Narrative Works

Becoming a Nurse
Stories of Vulnerability

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Volume 7, Number 1, 2017

URI: https://id.erudit.org/iderudit/nw7_art01

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Publisher(s)

The University of New Brunswick

ISSN

1925-0622 (digital)

Explore this journal

Cite this article

Jacobsen, F. F., Søvik, M. B. & Synnes, O. (2017). Becoming a Nurse: Stories of Vulnerability. *Narrative Works*, *7*(1), 1–20.

Article abstract

This article sets out to analyze written stories of nursing students focusing on challenging situations from clinical practice The analysis involves looking at how the stories present various versions of being and becoming a nurse. On the one hand, this calls for an examination of what is found in the stories, narrative structures, linguistic devices, word choice and so on. On the other hand, it implies looking at what is not found by reflecting on notable absences from the stories. The analysis underscores that vulnerability is a prominent feature of these stories. The article stresses the importance of honouring the stories while at the same time advocating the use of narrative pedagogy to put the stories in a larger context and thus develop the student nurses' narrative resources.

NARRATIVE WORKS
Issues, Investigations, & Interventions

Becoming a Nurse: Stories of Vulnerability

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This article sets out to analyze written stories of nursing students focusing on challenging situations from clinical practice The analysis involves looking at how the stories present various versions of being and becoming a nurse. On the one hand, this calls for an examination of what is found in the stories, narrative structures, linguistic devices, word choice and so on. On the other hand, it implies looking at what is not found by reflecting on notable absences from the stories. The analysis underscores that vulnerability is a prominent feature of these stories. The article stresses the importance of honouring the stories while at the same time advocating the use of narrative pedagogy to put the stories in a larger context and thus develop the student nurses' narrative resources.

"When I look back I think in fact that I did a good job. Yet, the words of the daughter remain with me to this day, several years after. As a small notch in the gramophone record." These are the final words of a story told by a nurse enrolled in a post-vocational study program in a Norwegian university college. She has practised as a registered nurse for several years after finishing her bachelor's program in nursing, and has become an experienced professional. Her story dates back to when she had newly graduated from nursing school, and an occasion when the daughter of a terminally ill man expressed distrust in her skills as a nurse. Why is her experience still haunting her? More generally, why do experienced nurses tell similar stories of "notches in the gramophone record" due to experiences that date back to their nursing school period or as newly graduated nurses?

This article does not intend to analyze the thematic characteristics of nursing students' stories, but will argue for how these stories can help us understand how nursing students or registered nurses construct, configure, and reconfigure themselves through narrative. In the analysis we are inspired by Arthur W. Frank's (2010, 2012) dialogical narrative

analysis which is concerned with how stories shape people's sense of self and how they are positioned in groups. An overarching research question we pose with regard to these stories is: "What resources shape how the stories are being told?" (Frank, 2012, p. 44). According to Frank, narrative resources are intrinsically bound to the stories that are already circulating in the environment and which will shape the character types, plot lines, genres, etc., of the telling of new stories. Related to the issue of resources are questions of voice: what multiple voices do we hear in the stories? Do they merge with or oppose each other? (Frank, 2012, p. 33). By looking at the narrative resources, including the different voices that are heard in the stories of nursing students, we believe that the analysis will offer important glimpses into the meaning constructions that are present in the processes of becoming a nurse and how these meaning constructions are shaped by the context and setting of the students. We have chosen to work with personal narratives, since they represent a manageable way of entering into complex experiences, situations, and activities (Bruner, 2002; Riessman, 2008). In this article, we present a narrative analysis that highlights both what is told in nursing students' stories and what is not explicitly there.

The nurse quoted above was one of several Norwegian nursing students each asked during spring 2015 to provide a written story concerning a challenging experience from their practice. The students were instructed to focus on a particular situation, explaining in detail what happened and being specific about the time, place, and people involved. Thirty-six students provided stories; 19 were third-year bachelor's students while the rest were registered nurses in different post-vocational education programs. After we read through the 36 stories many times, we identified "becoming a nurse" as an overarching theme in the stories of both the bachelor's students and the registered nurses. Within this "becoming a nurse" theme, a strong sense of vulnerability was particularly apparent as an undercurrent in the material. When analyzing these stories, we were surprised to discover that there were no significant and apparent differences between the stories of the bachelor students and the registered nurses. In the presentation of the stories we therefore emphasize the span and variety in the material as a whole, not the difference in educational level.

Narrative Knowledge and Narrative Pedagogy: Theoretical and Methodological Considerations

Although several research publications deal with nursing students' stories of practice (e.g. Bradbury-Jones, Sambrook, & Irvine, 2007; Gunther, 2011; Sasso, Bagnasco, Bianchi, Bressan, & Carnevale, 2015; Thomas & Burk, 2009), few take a narrative approach. In most of these studies, the students' stories are analyzed according to thematic analysis and the findings are related to various concepts of challenges that the students encounter, for example, "moral distress" (Sasso et al., 2015), "empathic anger" (Gunther, 2011), "vertical violence" (Thomas & Burk, 2009), and "empowerment" (Bradbury-Jones, Sambrook, & Irvine, 2007). A notable exception is the research by Rees, Monrouxe, and colleagues in Britain, who analyzed many stories by nursing students, medical students, and other health care students using thematic, discourse, and narrative analysis (Monrouxe & Rees, 2012; Rees & Monrouxe, 2010; Rees, Monrouxe, & McDonald, 2015; Monrouxe, Rees, Endacott, & Ternan 2014). The research of Rees and colleagues is steeped in the narrative tradition of William Labov, and emphasizes not only the thematic content but also the narrative details of the "who, why, what, where, and when" of events. In their various analyses of nursing students' stories, Rees and colleagues underscore how the negative emotional talk is constructed in nursing students' narratives, resulting in emotional residue and an influence on professional identity development (Monrouxe, Rees, Endacott, & Ternan 2014; Rees, Monrouxe, & McDonald, 2015). They advocate that nurse educators should facilitate and help students in constructing emotionally coherent narratives for future development.

In this article, we present material from a Norwegian context that represents both nursing students and experienced nurses enrolled in post-vocational programs. Our particular use of stories to elicit students' stressful and challenging experiences from practice is founded on a conviction that working in health care settings requires "narrative knowledge." In her seminal book *Narrative Medicine*, Rita Charon (2006) emphasizes how medical doctors and health care workers need to encompass narrative knowledge to "understand the plight of another by participating in his or her story with complex skills of imagination, interpretation, and recognition" (pp. 9–10). Reading and interpreting the other and realizing that illness is always played out in relation to each person's life story is a fundamental competence. However, this also calls for a "narrative pedagogy" (Goodson & Gill, 2011) that emphasizes the

pedagogic encounter that takes place in the process of the construction and exchanging of stories, and how this is an important learning potential, not least for the development of professional identities in general as well as for medical doctors (Clandinin & Cave, 2008) and nursing students (Andrews et al., 2001; Brown et al., 2008). When analyzing the narrative resources that shape the stories, we specifically wanted to examine the narrative knowledge displayed; that is, how the student "reads" and interprets the patients and the various situations. At the same time, we also wanted to consider the narrative pedagogy of the stories—understand how narratives construct and define various versions of being and becoming a nurse.

The students' stories are *autodiegetic*, meaning that the narrator is also the protagonist (Genette, 1980). Furthermore, the stories are *autobiographical narrations*, which implies a real-life temporal difference between the narrator and the protagonist. This distance between an experiencing "I" and a narrating "I" enables the author to establish various attitudes towards one's earlier self (Löschnigg, 2008). One interesting aspect of the students' stories is precisely how the narrators interpret past events or challenging experiences and how these influence their present-day identities as nursing students or registered nurses, and thus might also influence their future professional identities. According to Phelan and Martin (1999), narrators perform three kinds of telling: reporting, interpreting, and evaluating. The students' stories illustrate the intertwining of these three levels in the texts and underscore the fact that stories are always related to ethics—by presenting one version among many based upon the events that are chosen for narration and by the interpretation and evaluation of the same events.

In the following sections, we will look at how the stories present various versions of being and becoming a nurse. On the one hand, this calls for an examination of what is found in the stories: narrative structures, linguistic devices, word choice, and so on. On the other hand, it implies looking at what is not found by reflecting on notable absences from the stories.

Strong Presences

A strong presence of emotion characterizes most of the stories. One student said, "I felt that I was surrounded by a thick fog of sensations," while another stated, "Our legs trembled and felt like jelly when the reaction came," after experiencing an acute and unexpected

medical incident. Yet another explained, after experiencing a lack of recognition from family, "I was taken aback and was in tears. I actually can still feel the lump in my throat as I write about it now. I feel I want to comfort the uncertain me."

While several words and concepts are notably absent from the stories, other words are very much present. This pertains not least to feelings and experiences. The expression "I felt/feel" appears 38 times, while "I experience(d)" is utilized 12 times in the stories. The word "difficult," mostly in relation to care situations, appears 17 times, "demanding" six times, and "frustrated/frustration" five times. Those charged words primarily relate to the narrators' own experience, and secondarily to dyads (self–patient, self–colleague, self–family member, self–administrator).

The stories naturally take a clear first-person singular voice from the perspective of an "I." That said, it may be worth noting that "we" and "our" occur 90 times in the stories, while "I," "me," or "my" occur 474 times, more than five times more frequently. The following story exemplifies the strong presence of emotions and the clear voice of an "I." The narrator was enrolled in a post-vocational program but looking back at when she was newly graduated from a bachelor's program in nursing. She was young at the time and frequently experienced patients' mistaking her for a nursing student or a nursing assistant, asking her things like, "please go get the nurse!" One day, she "decided to be more courageous" and "felt ready for new challenges." Listening to the advice of a colleague, "Marie," she decided to offer to attend to a "straightforward and nice patient," a man dying from cancer, his daughter sitting by his bed, a "perfect terminal patient for a novice like me":

> The doctor prescribed new medications that I administered. The patient calmed down and looked once more to be peaceful. When I was on my way out, the daughter stopped me. Daughter: "Excuse me for asking, but…" (pause). "What?" I said. Daughter: "No, well, I do not intend to be rude, but I think everything went so much better earlier in the day. Marie came somehow once we called and everything seemed to be under control...?" All the time while she talked she looked down at her handiwork, just glancing up a few times. She said something more after this, but I cannot recall it. Anyhow, *I experienced it as* an attack on me as a person and as a nurse. *Implicitly, she said that I was a worse* nurse than

> Marie and that she was not comfortable with me being for her father (…).
>
> *I later thought about if there was anything I could have done differently* and, not least, what it was that made his daughter regard me as worse than Marie. *I obviously displayed non-verbally that I was unsure*. The daughter's age and a new patient case made me especially alert. I was terrified but tried to hide it— *and thought I was* successful in doing so. *Perhaps* Marie managed to hide it better, or maybe even wasn't so unsure. *Maybe* she did a better job and that I deserved the criticism? *Maybe*. Instead, *I think it was* more the fact that the patient changed during the death process, and [it] is about [how] the patient changed as a result of the death process, and that was certainly beyond my control. *When I look back I think* in fact that I did a good job. Yet, the words of the daughter still remain with me to this day, several years after. As a small notch in the gramophone record (emphasis added).

Notable Absences

There may be several possible explanations for notable absences from the stories. Things that appear self-evident to the narrator and which are taken for granted are frequently left out (Jacobsen, 1998). Other things omitted may simply not be part of the horizon of the narrator (Labov, 1982), or not conceived as important (Mandler, 1984). There may, of course, be several other explanations, such as the exclusion of painful or very personal experiences from the stories.

The following story illustrates how contextual information is frequently taken for granted in the stories. While the previous story displays strong emotions, the following story is by and large characterized by a suppression of emotions. After briefly stating that the story is about a night on duty in a hospital ward, and presenting a quite lengthy description of a busy night on duty, the student goes on:

> Have to wake up a young man in a singular occupancy, move him and his bed far down the corridor in order for him not to witness what we are doing. Told him that we need his room because a patient's condition had become worse. Cover the dead person and roll him into the singular occupancy. The young man gets the bed no. 2. Wants to read a bit since he has been woken up. Bed no. 4

> cannot stand to remain in his room. He walks into the corridor and sits down. Gets something to drink. Chats a bit with him. He is anxious. The young man doesn't manage to go to sleep, and he walks into the corridor and sits down together with the bed no. 4 man. The bed no. 4 man tells him what happened during the night and about his anxiety. The young man talks about his job and everyday life. Chat a bit with them and go on to do unfinished work. Go on to call family members that I couldn't get hold of. Talked to the doctor. Mors care [care of the body after death]. Report and handing over work tasks to the day shift. I felt sad when I left my job. This was a "shitty" night on duty.

One could argue that the nightshift story above is predominantly steeped in a biomedical discourse. It is a detached, matter-of-fact, and almost stenographical description of the events where there is no room for personal involvement. Throughout the story, the narrator presents an objective, distanced, and descriptive version of the happenings on the nightshift. This distance is not least apparent in the characterization of the patients, where they are simply portrayed as "a young man" or even as the slightly absurd "bed no. 4." However, this distanced description also includes the narrator; we only get to hear about what happens, not the narrator's inner reactions or emotional responses to the dramatic occurrences. Not until the final two sentences do we get to hear the narrator's evaluation of the nightshift: "I felt sad" and "This was a 'shitty' night." It is almost as if the story's tempo mirrors the tempo of the nightshift—a description in present tense of events and tasks that follow each other with no room for inner reflections until the shift is over.

Interestingly, this story has a prominent report-like style, full of abbreviations and medical concepts. Moreover, it contains several examples of so-called *forceful features* (Grant & Marsden, 1988; Lamond, 2000), items of information functioning as key features that enable an individual to infer larger knowledge structures. Other researchers label such features as *triggering cues* (Narayan & Corcoran-Perry, 1997) or *identification knowledge* (Marshall, 1995). In a staff report meeting, forceful features may make the flow of communication easy and efficient, provided that all actors present are part of the staff community. For readers who do not share the relevant professional knowledge and experience, the story provokes several questions, like what does "bed no. 2" mean? What kind of care is "*mors* care"?

Absences may pertain to specific themes and aspects. For example, there is little mention of mastering technical skills; although advanced technical medical equipment is an element in some of the stories, mastering it is never at the forefront. None of the students mention aspects of wider contexts and systems of which they are a part, which means even the system of administration in their particular workplaces is not explicitly dealt with. Moreover, certain words and concepts may be notably absent. Interestingly, even though moral dilemmas and moral distress seem to be a prominent theme in several of the stories, such concepts as "moral," "morality," "ethics," and "ethical" appear nowhere in the stories. The students never use the words "right" and "wrong," and even the word "care" is merely mentioned twice.

Markers of Uncertainty: Morality and the Search for Moral Support

The first of the two stories is that of a humiliated young nurse. She has never come to grips with this incident, and it has haunted her mind ever since, like "a notch in the gramophone record." For her, it is difficult to understand how she could have been "a worse nurse than Marie." She adds that "we had a pretty similar basis; the same education from the same college, the same amount of time on the ward, and we were even a bit similar as persons."

The story illustrates a highly pronounced trait in several of the students' stories, namely markers of uncertainty. Words and expressions such as "if," "perhaps," and "from my point of view" occur frequently in the student narratives. Moreover, several sentences end with question marks, as in the story above.

The stories contain many examples of what literature scholar David Lewis (1973) labels *irrealis*, a framing device inviting the audience to take part in the narration. Irrealis is a grammatical device that opens up various possible interpretations, not by implying a judgment of what the speaker or narrator thinks is likely to happen, but merely by pointing to possibilities and opening up what may be labeled "possible worlds" (Gaik, 1992). Such irreales are typically marked by words and expressions such as "maybe," "it could be that…," and "if this was me, I would have…," the latter example implying a conversion of perspective. Irreales seem to be abundant in stories particularly concerned with morality and moral evaluations, such as those dealing with sickness, misfortune, and injustice (Good, 1994a; 1994b). Such stories may be

dealing with such questions as "Did I treat the patient with due respect?" "Did I do what I could for my sick child?" "Was my boss fair to me?" We find these markers of uncertainty in many of the nursing students' stories. A narrative in daily life is most often addressed to an audience (Gaik, 1992). In the above story, the humiliated nurse appears to invite readers to participate in her pondering and moral evaluation of what happened. There are almost no definite statements in her story. "Perhaps," "maybe," "when I look back, I think," and "I later thought about if there was anything I could have done differently" are examples of the abundance of markers of uncertainty.

Humiliating Experiences and Holding One's Own

Narratives are a strong device for reasoning about past unjust treatment. The question of what (really) happened is vital with regard to moral imagination (Johnson, 1985), moral evaluation (Jacobsen, 2012), and moral distress (Sasso et al., 2015). As Frank (2010) stresses, understanding stories requires asking what is at stake and for whom. The following story, written by a nurse in a post-vocational program, recalls a humiliating experience as a bachelor's student:

> I was [a] nursing student and practicing in a heart/cardiac department. After several weeks of practice, I had [achieved] good knowledge about cardiac arrhythmias and the use of telemetry. One morning, I was given the responsibility for a patient with atrial fibrillation; she had [a] high pulse [a lot of the time] during the night. In the morning, I went to say hello to the patient and registered vital signs, including manually measuring the pulse. The patient's pulse was 75/min at the moment and a bit irregular. I reported this to the nurse in the room together with the patient, and the nurse replied quickly and strictly that this could not be correct because the patient had had a high pulse the entire night. I was told to call Mio (the surveillance unit) to find out what this pulse "really" was. I experienced this as extremely humiliating, in particular because the patient noticed what happened. I started to doubt my own judgment and I thought that the patient would never trust me again. I called Mio and they confirmed that the patient had a pulse of 72 at the moment and had been relatively stable the last hour. I reported this to the nurse, who reacted only by saying "Hmm," and then she left.

This story concerns a humiliating past experience of a nurse demonstrating her power as the superior of the student by seemingly ignoring her. At the same time, stories are enactments of resistance. In the story above, the nursing student establishes a version of the past in which she is rehabilitated in her own eyes and in the eyes of the implicit reader as a trustworthy nursing student. As Frank (2010) argues, stories have the capacity for people of "holding their own" when encountering a threat to the value of the self. Several of the stories in the material can be read as attempts at holding one's own in the face of humiliating experiences. In other stories, we read of students who are not able to sustain a professional self. This is seen in a third story of humiliation in which a professional nurse dwells on a possible future and is unsuccessful in coming to terms with a past incident.

> I had practice in a cancer ward as a student on a post-bachelor's program. My contact nurse and I had a good working relationship and I felt that I learned a lot. When my practice was close to completion, I experienced a very challenging and stressful situation. I had to go on a shift with another nurse. When we had to discuss patient situations, I felt I had to defend my actions and justify them very thoroughly. Before this clinical training, I had had some work experience, and I knew what to do clinical. It became evident that whatever I said, I was wrong, according to this nurse. At the end of the shift, I felt very tired and frustrated, and I felt that, according to this nurse, I had no knowledge. A thought struck me that I had been treated as if I was a student on a bachelor's level. I shared this experience with my contact nurse. I then felt that I was met with understanding and empathy. To be met with an attitude of a person who has "power" in a situation and who is pointing toward what is "wrong" and has a top-down attitude is very challenging. I will bear this experience with me and remember it for a long time.

This story, by the highly suggestive last sentence, clearly points towards a possible future. We do not know, however, how she imagines the incident will influence her in the future. Neither does the nurse reveal to the readers why the positive experience with the contact nurse encouraging and supporting her made a less profound mark on her memory of the incident than the humiliating encounter with the first nurse. Her memory is a very painful one, summarized in the utterance that

"I had been treated as if I was a student on a bachelor's level." The humiliation, in other words, consisted of being downgraded and devalued as a professional. As in the two previous stories of humiliation, the story is characterized by expressions of strong emotions and markers of uncertainty. As in the two previous stories, this nurse takes part in a post-vocational program. Unlike the two other nurses, she has previously been enrolled in another post-vocational program, and her story relates to the trainee work element of the program. Like the two previous stories of humiliation, the story is characterized by expressions of strong emotions and markers of uncertainty.

Becoming a Nurse: A Never-Ending Story?

The bulk of the 36 stories concern personal experiences of being misunderstood, unfairly treated, or humiliated. Hence, the three stories referred to above are not unique, which triggers the question of why more of the stories do not concern the fate of patients, family, or other colleagues. Some of them do, but this is still exceptional. A possible explanation relates to the nature of becoming and being a nurse. Being a professional teacher, nurse, physician, or social worker involves more than being educated, technically skilled, knowledgeable, and experienced. The professionality involves dimensions of suitability related to who you are as a person and as a human being. Hence, judging oneself as a professional cannot be separated fully from assessing oneself as a person. Moreover, in contrast to teachers and social workers, the professional conduct of nurses and physicians relates to acute matters, to the life and death of patients.

We chose the three professional nurses' stories for a special reason. Even as the inseparability of being a professional and a person very much pertained to them as younger bachelor's students, why do incidents of humiliation and a lack of appreciation remain with them after many years of practice and many years of becoming skilled and experienced professionals? Why is the incident still a "notch in the gramophone record"? A possible explanation could be that their professionality, which by nature means intimate involvement with vulnerable receivers of professional services, will forever make the professional vulnerable in a way that will not be the case for most engineers, for example. Professional health workers will, to a lesser degree than other professionals, be able to state when they have offered everything that can be offered, and have truly done their best for the

patient (Vike, 2004). Moreover, they may never feel secure that they are skilled enough to deal with a given patient-related situation.

Another story, also written by a nurse in a post-vocational program, also relates to a traumatic incident "some years ago":

> In a hospital department, I had the responsibility for a patient with cancer. He struggled terribly with dyspnea. This happened some years ago so I don't remember all the details. He might have been in his 70s and had lived with cancer for awhile. His health had deteriorated over a few weeks, and it was not expected that it would turn. The end was closing in and dyspnea was his biggest problem. It had been like this a few days, but it had become worse now. It was so bad that he could not speak much, but he was mentally clear and alert and was able to express yes/no. We managed to uphold satisfactory saturation with an oxygen mask, but subjectively he struggled terribly with breathing. He visibly struggled to breathe. I cannot remember a possible reason, but that I was running back and forth and tried one thing after the other. Inhalations, morphine, diuretics, sedatives. Nothing helped. There was nothing the doctors possibly could do. I felt helpless and distressed since I could not help. It was obvious that the patient suffered immensely, he seemed afraid and distressed, and was probably terribly exhausted. I thought that there is nothing more medical I can do here. So I should stay here with him; perhaps that will make him less afraid. He had relatives, but they were not present now. I sat down by the bed, didn't say anything, I think, but took his hand. Then he pulled back his hand. Made it very clear that he did not want the care I tried to give. What a rejection! I still feel it strongly. I have never had such a strong feeling of being rejected before or after this, neither at work nor in private. It fascinates me. I think this has much to do with the despair and shortcomings of not being able to help, and by rejecting me the patient confirmed that I could not. Perhaps he didn't like me, thought that I behaved wrongly, that I did not do a good enough job? Or perhaps this was not personal. I cannot know. I do not remember what I did later that shift or how our relationship developed. But in that situation I left the room with a promise to come back soon.

In the unending process of becoming a nurse, this incident of being rejected remains with the narrator: "What a rejection!" she exclaims. Nevertheless, the narrator expresses that the happening "fascinates me," and that "perhaps this was not personal." To a greater extent than the three other stories, this story allows for the perspective of others. The expressed possibility and hope is that it was not "personal"; however, the word "personal" highlights the intriguing blurred boundary between professionality and person, and professionality and self, in the nursing profession.

An important element of the nurses' stories involves how their work performance relates to different possible audiences. They are almost continuously "on scene" (Goffman, 1959), where their acts and handling of a given situation are often witnessed by patients, colleagues, and, in some cases, by family. While a car mechanic, for example, may retreat "backstage" when doing the job, to a "back region … typically out of bounds to members of the audience" (Goffman, 1959, p. 124), this is not the case for nurses. Even though nurses frequently have their exclusive territory for compiling work shift reports, most of their performance is witnessed by audiences of various compositions. Indeed, several of the students' stories deal with the experience of being humiliated in front of patients or family.

Questions of Character

We began this article by emphasizing the need for narrative medicine and narrative pedagogy in health care. An important goal of narrative medicine is teaching health care workers and students how to understand the suffering other through their life-worlds and through an understanding of their life stories. Reading these stories detailing the students' interpretations of challenging experiences from practice underscores at least two points related to questions of narrative resources and character: *How are students characterizing themselves as the protagonist in the story?* and *How are the other characters presented?* We find it fruitful to look at these questions through English novelist and literary critic E. M. Forster's (1927) well-known distinction of characters as either "round" or "flat." According to Forster, round characters are multi-dimensional and complex; they can surprise us and have the capacity and ability to change during the course of narration. Flat characters on the other hand are one-dimensional and are often constructed around one particular characteristic or trait. Reading the

students' stories, it is apparent that the protagonists, meaning the students themselves, are essentially the sole round character in the material. The other persons in the stories are predominantly flat characters, where the experienced nurses often are portrayed through negative characteristics such as grumpy, nasty, critical, dominating, or abusive. At the same time, patients and family members are seen through clear-cut concepts as being demanding, depressed, anxious, demented, and so forth. One specific character trait becomes the whole person.

One might ask what a seemingly stereotyped characterization does to the students' own perceptions of what is at stake in the stories, and how one can act. Presenting the other persons involved in the stories as flat, no matter if they are positive or negative, might hinder one as a student to see possibilities for change. Naturally, it is difficult to draw clear conclusions from these short stories, and it might not be reasonable to expect overly advanced and complex character depictions. However, a similar kind of characterization is found in the stories of health care and nursing students in the UK, where the narrator often presents the characters through fixed roles as either hero (the student-narrator), villain (the mentor), or victim (the patient) (Rees, Monrouxe, & Ajjawi, 2014; Rees, Monrouxe, & McDonald, 2015).

At the same time, some of the narrators in our material manage to present patients as round characters, which gives the stories a more complex reality that underscores possibilities and potentials that might not be apparent on the surface. One bachelor's student writes about her practice in a nursing home, where she was assigned an older woman described by the staff as "difficult," "ungrateful," and "grumpy": "I learned quickly what they thought about the patient. But in my eyes, it was not as bad as described. If you met this patient with a little bit of humor, balanced with being there for the patient, it meant that her whole attitude changed." The student continues questioning the premise for the staff's descriptions of this woman and offers a different interpretation of the woman being difficult, namely the need for human contact and her suffering from anxiety. Through the student's eyes, the older woman is cast in another role than the one she is assigned by the staff.

As Jerome Bruner (2002) argues, the need for stories is grounded in the recognition of suffering people not just as patients but as human beings with *plights*. And as Rita Charon (2006) stresses, we need to enter the worlds of our patients, "if only imaginatively, and to see and interpret these worlds from the patients' point of view" (p. 9). Another apt example of imaginative interpretation is found in the story above of the student

who experienced the rejection of her hand when she tried to comfort the dying cancer patient. This could have made her unsure or made her feel humiliated, which might have resulted in her withdrawing from the situation. Despite admitting that the rejection is something she still feels strongly, it also fascinates her, and thus she starts a reflection in which she honours the struggle and plight of the suffering man. At the same time, she acknowledges the other truly as the *Other* when she reflects on his reasons for withdrawal: "I cannot know."

These stories offer a depiction of complex characters, which leads toward a moral obligation and engagement that is lacking in the other stories in the material. Casting the patient as a round character implies an opportunity to consider the infinitude of the Other and exemplifies Frank's (2012) emphasis on stories' potential as dialogical commitments.

Concluding Thoughts: Vulnerability and the Potentials of a Narrative Pedagogy

We opened this article by asking how Norwegian nursing students configure themselves in stories of challenging experiences from their practice and what narrative resources are prevalent in the stories. Our analysis underscores how much the stories are stories of *ethics*, revealing that becoming a nurse is a vulnerable and lifelong process; past experiences are very much part of daily life as a nurse, while at the same time the past may influence and implicate thoughts of the future.

The work of nurses, whether student, newly graduated, or experienced nurses, is characterized to a large degree by being on stage, with a continuously changing audience of important others, capable of praising, humiliating, ignoring, or being attentive to the nurse. Being a professional nurse blends into personal attributes and suitability as a person, meaning that threats to professional integrity may be experienced as threats to personal integrity. This threat is likely to be much stronger among students compared to experienced nurses, which is clear in the stories included in our analysis, where the threats to personal and professional identity by and large constitute a vulnerable protagonist and storyteller.

The vulnerable protagonist and narrator is clearly seen in the characterization in the stories, all of which involve a strong "I." The student nurse narrator is usually the sole round character in the material, while the other characters appear as "extras," portrayed as witnesses to the social drama with the student as the main character, or as agents

supporting or inflicting pain to the student. The "I" mostly appears as a vulnerable, and to some extent wounded, narrator, and strong emotions are explicitly present in the stories. The wider system involving, for example, local and higher-level administrators, is noticeably absent. This is a particularly interesting, or even critical, finding that is also evident in a recent PhD thesis on Norwegian bachelor's students' essays and curricula (Knutstad, 2016), prompting reflections on how nursing education might be too concerned with the nursing and patient perspective and less with the structural realities and limitations of health care. This underscores a lack of narrative resources that could expand the configurations of a lonely, humiliated nursing student at the mercy of patients and abusive nurses.

These stories raise important questions about becoming a nurse, questions that can be fruitfully seen in relation to the potential of a narrative pedagogy and an expansion of available narrative resources. How do we acknowledge the protagonist's and narrator's perspectives while at the same time realizing the possible openings in the stories that are not always recognized by the narrators? We suggest that these and other nursing students' stories need to be brought back to the students. The vulnerable stories of becoming a nurse need to be given a larger audience, not least for the students themselves, who are often mute and voiceless with regard to their difficult experiences. Supplying an audience for the stories of vulnerability might be another way of holding one's own, both for the present and the future. As Gjengedal et al. (2013) argue, vulnerability is an existential, contextual and relational phenomenon. They demonstrate how vulnerability always is a part of interactions between health professionals and their patients or patients' relatives. Even experienced health professionals feel vulnerable and how they deal with their own vulnerability in interactions with the other determines how well and ethically they meet patients and relatives. Gjengedal et al. (2013) identify two main strategies in relations between professionals and patients. When the professionals' own vulnerability becomes too prominent, the relation to the patient is impaired. However, by being sensitive to the patients' vulnerability, health professionals may act without letting their own experiences overshadow the vulnerability of the other. In the research of Thorup, Rundquist, Roberts, and Delmar (2012) nurses' personal experiences with suffering and vulnerability are conceptualized as a sore spot that may either help them better understand the patients' situation or that may develop into a blind spot in the relation with the patient. Hence, nurses need to have some distance to own

feelings and experiences—not to mix these with the patient's, and not let their own vulnerability overshadow that of the patient. However, we also share the concern of Bickhoff, Sinclair, and Levett-Jones (2017), who stress the need for the small but significant number of positive stories in which students actually manage to show moral courage in demanding situations. At the same time, the *narrators* are also restricted by the larger narrative discourses of health care and society. Which and whose stories are supported by the dominant discourses? We believe that by giving nursing students the opportunity to tell their stories, and giving them an audience and a critical environment where these issues can be discussed, we can provide a foundation upon which their vulnerability can be honoured, while at the same time allowing for an enhanced understanding of the limitations and possibilities of the processes of being and becoming a nurse.

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