone, by email, or in person. You may answer only the questions that you choose to answer and may stop the interview at anytime. You will be given an opportunity to read transcripts of the interview and my interpretations of the interview. I assure you that your responses to my interview questions will remain confidential. If you are willing to
consider participating in this study, I would ask that you complete the questions below. These questions should take only a few minutes to complete.

1. Name__________________________________________________________

2. College/University _________________________________________________

3. How many years have you been in nursing education? _________________

4. What is your area of clinical practice? _________________________________

5. Have you used storytelling as a teaching tool in the classroom/clinical area? _______

6. Are you interested in participating in this study?        Yes ☐    No ☐

If you would like to participate in this study, please indicate the best way to contact you and a good time to do so. Please highlight or circle preferred method of contact.

Phone: (H)__________________ (W) ___________________ (Cell) _____________________

Email: _______________________________________________________________________

Best time to contact:____________________________________________________________

You may email this questionnaire back to me at susan.sochacki@utoledo.edu, or return it to the address listed below. Please contact me by phone (419-261-3112), or email if you have any questions. You may also contact Dr. Robert DeBard, my dissertation faculty advisor, Department of Higher Education and Student Affairs, at rdebard@bgsu.edu. Thank you in advance for your assistance, and I look forward to working with you.

Susan Sochacki, MSN, RN
Doctoral Student, Bowling Green State University
Appendix B

Informed Consent Form

Investigator: Susan Sochacki

Title of Study: The Use of Storytelling in Nursing Education

I have been informed that this study will explore the experiences that nursing faculty have in developing and using storytelling as a method to help students learn nursing content. Data will be collected by interviews, observations, and document analysis. Interviews will be scheduled at a time and place that is convenient and will last approximately 2-3 hours. I have been informed that I will be asked to respond to interview questions. I agree to have my interviews audio taped. I also have the right to stop the taping or not answer any questions during the interview for whatever reason without any penalty. I have also been informed that follow-up interviews may be requested to clarify any information from the first interview, and that may be accomplished by phone, email, or in person. This follow-up interview will last approximately 30 minutes if it is needed at all.

There are no anticipated risks associated with this study greater than those encountered in normal daily life. There is a potential risk of inconvenience to me, and scheduling the interviews, observations, and document analysis at a time that is convenient for me will control this potential risk. A benefit of this study is that I might obtain an expanded or new understanding of my experiences as a faculty member in the use of storytelling as a teaching strategy.

All information will be kept confidential with only the researcher, the peer reviewer, and the dissertation chairperson having direct access to the data. Confidentiality will be maintained by a coding system of pseudonyms for all participants to include institutional affiliation. Only the researcher will have access to the code. I have been informed that I will be given drafts of my case report and the analysis for clarification and input. I have been informed that I may be quoted but my confidentiality will be maintained. I will be given a final report of the study.

My participation in this study is strictly voluntary. I may stop the interviews or observations at any time. I have been informed that at any time I may withdraw from the study for any reason without any repercussions in my relationship with Bowling Green State University or the nursing program within which I teach.

Susan Sochacki can answer any questions about my participation in this study at 419-261-3112, or email susan.sochacki@utoledo.edu. Questions or issues regarding this research study may be discussed with Dr. Robert DeBard, Faculty Dissertation Advisor, Department of Higher Education, Bowling Green State University; phone: 419-372-9397 or email: rdebard@bgsu.edu. For questions or concerns about my rights as a participant in this research I can contact the Chair of the Human Subjects Review Board at Bowling Green State University at 419-372-7716 or email: hsrb@bgsu.edu.
My signature indicates that I have read the information provided above and I have agreed to participate.

Researcher _________________________ Participant ______________________________

Date ______________________________ Date ____________________________________
Appendix C

Questions for the Interview- Only a guide

Introduction

Purpose: To give you the opportunity to describe your experience with storytelling as a way to help nursing students to understand nursing content.

Interviewing: Four to five other nursing faculty

Confidentiality: Nothing you say will be identified with you personally or your institution

Taping of interview: So that I do not miss anything you say

Turn off the recorder: You may ask me at anytime to turn off the recorder

Questions you do not wish to answer: You may refuse to answer any question at any time with no penalty at all to you

Questions: Please feel free to ask me any questions as we proceed through the interview

I would like to begin with a few questions about your past experiences

• What inspired you to become a nursing educator?
• Tell me about your experiences with storytelling in nursing education.
• How did you discover the use of storytelling as a teaching and learning process?
• Have you ever taken a class where the instructor used storytelling?
• What was that like for you as a student?

Experience with Storytelling

• Could you provide an example of a story you have used and explain how you know it has been effective?
• How do you prepare to use stories? Are they researched or spontaneous?
• How do you decide what content best fits storytelling?

• Have you found content that does not seem suited to storytelling?

• What learning outcomes do you hope for when you use storytelling?

• How do you assess these learning outcomes?

• What has student response been to your storytelling?

• How has student feedback impacted your use of stories?

• How do you decide when to use storytelling?

• What challenges did you encounter in delivering stories in the classroom/clinical area?

• Would you be willing to allow me to listen/tape your delivery of a story in the classroom?

Thank you so much for sharing your experiences with me.

Transcribing this interview and developing a case report which I will be asking you to read for your input and comments.

Another short interview to clarify or ask new questions which emerge as I analyze the data.

Thank you again!