15

Telling Tales: Creating a Space for Stories in Practitioner Education

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This chapter will consider the importance of storytelling as a creative medium in teaching and learning about practice. Beginning with an overview of why stories matter, the chapter will consider some elements of storytelling and reasons why this might be a good way to learn about values. It also considers the re-emergence of stories as a teaching and learning tool when values are in the spotlight. Drawing on author experiences of being a discipline lead in the United Kingdom, working with multiple universities and working internationally on using stories in technology-enhanced learning, the chapter will briefly consider some of the ways in which the teaching and learning community creates spaces for stories to be told and heard. It will then consider one particular interdisciplinary programme case study as a way of exploring the work of stories and the importance of stories in promoting connections and interconnections which support and enable learning and sharing examples of the approach used to enable disparate groups to learn together.

Stories are all around us. From early childhood, we are encouraged to tell stories about ourselves and others as a way of understanding the world. Even the smallest of conversational cues: '*How was your day*?' begins the process of unleashing the thoughts within ourselves and the unfolding story of our lives. Stories often begin with the most interesting thing that happened, and experiences are then sorted shaped and moulded into an account which tells of the perspectives and priorities of the teller and listener alike. Good listeners tend to evoke more detailed and nuanced stories. Their body language, vocal cues and comments give room for expansion, sometimes even embellishment. Most people enjoy being in the company of a good listener. It is good to have another person attentively and actively listening to part of your story, it is valuing and life affirming, but we notice it most by its absence, in the cues which are not followed, the opportunities for expression which lie fallow.

In health and social care, the telling and receiving of stories is fundamental to practice. If we do not learn to listen to the stories people tell, then valuable knowledge is lost to us. Knowledge makes us more effective practitioners, so learning to listen is fundamental to learning to care. The Francis Enquiry (2013) into the events at the Mid Staffordshire Hospital Trust (UK) led to a re-evaluation of the prioritisation of skills and values in the National Health Service (NHS). In an era when people, including students, are surrounded by information, the challenge is to find a way of embedding human values into education programmes. Storytelling is one way in which learners can be

encouraged to reflect on their own responses and values, the underpinning issues beyond physiology and disease, to consider the lived experience of the patient and his or her carer, and also the lived experience of the practitioner, who is exposed to the difficulties and challenges experienced by others in a way which may be totally dissimilar to anything they have ever experienced before.

For two years I (Dawne), was privileged to hold a post which enabled me to visit most of the universities in the United Kingdom and to talk to practitioners about their work as educators. I had a plan to follow and particular support to offer, but a pattern emerged which shared some commonality across visits and involved the unscripted sharing of stories. At some point during the visit, either after or between the 'planned' part of my visit, we would find ourselves in some more informal setting over a lunch break or a post-meeting cup of tea, and people would begin to share information about themselves. They would begin to tell me about their journey into teaching or the experiences which had been a catalyst for their development as a teacher. Often they would then foray into stories about practice, stories about the issues and feelings that had propelled them towards teaching. Some were stories of escape from situations they found difficult or stressful, but the majority were about the patients and carers who had impacted on their lives, and the desire to improve outcomes for patients by influencing learners.

Sometimes I would, when prompted, share stories myself about practice, often in response to questions about why I was engaged in supporting teaching and learning, and what had motivated me to accept the role. Over and over again in different settings people became animated when listening to or sharing stories. I noticed that at a time when the image of the caring services was coming under pressure due to the publication of government reports into standards, that one way of coping with this as a member of staff was to reflect on positive elements and experiences of care and to find a way to articulate these. Sometimes such stories were humorous, touching on how it feels to be inexperienced and to need to expose the vulnerability that comes from lack of knowledge in order to learn. I lost count of the times that someone said to me, that students liked the stories about when staff felt vulnerable or even when things did not go according to plan, as they can identify and learn from the honest accounts of others, finding it easier sometimes to identify with the feelings of inadequacy that come from needing to know lots of new information at once and feeling the vulnerability that comes from worrying that the paucity of one's underpinning knowledge may be easily exposed.

I learned, or rather relearned, sitting in classrooms and staff rooms across the United Kingdom, the importance of finding the space for telling and hearing stories and the importance of the work that storytelling does in education. I reflected on the importance of seeing oneself as a 'teller of stories', someone who recognises the way in which others identify with a good story. Even in popular media the general public identify closely with stories about care. How else could the popularity of programmes based on the narratives of Jennifer Worth (*Call the Midwife*) or

James Herriot *(All Creatures Great and Small)* be explained? That such stories capture the imagination is evident at University Open Days, when potential students discuss the influence of these narratives, but the challenge for educators comes in finding a way to translate stories into education and discussion into reflection on values.

So, we begin with the recognition that we all have a story to tell even if this is the first time we have done something like this, that our story is just beginning, and also that we can learn from the stories of others. We can go back to the early culture we shared of making sense of the world through stories and reflecting on the ways events 'hold together'. We can learn about how stories begin, which is the important factor, what becomes the subject or point of the story and why does it matter? We can then consider the art of storytelling – what makes a good story? Whether listening to a practitioner tell of their experiences in practice, or a service user sharing about their lived experience, or a student telling a story about beginning the journey, there is an awareness that there is a way of telling a story which resonates with others.

It seems to me that authenticity rather than storytelling talent is the key, but being able to tell a story with different dimensions, to take the listener with you into that place where the story occurred, is a key skill of storytelling. Primo Levi (1959, p. 175) cites this powerfully in his narratives about his life: '*We must be listened to: above and beyond our personal experience, we have collectively witnessed a fundamental unexpected event, fundamental precisely because unexpected, not foreseen by anyone. It happened, therefore it can happen again: this is the core of what we have to say. It can happen, and it can happen everywhere*'. So learning from stories is not just learning from facts, although that is important, but there is also an element of a story 'well told'. Art Frank (2013, p. xi) states, *'suffering needs stories: to tell one's own story a person needs others stories. We are all, I realized, wounded storytellers'.*

Creating a space for stories

Everyone to some extent is a repository of stories, albeit the stories of their own life and experiences. Some people can paint a picture, and others can paint a picture with words. The key is not really in how a story is told, but that the story is found, amongst others in a repository, and is brought to the fore to be shared and explored collaboratively. Key to telling a story are understanding that there is a story to be told and being aware of one's own skills and knowledge. Confident storytelling is about recognising the point of the story and being confident that the story is worth sharing. As we journeyed throughout the universities of the United Kingdom, it was clear that there is much evidence of the space for stories to be told and heard. There are many settings for stories and many styles of storytelling, both conventional and alternative. In 2012, the UK Government published a consultation document on decision-making, 'No Decision about Me, without Me'. In many universities this approach reinforced an existing desire to include the patient voice in education for health and social care. Service user engagement is well established

in the United Kingdom, in some settings more than others. The different levels of integration have been described as a spiral of service user engagement, which draws on the Ladder of Engagement (Tew, Gell, & Foster et al., 2004), which ranges from little involvement to full partnership, to an exploration of the ways in which service users can be involved in education. Stories are a part of this process, and many universities have established service-user and carer communities which work in partnership with academic staff and students to develop, deliver and assess learning, including the use of personal stories and case studies in education.

Figure 15.1 Spiral of service user impact

Service users and carers are engaged in telling their own stories rather than having stories told about them. It is important that people are encouraged to 'speak' rather than be 'spoken for', whether as learners or service users. Face-to-face stories are often shared in classroom settings, where a service user directly addresses a class in a formal or informal way. These stories can take the place of interviews or narratives, small group work or discussions, and are valuable to students, not just in terms of listening but also in terms of finding their own voice, be it asking questions or sharing their own experiences. There are other ways of bringing this experience to learners. Some colleagues in higher education use Skype to engage service users who are living at some distance from the university, or who feel unable to attend a session, or those who find speaking to groups of students in person daunting. Some institutions have ' human libraries' which operate as an ordinary library does, only the 'books' are people with different health experiences, and the borrower checks out a 'book' for 30 minutes to explore a particular pre-arranged theme. There is a set of rules for engagement, and topics are advertised in advance. The 'human libraries' began as a way of addressing stigma with the general public, but have proved a good way of connecting learners with service users and allowing them the space to share and listen to experiences.

Digital stories incorporate a range of words, pictures, narratives and sometimes music to enable a story to be told using digital media. Using digital stories can be a powerful medium, as a product is created which can be accessed multiple times in different settings. Digital stories are not just a collection of words and images. They do have a story line, and participants work on developing an idea or focus and then creating an unfolding plot so that the story has a beginning, ending and a central theme. Using digital stories is a powerful tool for learners, particularly when the stories are formulated in workshops, where they work alongside service users and carers. Digital stories provide a route for expression and engagement, but can lack the interactive element of real-time storytelling.

Online stories can be more interactive. Work with one university involved an online forum in which housebound service users were able to interact with learners and share their stories and experiences. This particular innovation led to other work on blogs, reflective logs and even a petition which gained thousands of signatures to effect a challenge to changes to disability welfare benefits. In this instance an innovation which began as sharing a

story led to a much wider impact. Creating a space using technology where people form a community online can be very challenging, due to technical difficulties and timing, but can also be a very rewarding experience, as it has the potential to bring into one space, people who would not usually meet. A similar project with retired practitioners (which began as a history of nursing project) was also useful in allowing people to share stories which can enable reflection on practice and also the ways in which people cope with change. Online stories also enable sharing between different geographical locations and enable learners to listen to stories which may be very different to the ones that they hear around them. A project linking service users and carers from rural areas with those from urban centres underlined to students the differences in provision of services and access to services in different parts of the country. Stories told in this way also enable sharing across national boundaries and working intercontinentally, thereby enabling learners to understand the way in which other health services operate. (Gurbutt et al., 2015)

Participation in different activities can also highlight that the ways in which we tell and receive stories may differ according to learning styles (see Honey & Mumford, 1989) and also confidence in using language (important for learners whose first language is not English). Sessions with service users and learners working on storytelling using images, including comic strips and storyboards, collages, fabrics and patchworks, have all illustrated the benefits of employing shared goals and team activities to convey messages and stories around care experiences. One presentation involved a service user's explaining what it is like being confined to an Intensive Care Unit (ICU) bed. They made use of textiles and materials to demonstrate how fabrics marked the parameters of their world (delivered in an environment dominated by a bright light to simulate the experience of being in the ICU environment and how this heightened other senses).

On another occasion I recall being invited to smell the scents associated with infancy (baby powder and baby soap) as an adjunct to a mother's story of losing her child as a result of Sudden Infant Death Syndrome (SIDS). Other memorable sessions involved the use of photography. One student showed the group images of a client's front room on different days, using photographs only of the windows and the curtains, explaining that the extent to which the curtains were pulled back in the morning either facilitated or limited the view of the bed-bound occupant of the room. A small act such as drawing the curtains back fully meant that they had a full view of the street and anyone standing at their own front door, while partially drawn curtains limited their view until the next carer called. Sometimes a picture is more powerful than many words. The feedback of the group as they left the classroom was that they would '*always look at the curtains now before leaving anyone alone*'.

Research projects also benefit from an understanding of the place of stories, and in particular that stories are sometimes told through silence as well as words. Working on a research project on SIDS (Gurbutt, 2007) provided a focus on not just the accounts of mothers whose babies had died, and the stories they shared of the event and the days

that followed. But the research also illustrated powerfully the other stories that circulate and which people have to navigate – the stories society tells itself about loss and bereavement, the 'horror stories' in the press, and the burdens that the stories the media choose to tell, place on others. Hence storytelling can be about the individual or the bigger narratives which circulate in society. Neither is storytelling static. Stories evolve over time, become edited as the listeners show interest in some aspects and not in others, lose some detail and gain other detail as the story is told and retold. Audiences impact on stories, and it is evident from the feedback of service users and carers following contributions to sessions that often no two sessions are at all the same.

A case study of storytelling

The remainder of this chapter focuses on a particular storytelling initiative which was devised to support the development of interprofessional learning at the University of Central Lancashire. Interprofessional education occurs when '*two or more professions learn with, from and about each other to improve collaboration and the quality of care'* (http://www.caipe.org.uk). This forms the basis of the definition used by the Centre for Advancement of Interprofessional Education (CAIPE). Interprofessional or collaborative learning of this kind is a worthwhile endeavour, but it is notoriously difficult to achieve within the confines of departments of health and social care due to the pressure on time and the requirement of professional bodies for placement and work-based learning. The validation of new programmes and the emergence of new provision provided a catalyst for change

The challenge was to bring a group of health professionals together in the first year of their course to share learning and experience, with meaningful learning outcomes for each group of participants, alongside the timetable constrictions with each group's being engaged in placements and work-based learning and having different fields of knowledge. One group, the medical students, would be comprised completely of overseas students. From initial meetings with colleagues from another department, it was clear that the most accessible way of achieving this was through stories. We began by thinking about the stories we felt needed to be heard and then considered the ways of telling them.

Our first scenario was based on an 'emergency case study' following a 'patient' on a journey through the Accident and Emergency department. There is obviously the account of the patient, and that is the central story to be told, the focus for the students and their learning about the lived experience of the condition or disease. But there are other stories too, interwoven around the patient, other issues that the students needed to be aware of and other people who can add perspective and depth, telling different, but contributory stories about the experience. There is the carer, the driver, the paramedic, the receptionist, the triage nurse, the emergency department staff, the doctor, the staff conducting any tests, the relatives at home – each person with a story to tell, each one with a 'bit of the jigsaw' to contribute. As one group of students are all from overseas, there were other stories or narratives to be told too. '*What*

does the emergency department look like in a UK setting?' 'How does the system operate?' 'How does someone access it?' 'How does the environment impact care?'

This raises other issues for the story teller(s) too. Putting oneself in the place of the 'other' as a storyteller, means that the story must be told in a way which can be understood by the reader or listener. Telling stories about a particular medical setting includes using words which may not be familiar to a speaker of English as a second language – careful use of words is important, so that the story is unambiguous and well told. A glossary might be helpful in identifying words which are new to the hearers. (This can be useful to British students too, when unfamiliar or technical language is employed). Telling such stories can also include images, sounds and collages to represent and convey complexity.

Then there is the context to consider: how to inform learners of the 'narratives' which surround the story which is to be told. This could include narratives around policy, how the health-care system operates, changes in the system and the catalyst for change. There is also the narrative around 'health' to consider and the challenges facing practitioners in a given area, the socio-economic determinants of health, lifestyle effects and cultural issues.

Unpacking the various components of the story revealed a case study embedded in other stories embedded in a narrative. There was a web of stories, complex and interwoven, and yet each important in the understanding of the key story, in short, a story reflecting life. There are multiple places in which such a collection of stories can begin. The focus of the main story was the 'service user' – so this was the central story to be told – told in person by the person themselves. This was selected as the centrepiece – the 'class based' story – related to all the students simultaneously, with the opportunity to discuss issues and ask questions, and to be interspersed with group activities (some based on pre-session learning) in order to prompt reflection, a discussion on decision-making or a consideration of ways in which care could be improved. Such an approach necessitates preparatory work with the person telling the story – stories about times of anxiety, pain and uncertainty can affect the teller as they are retold and support is needed in framing and delivering the story, but also in the opportunity to debrief afterwards. Comensus, the service-user engagement group at the university, has developed processes and strategies to offer this support.

The other aspects of the 'case study', the other stories, needed to be presented to the learners too. But this need not necessarily be within the confines of the classroom. It was decided to utilise the 'flipped classroom'. The flipped classroom is a method by which '*students cannot passively receive material in class, which is one reason some students dislike flipping. Instead they gather the information largely outside of class, by reading, watching recorded lectures or listening to podcasts*'. This is described as '*an inversion of expectations of the traditional college lecture*' (Berret, 2012). Tucker (2012) highlights the importance of the videos and other tools used in flipped classroom situations being controlled, monitored and of sufficiently high quality as learning resources. The imperative

for students on the programme was engagement with narratives and stores. A model was devised to facilitate the flipped classroom but also to enable learners to differentiate between the types of stories being told.

Figure 15.2 A model of the flipped classroom used in storytelling

This included three flipped classroom sessions, and each session was scheduled to last for 30 minutes. The first one concerned policy, specifically a timeline of policy in the United Kingdom relating to provision of emergency health-care, an overview of current issues and a brief explanation of how the system currently operates. This was presented with visual elements and a voice-over by a member of the teaching team. The second flipped session was a series of two digital stories. The first was a patient's-eye view of the journey to the hospital, offering an insight through pictures and images of the surrounding geography and the location, the sense of immediacy of the journey and the images of triage and reception. This was accompanied by another digital story of the 'other side' of the desk, including images of the triage board, the number of patients waiting to be seen, the constant arrival of patients and the updating of information, and conveying a sense of the 'competing priorities' of the unit. The third flipped classroom session took the form of a series of 'talking heads' short video clips from other participants: the carer talking about how it felt to accompany a relative to the Emergency Department; a doctor and Emergency Department nurse reflecting on the shift and work in an Emergency Department; and a short clip from other staff (a paramedic, a radiographer in the X-ray department, a lab worker, the plaster room technician and a member of the cleaning staff).

The flipped classroom stories were then utilised within the classroom session, not in their entirety, but as prior learning that the students could draw on in order to contextualise the story related by the service user and to stimulate questions. The desired learning focused on not just the clinical and interprofessional elements of the case study but also on the lived experience of the service user. This approach provided students with the opportunity to access material in their own time, but also to understand the interrelationship between different aspects of the narrative and the context, to understand the lived experience of the service user and also to consider the issues which drive this experience, and the actions which could change the lived experience for the patient. This is brought together in the classroom session – facilitating learners in listening to the accounts of others, contributing aspects of their own accounts and situating these within the wider narratives. The final flipped classroom session is for students to reflect on the session and the complete package of learning, using questions and activities as prompts. They are encouraged to think about their learning and also what they have learned in order to understand the subject further, but also to understand more about how they learn.

Stories and storytelling are very important in health-care. The way in which stories are told matters, as does the language which is used for narrative work. Traditionally health-care practitioners have spoken of 'taking a medical history', but this process may be very different to 'receiving a medical history'. Communication skills are important if

the necessary information is to be obtained with the patient feeling that they have been able to tell their story and that the practitioner has listened to their story. In terms of clinical decision-making skills, this is part of 'knowing the patient', described in relation to the professional's approach to care, blending different types of knowing as a person to be understood, a 'condition' to be managed and a person needing professional intervention (Gurbutt, 2006). In research undertaken with nurses working with service users in both the United Kingdom and Canada, the way in which they expressed understanding of the service user was dependent on the story, or narrative, that they developed in their minds. These stories integrated a range of information types from different participants in the care situation. Some nurses majored on particular aspects of their role at different times, and this mediated the selected part of their story of knowing the service user that they discussed to serve a particular purpose (such as proposing steps to address an identified issue).

What is important here is the everyday practice of decision-making, of making sense of a situation with another person, and the information that is attended to when listening to a service user, observing them and triangulating that story with others to verify developing impressions and the labelling of emergent issues. If the service user is apart from such decision-making, or their story is dismissed, or for whatever reason their communication is not attended to, then decisions will inevitably migrate towards professional centric perspectives. In such cases there will be a departure from the ideals of shared decision-making and 'no decision about me without me'. Stories therefore remain central to developing ways of knowing the service user and so must be a part of professionals' thinking. Stories are important in health-care, whether it be knowing the patient or being able to use accounts to 'blog for a change'. Practitioners need to learn how to listen to stories and to 'see the patient' in a story and not just the condition. They also need to learn how to tell a story – to those who provide resources and to learners who need to understand, and to use words effectively with patients and carers.

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