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FINDING MEANING AND SENSEMAKING IN HOSPITAL NURSING TEAMS: THE PROMISE OF NARRATIVE MEDICINE

by

Shelley J. Bobb, B.A., M. Div., S.T.M., M.D.R.

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ABSTRACT
FINDING MEANING AND SENSE-MAKING IN HOSPITAL NURSING TEAMS:
THE PROMISE OF NARRATIVE MEDICINE

Shelley J. Bobb, B.A., M. Div., S.T.M., M.D.R.

Marquette University, 2016

Purpose. Narrative medicine is an innovative field that has provided meaning and increased communication between health care providers and their patients. This study explored the significance and nature of the practice of Narrative Medicine and what impact this had with NICU nurses on their team interaction with respect to team functioning, sense-making, and vocational understanding. This study seeks to provide nursing teams another tool to find meaning in their work and strengthen their teamwork. Using Narrative Medicine and the theory of phenomenology, this is a new approach that may bring nurses to draw on fresh ways to engage their work and each other. This has the possibility to demonstrate how the work of Narrative Medicine creates clarity and lucidity for nurses. This study asks the question of how meaning is constructed discursively in the practice of nursing.

Method. In this study, 11 NICU nurses participated in the practices of narrative medicine. This included 3 group sessions, one individual interview, and observation of each participant for 3-5 hours. Participants examined and discussed the ways they viewed their work in terms of functioning, sense-making, and vocation. Field notes were read by myself and coded for emergent themes in the phenomenological theory tradition.

Results. Patterns of communication and teamwork were complex and nuanced. Participants reported building stronger relationships as they grew more aware of each other's stories and had the opportunity to reflect on their work among their coworkers. This led to an intensified individual and team understanding of their roles as healthcare professionals. Participants responded in the group, individual, and observation time about how this process positively contributed to their individual and shared identity, value, and meaning as a nurse.

Conclusions. Conversations in the Narrative Medicine exercises, individual and observational time demonstrated how the influence of these practices assisted to remove barriers so that relationships were enhanced. This positively contributed to team practices of asking for and offering help to other teammates, increased trust, team task functioning, sense-making, and increasing a sense of their "call" or vocation in the practice of nursing.

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Shelley J. Bobb, B.A., M.Div., S.T.M., M.D.R.

Before I started working on this degree, some people told me it was a lonely path and that it required a lot of solitude to do the work. It's true, I did need a lot of time alone. Yet, I also found myself cheered by many people who were renewing me; I was never lonesome. Some of those people were my doctoral committee, others were close friends and cousins. Others are dead and yet their particular voices still rose and offered encouragement.

My doctoral committee included bright scholars and strong hearts, which is a winning combination. The chair of my committee, Dr. Kevin Gibson, provided excellent leadership and navigated me through the bureaucratic paths of this degree and also gave hands on academic advice for me as a new learner in the social sciences. Dr. Sarah Bonewits Feldner took on the role of second chair and patiently taught me the specialized ropes of qualitative research and writing. I owe her an incredible thank you for the time she graciously gave to me and the sharp insight she brought as she taught me about how to handle data and conclusions. She is a gifted teacher and knows her craft. I was lucky enough to have her in the capacity to edit and revise my rough work. Dr. Joyce Wolburg gave insight into theory and method and refined my work in ways that deepened it and made it clearer. Dr. Margaret Callahan stayed the course through several significant professional job changes, yet steadily gave vision and a nurse's scientific mind to my work. Dr. Callahan also has the soul of a Jesuit and from our first meeting to the last, I was grateful for her understanding of these principles, which are important to my life. Dr.

Tom Janisse introduced me to narrative medicine and remained steadfast throughout the process, tending my own growth and understanding in the field and offering encouragement along the way. As a physician, his perspective brought an enlightened viewpoint and his enthusiasm for the project was always appreciated. I often described my doctoral committee as "The Dream Team" and will always be grateful to them.

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My other brother, Jeff, died ten years ago and his spirit of fighting hard and hanging with things when they got rough gave me a boost each time I thought of him. His picture is on my desk – throwing a discus in the Special Olympics with his whole six foot frame arching to give it his best shot. Thank you, Jeff, for being such a wonderful brother and an inspiration.

My Dad, Harry, died twenty years ago and I know how incredibly pleased he would have been with his daughter getting this degree. He taught me to stick with things and hold fast. My mom, Julia, died suddenly three years ago. In our last conversation a few days before she died, she asked, “When will you be finished up with this? Before I die?” At the time, we both laughed. She taught me to love words and learning. Both of my parents were loving and steadfast in their dedication to giving me and my brothers a caring home life and raised us to be strong people. Any goodness I may have, I owe to them. So, as a way of saying thank you to them for their utter graciousness and love, this work is for you, Dad and Mom. With thanks and love.

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CHAPTER 1

INTRODUCTION

Medicine relies on teams of highly skilled personnel who collaborate and work well together and often those teams use communication theory and operational methods that provide a way for them to deepen their understanding of teamwork. Teamwork in hospital settings is important for the operations within the actual healthcare team and for those who utilize the services of a health care team. Patients who are vulnerable in the most routine procedure are even more so when the stakes are higher. This means the health care team must demonstrate excellence in not only technique but in those practices of relationship, dialogue, and communication. These actions connect a team and actualize enable technique in a beneficial way. As patients, we count on and even demand that our health care teams work well together because we put our lives in their hands. As a family member or loved one of the patient, we trust that the clinical team will be able to practice their tasks at their absolute best, which must include excellent communication. Although strong healthcare teams might be the aim, the complexity of establishing them and the issues that are present in keeping them running smoothly are not simple. New approaches and techniques are required. We need to understand how health care teams can work together better. "Healthcare leaders need innovative, courageous and collaborative approaches to effectively address the multitude of complex issues facing health care systems today" (Sharlow, Pagenhoff, Aslam, Spiers, & Cummings, 2009, p. 318). As Sharlow, et.al. note, research is not providing everything that is needed to strengthen healthcare teams and that is why the proposed research that is offered in this type of study is needed. Current research does not fully address the needs of health care

team underscoring the salience of this research. A gap in health care team training and the way it is approached to enhance team functioning is needed. This new approach could be fulfilled by narrative medicine, which could add to the body of knowledge of how health care teams find purpose in their work, make important connections with other team members and strengthen their teams. Rethinking the usual approach to healthcare teams working together can provide a fresh understanding for teams to think about how to approach their teams and each other.

Team-building is essential in most places of work. Whether the team is a small group of people who are charged with a specific task for a short period of time or a larger group that maintains its working relationship over years, participating in a team means a lot more than just showing up. For most workplace teams, working in a healthy way means that communication is genuine and flowing, collaborative practices are evidenced by honoring each other's skills and wisdom, trust and respect are high, there is a sense of shared purpose and values, and although problems inevitably come up, there is an ethos of creative problem solving and conflict resolution (Opie, 2000; Cheney, Christensen, Thoger, Zorn, 2011). While all of these issues are considered important to create a healthy working team, there are unique challenges for teams within a healthcare setting (Ellingson, 2005; Van Servellan, 2009; Brown, Crawford & Carter, 2006). This dissertation proposal acknowledges the work that is in place in the field of teamwork and notes the problems that are still evident. This study seeks to make a contribution by examining how the practices of the discipline of narrative medicine impact healthcare teams in a health care setting.

In this study, changes that happened were not susceptible to clear metrics. There was a shift in knowledge about team functioning to sensemaking among team members. This "cause" of the change was represented and animated through the discursive method of narrative medicine, which affected the function and outcome of this study. The qualitative data collected established that the methodology of the narrative medicine method made the difference in team functioning and sensemaking. The research participant *did* something and made meaning within the practices of the narrative medicine's methodological moment.

Within the group work, participants co-constructed meaning with each other, which also "caused" improved team performance and an occasion for reflecting on vocational meaning. In this study, I constructed a theoretical framework, which was not applied to make "better" teams, but to explore the nursing vocation in general. What was necessary was the participants' lived-in experience as they went through the narrative medicine practices. The narrative medicine method was utilized to capture the understandings and perceptions of how nurses viewed their work and each other within their team. This was not a privation calculated at a distance. Instead, in their experiences and reflection upon their daily work lives, they appropriated the depth of their experiences and how that affected their teamwork and work meaning. This method presented the opportunity to allow participants the freedom to interpret their work in a new way. By having the occasion to think about the domains of their work, participants discovered the things that matter and have meaning, which also gave rise to changing habits and practices, awakening practices and ideas that resulted in better teamwork and deeper meaning. The results presented were a change: the team was better off for this

intervention, which is a personal perspective rather than an external metric. Ultimately, this method gave voice to the interpretive lens about thing about which we may not always be aware, yet how new awareness can help us change.

In the literature review, I first present the central issues that face healthcare teams. Understanding the problems that healthcare teams encounter provides awareness and grounding for investigating the relatively new path of narrative medicine and how it could impact healthcare teams. The second section will present the theoretical framework of phenomenology and narrative performance theory, which will be used to consider the ways that narrative medicine responds to the issues within healthcare team functioning.

CHAPTER 2

LITERATURE REVIEW

Quality healthcare relies upon the level of functioning of healthcare teams. Poor functioning teamwork can hinder healthcare patientcare and clinical outcomes. Unique problems are inherent in teams in healthcare settings. Significant concerns such as weak communication patterns, disputes that are not addressed, incivility among co-workers, and lack of emotional support are prevalent in clinical team settings and the problems are often dismissed without follow up. While challenges with team work are prevalent in healthcare, they often are dismissed for several reasons. The dominant culture of silence in health care teams makes acknowledging problems difficult. The structure and culture of clinical settings, particularly in hospitals, is highly complex and hierarchical, which makes recognition challenging (Nemeth, 2008). Trust is often low between health care professional and the table is uneven for negotiating with layers of hierarchy and roles that create discomfort for those challenging problems or issues within the team (Kritek, 2002; Marcus, 1995). Due to a fast-moving pace, high stress, the demands for quick-thinking and fatigue, the levels of functional communication can be strained, which can have catastrophic outcomes for the team as well as care for the patient (Nemeth, 2008; Gerardi, 2003, 2004, 2005).

In health care settings, the layers of complex entities, which include physicians, nurses, insurance providers, specialists, patients their families are natural stakeholders and add to the matrixed web in healthcare teams (Charnes & Tewkbury, 1993; Veltman, 2007). As well, technical personnel, specialists and those who are uniquely trained, may

have differing opinions and values among themselves when decisions must be reached (Erickson, 2010; Hesselbien, Goldsmith & Beckhard, 1996). The current models for exploring healthcare teams come from the traditional sectors of business and communication, which offer sound reasoning and ideas about healthcare team models (Valikangas, 2010).

Scholars from the fields of communication, business, medicine, psychology, organizational behavior and dispute resolution have researched team functioning within healthcare settings, addressing questions about how teams are impacted and making sense of their work within the team (Gerardi, 2004; Dauer, 2005; Lebed & McCauley, 2005; Longo, 2010; Mills, 2002; Skorshammer, 2001; Weick & Sutcliffe, 2001;). As healthcare has grown into a complex and highly complex business, the culture with that setting often becomes fragmented and has not kept pace with being a functional and healthy system (Briles, 2009; Krause & Hidley, 2009; Park, 2009;).

Research demonstrates noteworthy problems with healthcare teams and more study is needed on communication within healthcare teams (Biasini, et. al., 2012; Wittenburg-Lyles, et. al, 2010, 2012). Major facts that contribute to dysfunctional teams within healthcare settings are wide-reaching and can be physically dangerous and violent, exemplified by bullying and physical force (Briles, 1994, 2009). The psychological stress of threats and power abuses, which produce anxiety, fear and stress in the health care worker, can lead to cynicism and miss-communication (Reina & Reina, 1999, Krause & Hidley, 2009). As well, working in health care places one on the front lines of dealing with demanding issues such as life and death and biomedical ethical decisions that can

strain even the most emotionally resilient caregiver (Krause & Hidley, 2009; Erickson, 2010; Reiner & Reiner, 1999).

Conflict between team members can effect patient care and demonstrate a weak management system, which may be the result of inadequate training of unit directors and charge nurses (Dauer, 2005, Barnsteiner, et. al. 2001). These dysfunctions create a work place culture in the health care setting that is not only merely disruptive, but damaging to patient and team (Capitulo, 2009). The unique challenges presented in healthcare teams demonstrate that conflict in healthcare settings is unfortunately alive and well (Barnsteiner, et. al., 2001; Capitulo, 2009; Cooley, 2002; Dauer, 2005; Liang, 1998; Marshall, 2003; Marcus, 2002; Slaikeu, 1989;).

> Health care is offered in complex environments of multidisciplinary professionals: Physicians, nurses, social workers, pharmacists, administrators and others. The combination of legal and regulatory pressures, health care financing, and demands placed in interdisciplinary teams have created high pressure work settings. The nature of health care delivery also creates tension as professional care-givers seek to meet the needs of patients and their families as well as sometimes competing demands of the system itself. Differences in perspectives based in the educational socialization to their professions, position, authority, and power often lead to conflict in the health care arena (Mills, 2002, p. 522).

Other researchers note these issues as well and the pervasiveness of their presence (Bateman, et. al., 2003; Briles, 2009; Capitulo, 2009; Cerminara, 2002; Center for American Nurses, 2007; Erickson, 2010; Kenough & Martin, 2004; Veltman, 2007;). Ellingson notes several health communications scholars underscore these problems and identified substantial problems (Ellingson, 2005). Before teams can be most effective, these problematic issues specifically are represented within the organization, training (or lack of training), socialization, and management of health care teams (Bateman, Bailey,

& McLellan, 2003; Clark, 1994; Ellingson, 2005; McClelland & Sands, 1993; Opie, 1997; Saltz, 1992).

Obstacles to Health Care Team Communication

Problems are evident in health care team functioning and the obstacles appear to be staggering. The dysfunctional issues that present themselves in healthcare teams are not dealt with in a robust way or in a timely or adequate fashion. Researchers note that problems are often dismissed without follow up and that there is a dominant culture of silence, which compromises truth-telling, creating a low threshold for trust among teams (Briles, 2009; Kupperschmidt, et.al., 2010; Maxfield, et.al., 2010; Porche, 2007). The unfortunate upshot of this is that it lays foundation for conflict among teams instead of cooperation (Gerardi, 2004; Lebed & McCauley, 1991). In healthcare teams, effective communication is essential but too often not in place (Abrahamson & Mizrahi, 1996; Gage, 1998). The clash between not only teams but various subcultures is evident. There is the internal culture of physicians whose goals and objectives are health. The external culture, which is that of patients, who usually have interests that are more subjective, i.e. receive caring treatment during their condition of dependency, also contributes to conflict (Dauer, 2005; Gerardi, 2004; Sands, 1993). Thus, in a workplace that has been characterized as possessing "wildly divergent cultures" indicates that these issues are not an easy fix (Leape & Fromson, 2006; Longo & Sherman, 2007; Longo, 2010).

Reporting inappropriate and damaging behavior appears to be difficult for healthcare teams to confront and reporting is met with a great deal of reluctance. The reasons for this reluctance are represented in concern for their job, fear, lack of

confidentiality around the report, lack of managerial follow-through on complaints of disruptive behaviors, and lack of information regarding where to get help (Briles, 1994, 1996, 2009; Gerardi, 2003, 2004, 2005). Intimidation also plays a role especially when the physician engages in the disruptive behavior (Longo, 2010; Sherman and Ross, 2010). However, in spite of these issues, research also notes a deep desire for a functional workplace in healthcare and segments of the field appears to be open for change (Erickson, 2010).

Research scholars note that the concepts of disruptive behavior found within a team can also be the result of an abuse of power and authority from members within the team (Blake & Rosenstein, 2008; Ellingson, 2005; Kriteck, 2002; LeBed, et.al., 1991; Leape & Fromson, 2006; Opie, 2005;). Power imbalances are not located within a small corner of the healthcare settings: there are widespread inequalities and imbalances of power within medical settings, which makes the work of dealing with them all the deeper (Farrell, 1997; Lebed and McCauley, 2005). While disruptive behaviors in a clinical setting enjoyed a "hands off" approach in the past, these behaviors are now being regarded as disruptive and unacceptable (Marcus, 2002; Mazadoori & Latham, 2004). Ironically, as the power shifts in healthcare and becomes more collaborative, due to the recognition of the value of teamwork and individual accountability, it is possible that those who have the most power and autonomy to lose, the physicians, may lead to further and deeper disruptive behaviors (Leape, et.al, 2006).

Clearly, evidence suggests that all types of teams in healthcare settings face challenges. Within this discussion some research focuses specifically on how nursing teams exhibit debilitating team functioning and require support and training (Stone, 2000;

Sherman & Ross, 2010). The vulnerability of a nurses' position is unique in healthcare. As team members who are usually in the most direct and constant contact with patients, nurses experience distinctive stress taking care of critically ill patients and encounter inappropriate abuse from patients, families, and colleagues (Briles, 1994; Gerardi, 2004; Kritek, 2002). Nurses must work within a team of other healthcare professionals and the high turnover rate underscores that there are many factors that make it difficult to function in an operational team (Anderson, 2002; Kritek, 2002; Longo, 2010; Gerardi, 2004; Briles, 1994; Rowe and Sherlock, 2005; Park, 2009; Kupperschmidt, Kientz, Ward, & Reinholz, 2010). Healthcare team building is compromised in every way when the nursing team is not soundly working together (Bray, 2001; Cox, 1987; Park, 2009; Kupperschmidt, et. al. 2010).

Day to day sound and reliable communication is prized for all work settings and has a relevant and important place in healthcare settings (Farrell, 2001; Fassier & Azoulay, 2010). Passing information about a patient, communicating future medical protocols or procedures, noting the expectations of a patient are critical practices to maintaining a good outcome for the patient and the team. Poor communication in healthcare teams is more than merely the result of broken message-bearing or inferior exchange of information. Failures in communication are more complex and enmeshed within the cultural, work practices, hierarchical differences, role confusion and ambiguity, work stress, biomedical ethics, and interpersonal power and conflict (Sutcliffe, 2004).

Communication has a point of utility in health care teams, which is where it identifies a problem, ambiguity, or critical knowledge gap (Lindgard, et.al. 2008; Van

Servellan, 2009; Wright, et. al., 2008). This functional use of communication often motivates a change of plan or encourages an action that would follow-up after the problem or "gap" was acknowledged (Lindgard, et.al.2008). Of course nurses' communication skill sets must be in excellent form with patients, however, as scholars note, more than ever, those interactions must be extended to the team context. This is because good communication within the team builds team morale and relationships, assists with coordinating team tasks, which facilitate patient care, and promote collaborative decision making (Propp, 2010; Wade, 1999). These decisions have direct impact on patient care. As a conceptual framework, based on the literature available based on outcomes, this study expects to find that narrative medicine will contribute to the perception and meaning of nursing teams. There are no research studies on how narrative medicine offers understanding or meaning in hospital or nursing teamwork. Although I am looking for outcomes suggested in the literature, I will also hear perspective and perceptions about nursing teams told from the nurses themselves and will be open to numerous outcomes that will present themselves. Some of those I do not have the ability to predict and will emerge through the nurse's comments.

Nurses need to feel safe enough within their teams to have the freedom to ask questions about patients and techniques, genuinely say what is on their minds, confront norms, or simply say they are confused and ask for help (Bradley & Beck, 1990; Reina, et.al. 1999; Briles, 1994; Ellingson, 2005). The consequences of not asking for help could be deadly for the patient, as well as undermine the skills of the practitioner. Researches who study communication in healthcare teams note the importance of healthy communication and have determined that it is not an ancillary component and that it is a

hallmark of well- functioning teams (Ellingson, 2005; Van Servellan, 2009; Wright, 2008).

Addressing the Issues

Although health care teams present challenges and obstacles to healthy functioning, research also demonstrates that the major issues have not only been identified but offered improvement. In as much as abusive behaviors and dysfunctional healthcare teams occur, nurses have a longstanding practice of advocating for their vocation and recently identified nine key elements that support the development of healthful practices within their work environment: a collaborative practice, which is essential in interdisciplinary teams; a communication rich culture; a culture of accountability; the presence of adequate numbers of qualified nurses; the presence of expert, competent, credible, visible leadership; shared decision making at all levels; the encouragement of professional practice and continued growth/development; recognition of the value of nursing contribution; recognition by nurses for their meaningful contributions to practice. This list was generated by the Nursing Organizations Alliance, a coalition of major nursing organizations throughout the Unites States in 2009 (Sherman & Ross, 2010).

Although some research portrays a troubling image of healthcare team functioning, there are also studies of healthcare teams that are using techniques that have made them stronger. As Gerardi, notes “creating a healthy work environment is as important, and perhaps more important, as mastering the newest technology,” and while it is not yet the norm, Gerardi sees progress (Gerardi, 2004, p. 182). Healthcare research shows that good

teamwork is essential to providing quality care for patients and families and creating an environment in which people want to stay in their positions within a healthcare team (Barnsteiner, Madigan & Spray, 2001).

Considering the challenges that are distinctive for healthcare teams, it is important to note the particular issues that healthcare teams face in their daily work as well as what practices that could impact their functioning. The potential benefits of effective healthcare teamwork may be summed up in six central theses: 1. Improved communication and partnership; 2. Role clarity; 3. Better response processes in addressing specific patient medical issues; 4. Improved coordination of healthcare delivery services; 5. High levels of satisfaction on delivery of services; 6. Effective use of health resources (Clement, et.al, 2007).

Exploring Options

Evidence demonstrates that many approaches have been taken to address health care team functioning, however, narrative provides a fresh and innovative possibility and option to consider. In healthcare, teamwork is an ongoing process of interaction between team members as they have the specific task of working together to provide care for patients (Clements, Dault, & Priest, 2007). The "shared objective" of patient care is at the heart of healthcare teams, yet fundamental concepts of teamwork must be in place for the healthcare team to carry out that objective. Being a member of a healthcare team means that team members sacrifice their autonomy and allow their activity to be either coordinated the team, either through decision by a team leader or through a collaborative process.

The conceptual framework in this study, based on outcomes of prior studies examined in this review, indicate that this proposal study can expect to obtain understanding and perceptions of the nursing team on the subject of teamwork using the practice of narrative medicine. There are no formal research studies on how narrative medicine offers understanding or meaning in hospital or nursing teamwork. This study will search for outcomes that are suggested in the literature review, but also look for new understanding that this researcher needs to be open to and listen for fresh outcomes and perspectives told to me from the nursing team members in this study. There are all kinds of outcomes that will present themselves, some of them are unknown. It is important to note that healthcare team members come to the team with a specialized set of skills or knowledge, and as a member of the team, each individual makes a specific contribution (Clement, et.al, 2000). Yet, they also must monitor the work of their teammates and manage any communication and functional issues that may arise. As one would expect, trust is key in the healthcare team (Baker, et. al., 2005).

Unique Realities of NICU Nursing Teams

The Neonatal Intensive Care Unit (NICU) by its nature works with a unique and vulnerable patient. As an ICU unit, newborn babies, who are often premature and sometimes very sick with serious and debilitating illness, arrive in the unit needing specialized care. The realities of a NICU confront nurses with some brutal issues and the demands of the unit do not allow for much reflection (Norman, 2001). Keeping thinking and feeling alive is a challenge: bringing that self forward to develop relationships with staff that allow for space for thought and containment of distress and leads to a better

understanding of the parent's experience make their work even more complex (Hegedus & Madden, 1994). NICU staff members also wrestle with profound bioethical dilemmas that can strain their own sense of integrity while attempting to respect the family's religious and emotional needs (Fenwick, Barclay, & Shied, 2001). NICU staff report feeling scrutinized and worry that a constant parental presence signals lack of trust in the care they provide, which may result with parents getting caught up in a kind of vigilant oversight of their baby's care or experience the opposite extreme where the parents are totally absent, leaving the nurse the without an opportunity to help the parents bond with their baby (Cescutti-Butler & Galvin, 2003; Orzalesi & Aite, 2011). Although burnout is evident in service professions, stress originates from frequent intense interactions with those who are served who have complex problems (Profit, et.al., 2014). Healthcare workers in the NICU setting may particularly struggle to balance work and personal lives amidst the onslaught of new rules, technologies, as well as high expectations for smooth delivery of empathic and very high-level care (Profits, et. al., 2014). Burnout in the NICU appears to have cultural and "climate-like" features, is prevalent, and associated with lower perceptions of patient safety culture (Profit, et. al., 2014).

Parents in the NICU have unique issues that they must confront: they cannot take complete charge of their newborn; they have to go home without their baby; they must try to develop a bond without being able to hold or touch their infant, who is in a plastic isolate with numerous lines invading the baby's body. Attaching to a tiny, unresponsive immobile newborn whose viability is in question challenges the emotional wherewithal of even the most resilient and mature parents (Biasini, et. al., 2012; Hegedus, et.al. 1994). As well, parents are in a state of frozen psychic shock and may have their preciously held

assumptions about having a newborn shattered, sometimes resulting in making the feel unsafe, distorting events and may perhaps even lead to frightening themselves (Tracey, 2000).

Nurses must receive and manage the projections of these parental anxieties, feelings of rupture, disruption, powerlessness, grief, and uncertainty (Hegedus, et.al., 1994). It is also important to state an obvious fact: the NICU is a place for babies who are often very sick, sometimes near death and have little if any real viability to live. NICU nurses confront these issues daily with their patients, but are faced with the patient's parents as well (Thomas, 2006; Cohen, 2003). Although most nurses have had little if any formal training in working with parents of NICU patients, it is a critical part of their task on a daily basis, placing strain on themselves and their team.

Narrative Medicine

Noting the gap in health care team functioning, the practices of narrative medicine present possibilities that may provide assistance. Medical schools and hospitals throughout the world are employing the practices of narrative medicine with greater regularity (Anderson, 1994; Branch & Paranjape, 2002; Rime, 1995; Suchman, et.al., 1997). Some medical schools, e.g. Mayo Clinic, University of Rochester Strong Memorial Hospital, University of Colorado, Brown University Medical Center, Geisel School of Medicine of Dartmouth University, Johns Hopkins School of Medicine, are initiating new departments of "professionalism," "development," and "medical humanities" to their overall curriculum, offering courses in communication, clinical ethics, spirituality, health policy and narrative medicine to their list of core classes. These

courses transcend traditional medical and clinical disciplines and seek to provide a framework for facing human problems and possibilities. Becoming acquainted with the practices of narrative medicine, a healthcare provider has the possibility to increase her or his own understanding of the patient and provide a more complete diagnosis (Anderson, 1994; Charon, 2006; Engel, et.al., 2008; Frankel, 1983; Mishler, 1984; Riessman, 1990; West, 1984).

The term "Narrative Medicine" was coined by Rita Charon, Professor of Clinical Medicine and Director of the Program in Narrative Medicine at Columbia University. At its core, Charon theorized that narrative knowledge is the heart of humane and effective medical method. As healthcare professionals become trained in narrative medicine, the aim is to develop a narrative competence, which is "the set of skills required to recognize, absorb, interpret, and be moved by the stories one hears or reads" (Charon, 2004, p. 862). For Charon, clinical competence consists of the logic and science of a patient's biology as well as the motivation and consequences of human action (Wittenberg-Lyles, et. al, 2010, p. 46). Charon wanted to explore the beneficial nature of building a trusting relationship between physician and patient. The narrative approach assists health care providers deal with emotional issues that sometimes accompany working with a patient, which contributes to the relationship between healthcare provider and patient (Frank, 2002; Marshall & Smith, 1995; Sparks, 2005; Suchman, et.al, 1997; Novak, et.al,, 1997).

Being a physician for many years, Charon also knew the grim realities of standard medical practice and she knew then narrative approach might not be embraced by even her closest colleagues. She wondered how absorbing those patient's stories would affect the physician as well, challenging the wall of indifference they had been trained to build

and how it might foster a vulnerability with the physician that would provide depth of meaning and understanding in their own work. The narrative approach rests on the premise that deep listening to patients is fundamental to clinical practice and that individuals frequently use narrative, or stories, to relate difficult, complex, and painful experiences (Wittnberg-Lyles, et. al. 2010, p. 47). She thought that if physicians were allowed, even encouraged, to be moved by their patient's stories, this could have relevance on patient diagnosis, prescribed care and the physician's own life and experience. This practice would encourage developing narrative competence, which Charon defines as the set of skills required to recognize, absorb, interpret, and be moved by the stories one hears or reads. This present a new level of engagement between clinician and patient.

Charon's (2006) thesis is that effective and competent care of the sick requires more than scientific and biological knowledge. Charon explicitly claims that narrative methods are needed for effective treatment of the body *and* the mind, which as practiced as narrative reasoning "constitutes a logic in its own right" (Charon, 2006, p. 41). In this understanding, Charon challenges the notion of the mind/body split, which takes on its most animated argument in positing that science will fix the body and the "softer skills" of psychology, charity and understanding will heal the soul. For Charon, the dual view of the body simply does not offer an adequate understanding of where medicine is currently located, by noting that the technical advancements of medicine need the discipline of the humanities in order to adequately construct a diagnosis. This understanding is also finds a place in the current understanding and paradigm of the shift from an information age to a conceptual age (Pink, 2005). Narrative medicine also finds a place for answering the

question of what a healthcare professional does with the stories of those who are ill (Anderson, 1994; Barritt, 2001; Engels, Zarconi, Pethel, & Missima, 2008; Garro, 2000; Langellier, 2009; Skott, 2001).

From this viewpoint, narrative medicine has the capacity to nurture a mutuality not only between patient and physician, it is possible that through the practices of narrative medicine that teamwork could also be impacted through sharing stories, observations, mutual experiences and creating a sense of community in the team (Charon, 2011; Jones, 1997; Kleinmann, 1988; Kumagai, 2008; Langellier & Peterson, 2006; Montgomery, 2006; Rider, 2004; Sparks, 2005; Suchman, et.al., 1997; Wald, et. al., 2009;). The essentials of narrative medicine lend itself to collaboration and interdisciplinary teamwork, which is essential in clinical settings (Ellingson, 2005). It is within the place of these important connections, which form relationships between team members, that a basis for developing awareness and understanding of narrative medicine and healthcare team building is offered.

There has been a considerable development in the use of narrative theory, as well as narrative, in narrative medicine over the past twenty years (Charon, 2006; Charon and Montello, 2002; Feudtner, C, 1998; Frank, 1995; Kleinmann, 1988; Mullan, Ficklen, and Rubin, 2006; Nelson, 1997). Narrative conceptual frameworks were advanced for thinking about medical reasoning, clinical relationships, empathy and medical ethics (Greenlaugh & Horrowitz, 1998; Hunter, 1991; Jones, 1997; Sharf & Vanderdorf, 2003). The use of structured narrative and reflective writing is well documented among clinical professionals (Brady, et. al., 2002; Fiege, 2006; Kumagai, 2008). Although the practice of narrative found an academic place among narrative and medicine, there were earlier

studies that gleaned narrative from people with a variety of illnesses. This took place before narrative medicine made its formal presence known as a recognized part of the academic community (Williams,1984; Kleinman, 1998; Viney and Bousfield, 1991; Garro, 1994, Capps and Ochs, 1995).

Reflective writing and narrative discourse are described as cultivating insights into the process of patient care and promoting professionalism as well as promoting the well-being of those who serve in healthcare (Launer, 2002; Shapiro, et. al, 2006; Zink, 2010). The foundations of narrative practices disclose who people truly are by revealing their humanity, emotions, reflection, and personal involvement with their work (Aloi, 2009; Hess, 2003; Rawlins, 2009; Sparks, 2005). As Arthur Frank notes, this creates "movement of thought," which notes the distinctions where dialogue has motion and movement or "breath" as Frank designates (Frank, 2010). Paying attention and being mindful of narrative, clinicians are better positioned to notice movement, reciprocity and constant flux of a patient's story and, in the clinical setting, his or her illness (Frank, 2010, p. 72). In as much as stories "breath," they also allow another to be in a privileged position of entering another's life in a profound way – a way that has a reciprocal influence, which is a tangible effect of narrative medicine.

Duke University ethicist Samuel Wells and Marcia Owen deepen this understanding by providing a thoughtful view of "being with" another from that Augustine of Hippo at the start of his book *On Christian Doctrine*. Wells and Owen track the movement of relational engagement from "underscores this theme of "being with" noting that each person in the clinical relationship seeks to discover the story of the patient and since this search takes place in dialogue, it can only be participated by being

"with" each other (Frank, 2004, p. 83). being for" to "working for" to "working with" to "being with," with the final category of "being with" being the deepest way that trust can be built between two people and relationship is formed. For the clinician, it is where the narrative and story is heard. For the patient, it is where their story has a chance to find its voice and reside. This is where the possibility of narrative medicine finds its most profound realization and outcome between and "with" the engagement of clinician and patient. Frank

Literary critic Mikhail Bakhtin underscores this understanding of the moral idea of human relationships developing through dialogue, which fins its most resonant seat in a dialogical framework where participants are "with" each other. While narrative medicine may raise the actual practice of a clinician's ability to hear what is happening to his or her patients, there is a *moral* grounding to be captured in the dialogical exchange as well. As Frank notes in his description of Bakhtin's communication theory: this moral demand in dialogue is that each participant grants equal authority to the other's voice (Frank, 2004, p. 44). This conceptual dialogical imagination can be appropriated into an understanding of what narrative medicine could achieve in practice.

Narrative also benefits the central issue that informs the clinician about the patient's clinical needs by raising the question: "what is at stake for whom?" (Frank, 2010, p. 74-75). Noting Alasdair MacIntyre's powerful description of storytelling, where MacIntyre states that "He [man/woman] becomes through his history a teller of stories that aspire to truth," Frank says that both hearing the patient's story and then telling stories from the clinician gives way and aspires telling the truth about illness, suffering, and medical care (Frank, 2004, p. 81). As Arthur Kleinman observes "we should be

critical of a therapeutic method that dehumanizes the doctor along with the patient" (Kleinman, p. 136). Narrative medicine offers the possibility to resist the "contribution of professional orthodoxy that inadvertently heightens the passivity and demoralization of patients and their families, which is all too common in the treatment of the chronically ill" (Verghese, 1998, p. 341).

The new work in medical humanities illustrates the arguments and approaches for a narrative method that appropriates information through several ways. One way is through the emotional interchange between patient and physician, in which through professionally appropriate emotions, most notably empathy, the physician can learn more about the patient and as a consequence intercede in a more effective manner to diagnose and prescribe a treatment (Halpern, 2001). Another view examines how medical science alone is not adequate to serve as a basis for individual decision making and does little to speak to the patient and any misgivings he or she might have (Montgomery, 2006). Montgomery contends that "clinical judgment" fills the gap. Montgomery (2006), uses several phrases to describe the term "clinical judgment": it is "not a science" (p. 32), "moral knowing" (p. 41), "practical wisdom" (p. 41), "interpretative" (p. 42), "narrative" (p. 42), "discursive" (p. 171), "a practice" (p. 176), and it requires "balance" (p. 199).

Using only tools from evidence based medicine, the explorations of the deeper challenges faced by practitioners in their struggle to integrate sound science and shared clinical action remains elusive (Silva, Charon, Wyer, 2011). Misak (2010) also concurs with this basis and states that using evidenced based medicine in an exclusive manner constrains the practice and study of medicine in unfortunate ways: "In its quest for objectivity, evidence based medicine has narrowed its conception of evidence and

imposed limits on inquiry in a way that impedes the search for getting the best to our answers. It puts medicine in one of those methodological straightjackets" (p. 137). As a consequence in narrative medicine, the art of listening takes center stage, complementing the practitioner's task of actually "doing something" to fix the medical problem (Remen, 1997; Selwyn, 1998; Verghese, 1993).

As physicians acquire the skills to develop the narrative competence to nourish empathic doctor-patient relationships, the outcomes for both patient and physician is that isolation is replaced with affiliation, meaning, attention as a way to respond to the challenges of the current health care system. From the patient's perspective, they often believe that their doctors are not listening to them and care about their suffering. Given these realities, the trust between patient and physician is low, which Charon believes has detrimental effects on patient care (Charon, 2005).

Embracing some of the narrative components and practices of narrative medicine can contribute to a narrative nursing model that when practiced could be called "narrative nursing" (Wittenberg-Lyles, Goldsmith, Ferrell, & Ragan, 2012). It is practiced with patients and their families as they "bear witness, sit quietly, and not run from another human who is suffering…. It bespeaks a compassionate presence that permits the time and emotional space for storytelling – that enterprise that is deeply rooted in our humanity and that connects us to each other as no other form of communication can" (Wittenberg-Lyles, et.al. 2012, p. 102). Although Wittenberg-Lyles, et.al. describe "narrative nursing" as practiced between patient and nurses, this term could be applied to other aspects of nursing as well, such as nursing teams working together. Nursing involves interaction between nurses and patients yet also involves working with other

nurses and working with the whole healthcare team, which of course involves medicine. The term "narrative medicine" therefore is apt for describing the practice that could be utilized to explore understanding of teamwork within a nursing group. My research will take place in a NICU nursing team, which must work collaboratively together (and inter-disciplinarily) for the sake of the patient. If the model of narrative medicine can be fostered for interaction between nurses and patients and their families, it could also find a place within nursing teams, creating impact between team members and sense-making of their work.

Sociologist Arthur Frank's research and work on storytelling within healthcare echoes this understanding. His focus on patients' stories, the telling of their stories, and how they offer care for others is a helpful link to not only Charon's work, but for understanding how stories operate in this context (Frank, 1995). Frank (1995) notes that it is "through their stories, the ill create empathic bonds between themselves and their listeners" (p. xii). Other listeners naturally include healthcare professionals. Part of the empathy that emerges from the listener is a common bond of suffering that when the listener hears the story and joins in the story, that person, physician or nurse, the ones who are the healers, become vulnerable and wounded, or in the words of some writers, become a wounded healer (Charon, 1994; Kleinman, 1988; Moyers, 1993; Nouwen, 1990).

Theoretical Framework: Phenomenology

To attend to the questions of how narrative medicine impacts a healthcare team, a theoretical framework that reflects the ways that health care team members operate and

communicate with each other is essential. In narrative medicine, narratives are explored in the fundamental relationships in health care: relationships between patients and clinicians; between the health care system and community; and the relationship of the nurse or clinician with her or himself. The basic concept introduced of narrative medicine represents one of the most recent steps in a movement to advance humanism in medicine, which complements the objectivist and reductionist approach of science-based practice with an empathic and human approach to the patient's human experiences and life (Cohen-Cole, 1991; Goodrich-Dunn, 1991; Novack, et.al., 1997; Suchman, et.al., 1997).

For this dissertation, narrative medicine concepts will be used to theoretically situate the complex communication challenges that arise between nursing team members. The stories from the NICU nursing team will be shared to further illuminate narrative medicine theory utilized in storytelling and the analyzing of those stories through the theoretical approach of phenomenology. Phenomenology theory will ground and demonstrate how language and narratives borrowed from the nurse's everyday lived-in experiences impact nursing teams (Aloi, 2009; Davis, 2009; Laine & Timmerman, 1999; Miller, et. al., 2009). Narrative medicine emanates out of phenomenology and provides new insights to enable individuals and teams to interpret themselves and their work in a new way (Baron, 1985; Charon, 2006; Kleinman, 1998; Tresolini, 1994).

By using a phenomenological perspective I seek to understand how narrative medicine makes team communication and collaboration in healthcare settings meaningful. This is not a cause and effect study; this study is seeking to capture understanding and the perceptions of how nurses view their work and each other within the team. Phenomenology is the methodology that focuses on capturing the way things

work from the perspective of the people in a specific study and trying to capture the understanding and the experiences of those being studied. This is about using this theory as an understanding of viewpoints and perspectives; narrative medicine techniques will be utilized to provide a way to understand the participant's view and used to see outcomes within the team, but will not be proving cause and effect.

Phenomenology's purpose in research is to describe one or more individual's experiences of a phenomenon or event. It is a return to the lived-in world, the world that is experienced, which is the starting point for describing our lives (Heidegger, 1962; Husserl, 1931; Merleau-Ponty, 1962; Gadamer, 1989). By focusing on the very things that are manifested, experiences are taken into account, noting that any knowledge has its origin in experience (Husserl, 1931). The foundational question that phenomenology seeks to address is what meaning, impact, structure and true essence of the lived-in experiences of a particular phenomenon by an individual or group and explore what is that shared experience (Holloway & Wheeler, 2002; Husserl, 1931; Walton & Madjar, 1999). Through everyday knowledge in daily existence we gain what has been termed "lived experience" (Taylor, Kermode, & Roberts, 2007). For the phenomenologist, consciousness is the intentional process that is constituted in thinking perceiving, feeling, remembering, imagining, and anticipating directed toward the world, by asking the central question of "What does this experience mean" (Pollio, H. R. & Thomas, 2001). Phenomenology searches for the invariant structures of individual's experiences, or the essences of their experiences, providing a deep and textured description of experience. Instead of focusing on what is particular or unique in each individual, phenomenological

researchers look for commonalities in groups in order to understand what the lived experiences mean to the participants (Taylor, et. al., 2007).

In this study, using a phenomenological theoretical framework provides an appropriate foundation for an inquiry about the essences of nurse's experience of being in a healthcare team, which attempts to grasp the essential meaning of experience (Van Manen, 1997). In the "life-world" a person's conscious actions and self are always engaged in something within the world, forming a relationship to and with it. This is called "intentionality" in phenomenology and points the researcher's focus to clarify the relationship between each participant and the meaning (or meanings) of the things they are living in or experiencing. Thus, phenomenology asks, "What does this experience mean?" A phenomenological researcher seeks to help participants articulate their world as openly as possible and how to clarify these elements such that the life-world is exposed and discovered.

The phenomenological researcher is involved in an activity of trying to see the world in a fresh way and to be attentive to the participant's understanding of that world. Stepping into the world of research through this lens, the researcher should be prepared and open for revelations from participants and ready to whatever may be discovered. In collecting data, phenomenologists look for concreteness in the quality of the data, which means they look for details rather than abstract interpretations. Penetrating the inner world of participants in research requires that the phenomenological practitioner view the subject in their own terms, from the level and viewpoints of where they consciously are located. As such, this moves the idea that human truly are creative agents in the construction of their own worlds. "Phenomenological understanding is distinctly

existential, emotive, enactive, embodied, situational, and nontheoretic; a powerful phenomenological text thrives on a certain irrevocable tension between what is unique and what is shared, between particular and transcendent meaning, and between the reflective and the pre-reflective spheres of the lifeworld" (Van Manen, 1997, p. 345). In terms of the quality of the phenomenological study, it is best assessed by its power to attract the reader into the discoveries that the researcher located, which allows the reader to possibly perceive the world of others in fresh and novel ways.

Narrative Medicine Performance Theory

In order to join the theoretical framework of phenomenology to the practices of narrative medicine, linking the theories of narrative medicine to phenomenology will provide a helpful intersection. Narratives become observable as ever-emergent relationships are captured within the narrative as well as within the performance of the narrative (Harter, Japp, & Beck, 2005). It is through an actual narrative that those who are in the healthcare system have the chance to create and express their personal values, sense of identity and role with regard to the medical events they encounter (Wittenberg-Lyles, et. al. 2010). For nurses, team members often engage in storytelling as a way to interpret and share their work. In the context of day to day team interactions with other nurses and their patients, the narratives they tell reveal the attitudes and habits connected to their work and demonstrate the dialectical tension between science and humanism (Babrow & Mattson, 2003; Wittenberg-Lyles, 2005). Nurses seek to make sense of their work and tell stories of their work to each other to fulfill that need. If one believes that sharing stories is a foundation piece of impacting a nursing team, then it is noteworthy to

imagine the results of what the absence of communication and telling stories about their work would bring.

The narrative process links human life experience with literature and enables a response that does not merely offer feedback for the teller, but offers a genuine capture of deep knowledge about the person and the lived-in experience of being a nurse. Narration practices provide those team nurses a way to interpret, change, understand, make sense of, manage, and respond to the daily work they encounter.

The four foundational theories of narrative medicine demonstrate not only theory but how it is practiced as well (Wittenberg-Lyles, Goldsmith, Ragan, & Sanchez-Reilly, 2010). Providing an understanding of these foundation theories will provide a backdrop for how the tenants of phenomenology can be utilized within narrative medicine. The first core foundation is that illness unfolds in stories, and therefore healthcare involves "The giving and receiving of accounts of self (Charon, 2009a, p. 120). The objective of narrative medicine is to bridge the gap between the body and the self that creates contradictory voices that come from the patient's own words, family's words, physicians' and nurses' words (Charon, 2009a). It is the physician's role to bear witness as the body informs the self (Charon, 2009a).

The second core foundation of narrative medicine is that health and illness present a unique time in which we become or discover who we are. Within this second foundation is a break-down of four narrative situations in the medical situation: physician and self, physician and colleagues, physician and patient, and physician and society (Charon, 2001b). A parallel chart is created to describe the physician's reflections about his or her patient's experience with illness as well as the physician's own thoughts about

caring for the patient (Charon, 2001a). This parallel chart portrays the facets of care that do not have a place within the clinical chart (Charon, 2004b). Through the parallel chart, narratives offer physicians an instrumental chance to witness the human side of being a physician and understand illness from their patient's viewpoint.

The third core foundation seeks to provide a hopeful path for a change in the way that medicine is practiced, attempting to strike a balance between objectivity and subjectivity. In this patient-centered approach, narrative medicine facilitates the subjectivity in medicine by uncovering the relations between physician and patient. Instead of emerging as a master authority, the physician allows meaning to emerge as a collaborative process between patient and physician (Charon, 2001b). The result is that physician understands the patient as well as the disease (Charon, 2004a). Emotion and subjectivity are at the core of narrative medicine (Charon, 2009b).

The fourth core declares that stories are seen as a form of knowledge that contributes to the overall care process. The process or "act of witnessing" necessitates that the physician listens, imagines the situation of the teller, recognizes contradictions in word and/or events, and is moved by the narrative (Charon, 2001b). this method facilitates "clinical narrative tasks," such as creating a beneficial relationship, generating a differential diagnosis, and expressing empathy for the patient's experience, all coming together to create effective patient care (Charon, 2001b). As a method of reflection, narrative has emerged as an important physician characteristic for professional development and learning in the clinical setting (Branch & Paranjape, 2002).

The narrative construction with any context creates a performance force as exemplified in the circumstances of the utterance, the spectators of the act, and the

cultural significance and historicity of the utterance are included in the performance (Wittenberg-Lyles, et.al, 2010; Worthen, 2004). Because it is an action and enacted, the performance is embedded in things that are common and everyday rituals, patterns, behaviors, and existence (Wittenberg-Lyles, et.al., 2010; Schechner, 2002). The performance creates an actual action and performance behavior then refers to how people enact live-in to their identity or role (Lindbeck, 1984). For example, healthcare team members become socialized and formed by the narrative style they use to communicate with each other and the patients and families with whom they work.

Some nurses may share the same "story", but the performer of the story will shape it differently than another voice from the same team and even shift. In each of the performances, nursing identity and culture is exposed. In many narratives, teams will discover who they are as individuals and as a team in their own storytelling, as if the revelation of saying the words creates and uncovers something fresh to recognize. In this sense, narrative performance theory accounts for what is done (actual performance) and what is then described (Lyles-Wittenberg, et.al., 2010). Not only does the nursing team and their context affect the story and performance, their engagement with the patients and their families also plays an important role in the nurses understanding their work.

Charon's themes of "movement" within the narrative medicine discipline attention, representation, and affiliation dovetail and augment the concepts of performance. Attention is the practice of emptying oneself or putting oneself aside to become a receptive vessel for the language and experience of the other (Charon, 2005). "Attention may be the most urgent goal in our work – to attend gravely, silently, absorbing oceanically that which the other says, connotes, displays, performs, and

means" (Charon, 2005, p. 263). For healthcare teams, listening to each other in this manner could change the routine of day to day interactions and create impact with issues that matter to each other, both as a team and as individual the team members encounter each other in a genuine and transparent way.

The next movement is that of representation, which Charon notes follows from attention is direct patient care. Charon says that the patient is represented by the clinician's witness of that patient. It is through that representation that complex and moving descriptions are told and as things are "put" in a certain way, what they think about those clinical situations and patient (Charon, 2005, p. 266). As healthcare providers write a narrative about their patient, they discover aspects of the experience that were not evident until the writing. Charon views that as a representative act and that is an important "position step" (Charon, 2005, p. 266). It is through the act of writing, or creating their experience in another form, that new facets of the situation are allowed to emerge. Once it is written, the author can "walk around" the representation (i.e. letter, poem, story) and realize aspects that, until giving it the specific new form, were not available. The nurses who serve in a team, representing what they have witnessed within the team and with their patients in the form of narrative, could offer new sense-making, which would have been formally unavailable until they wrote. Although using conversational aspects of interaction through venting or sharing stories might provide some new insights, the actual writing in the narrative medicine discipline provides the team with a new form, a tangible, concrete piece, that others can actual see and be part of. As they grow in their writing skills and capture more of what they witness through representation, the impact between team members could create a deeper understanding

and meaning of their experiences among each other. This captures the phenomenologist's theoretical understanding of intersubjectivity and the experiential understanding of the self in relationship with the other (Husserl, 1931; Levinas, 1969). As Charles Taylor writes, "One cannot be a self on one's own….A self exists only within what I call 'webs of interlocution" (Taylor, p. 36).

The last movement in Charon scheme is affiliation, which is built through attention and representation within the narrative medicine practice. An outcome is that affiliation is deepened and nurtured between colleagues, the institutions in which they work, the patients and their families, and their own calling as a healthcare provider. Health care professionals become aware that they are affiliated with each other "as humans, humble in the face of time, ready to suffer our portion, and brave enough to help one another on our shared journeys" (Charon, 2005, p. 269). Recognizing affiliation as a foundational theory within narrative medicine has possibilities to impact nursing teams and provide sense-making in their work. If the central aim of narrative medicine is to develop empathy, reflection, professionalism and trust, then developing skill sets of narrative competence that are associated with narrative medicine could impact not only physicians and patients but nursing teams as well in a way that would nourish their functioning, impact communication, and better serve their patients.

Given that healthy nursing team function is critical, particularly in the NICU, and despite rigorous study over the past twenty years, there are still challenges within the team and other options are needed to create effective performance. While recognizing that science has deepened medical knowledge, narrative medicine can help fill the gap of the pressing accusations against health care team practices such as the distancing,

coldness, and impersonality. By health care teams developing narrative competency and telling stories, listening to those stories and cultivating an openness to be moved by them could impact members of nursing teams. At the time of this writing, the benefits of narrative medicine have been considered with respect to patient to provider relationships. Aspects of how narrative medicine impacts team member interactions has not been considered. The theory of phenomenology provides a lens for considering group dynamics in a new manner. This study seeks to fill this gap by qualitatively researching a NICU team. The research is guided by the following questions:

Research Question 1: How does narrative medicine influence nurses' perceptions of how healthcare teams function?

Research Question 2: How does narrative medicine build understanding between nursing team members and help them make sense of their team interactions?

Research Question 3: How do nurses make meaning out of their role as a healthcare professional and team member through their use of narrative medicine?

Present Status of the Problem

The existing literature about narrative medicine focuses on its effects on physicians and how narrative practice can help physicians create a deeper understanding of their patients, which possibly provides better care. As well, narrative medicine techniques may assist the physician to absorb the patient's stories in a thoughtful way that can help make a meaningful connection. At the time of this writing, there is no formal research on the specific contributions of narrative medicine on healthcare team functioning. The research

I am proposing would contribute to the growing field of narrative medicine and assist with creating ways that hospital healthcare nursing teams could utilize this discipline.

CHAPTER 3

METHODS

This study utilizes qualitative research theory, which seeks to gain insights into the human behavior and lived-in experience, thoughts, and behaviors as NICU nurses. Qualitative research, through its illumination of people's perspectives and their experiences, contributes a particular kind of useful evidence for those who participate in the "caring" disciplines and practices, such a nursing teams. Qualitative research in this study offers a foundational base for several reasons. First, qualitative research is focused on exploring human or social problems from the perspective of the participants. As it explores the understanding the meaning that people make of their realities and their experiences, explaining why people think and behave the way they do. Second, qualitative approaches usually are interpretive and inductive, rather than positivistic and deductive. This means that answers to research questions derive from the data and not from testing *a priori* hypothesis. Third, qualitative research is conducted in a natural setting, which means that research takes place in daily, everyday settings where people naturally find themselves. This foundation lends itself to using phenomenology as a theory, because the complexity of behavior and thoughts can be explored in a natural, holistic, and contextual way (Arnold & Lane, 2011). Qualitative approaches are able to bring multiple perspectives to bear on a phenomena or process in order to determine "how something works" and can be used to develop a conceptual model, framework or theory (Whittaker, et.al., 2008). Scholars who do research in clinical settings and understand the discipline of evidence based medicine understand the need for broadening

the range of evidence in order to make sound judgments, in which narrative medicine is a compelling practice to employ, marking an albeit dramatic shift from purely quantitative data to the inclusion of qualitative as well (Misak, 2010).

Although there are a variety of approaches one may use in qualitative research, this study uses a combination of ethnographic and interpretative phenomenology methods that seeks to understand nurses' perspective about teamwork in a Neo-Natal Intensive Care Unit (NICU) and convey the meaning of the nurse's concept regarding explicit communication patterns. Through understanding the participants' perspectives and interpreting the meaning they have about teamwork, narrative medicine practices are also employed as a particular way to understand general principles that emerge from this study.

Combining these two methodologies offers a way to tell a credible story of the NICU nurses. Ethnography and interpretative phenomenology share some important aspects: both are exploratory and use the researcher as the data collection instrument. They both use interviews as a means of collecting data and a combination of open-ended and structured questions, looking for sense-making and meaning in narratives. As ethnography concentrate on individual views or shared views and values of a specific or particular culture, aiming to describe the cultural knowledge of the participants, interpretative phenomenology attempts to uncover concealed meaning in the phenomenon, which is embedded in the words of the narrative (Maggs-Rapport , 2000).

The method of ethnography permits a researcher to provide a written representation of a culture and selected particulars of a culture (Van Maanen, 1988). For this study, ethnography is a perfect methodology to construct a detailed description of healthcare

team communication and interaction. Ethnography is also called *participant observation* or *fieldwork*, as it involves thorough observation and interviewing that is documented in extensive fieldnotes (Lindof & Taylor, 2011). The methods of ethnography offer several benefits over experimental, quantitative, or highly structured qualitative data-collection methods (Ellingson, 2005). First, ethnography allows researchers to look at the healthcare team as a whole and the way they engage NICU parents and each other. Through my role in participant observation, I was able to not only observe interactions between nursing healthcare team members, but also nursing team interactions with patients, parents (and other friends or family members), and other health care professionals.

Second, ethnographic fieldwork is a qualitative method allowed me to examine the NICU nurses in a holistic manner, engaging content, process, language, habits, customs, rituals, and behavior in a medical context. This offered the advantage of simply identifying or counting types of communication practices of the NICU nurses from taped interaction or transcripts (Adelman, Greene, Charon, & Friedmann, 1990). Since healthcare team communication is not a tidy affair, utilizing a qualitative approach allowed for interpretation of the disorder of the healthcare team's functioning and using that action as a known reality, then sought to understand how communication and team functioning are animated in day to day work. This is to say that this is not a controlled study and a qualitative and ethnographic approach fits well into this context.

Within this holistic examination, I was able to observe conversation and also record details of mannerisms, tone, and emotion. This project allowed me to observe NICU nurses with each other, their patients, and family/friends of their patients and

through individual interviews, hear them vet out the issues that present themselves to the team.

Third, ethnography allowed me to set up my study while the team is actively engaged in actual work, instead of a conceptual setting (Opie, 1997; Sands, 1993; Sheppard, 1992). Through a prolonged engagement of the culture, I was allowed the vantage point of being located within the setting, situating me in a place to uncover the perspectives of the NICU nursing team (Sands, 1993). This kind of arrangement will offer insights that lend themselves to a qualitative study using ethnographic methods. As well, using an inductive approach by concluding general principles from specifics allows the researcher to conclude general principles to build understanding and "make sense" of things (Merriam, 1998).

This research examined the NICU nursing teams within their daily work context. Interviews, observation, and narrative writings are the foundation for their voices. Geertz (1973) constructed the argument that acts of meaning can be best understood through interpreting webs of action and communication *in the contexts in which they occur*; it is only there and then that their significance can be understood. Through this, Geertz believed that articulate and persuasive interpretations would allow others to engage and then understand the context and the action described. In the writing of the culture, through making a narrative of how the culture is portrayed within the actual field where it is located, the procedure of ethnography makes connections and links between fieldwork and culture. I wanted to move beyond the usual assessment that healthcare teams are best understood using the moral communication and organizational behavioral models and better understand the impact that narrative medicine might offer. By studying the NICU

nurses, I hoped to understand and realize how they make sense of their team, their work, and themselves. Since narrative medicine has not been used to investigate how nursing teams are impacted by it and knowing that narrative medicine is gaining a foothold in the medical setting makes this study a relevant reality that nursing teams possibly encounter. By joining culture and the place, the ethnographer is in the unique and privileged position not only to decode what is being said or displayed through observation, but to interpret the account. Accordingly, ethnographers respond to narratives and environmental cues, which is also at the heart of qualitative research, and renders ethnography as an excellent tool in this particular study.

In order to stay within the boundaries of narrative medicine practice, this was informed by a "realist" ethnographical perspectives designed to explore how the role of narrative medicine establishes and maintains culture within a healthcare team. The "realist" tale is described as having a "privileged" access to the character's thoughts and feeling and motives, as well as to their overt speech and action (Van Maanen, 2011). As Emerson, Fretz, and Shaw note, the one who serves as an ethnographer reports on the "realist tale" with a unique perspective describing, from the ethnographer's point of view, not only conversation but also feelings, thoughts, and motivations of the participant. This form of ethnography is a good choice in this study because it will allow me the opportunity to be a detached observer and yet distill and blend numerous perspectives into a distinct and particular "omniscient" voice. This social constructionist perspective will be naturally facilitated by being able to both observe and interview within this particular setting.

Interpretive phenomenology concentrates on the need to study human consciousness by focusing on the world that the study participants experience in a subjective manner. Phenomenology as a methodology and approach seems better able to handle human issues by adding new perspectives and broadening our knowledge of the issue (Sadala & Adorno, 2001). Starting with a phenomenon the researcher wishes to explore, texts can be analyzed by comparing emergent themes within the groups to discover commonalities and shared ideas (Morrison, 1992). Using interpretive phenomenology, the researcher attempts to interpret the situation, presenting texts as fully as possible while pointing out where their understanding has been confirmed or negated by the participants comments, which is unlike ethnography (Maggs- Rapport, 2000). This method, according to the foundational thinkers of phenomenology, Husserl, Heidegger and Gadamer, is exacting one's preconceptions or "unity of understanding" that channels new ideas and guides interpretation (Maggs-Rapport, 2000).

Husserl's philosophical understandings gave rise to the descriptive phenomenological approach and method. Husserl believed that subjective information should be important to scientists seeking to understand human motivation because human actions are influenced by what they perceive to be real. Heidegger suggested that rather than focus on people or phenomena, the exploration of the lived experience should be the focus (Thompson, 1990). This is the study of what people experience rather than what they consciously know (Lopez & Willis, 2004). Heidegger used the term "lifeworld" to express the idea that individuals' realities are influenced by the world in which they live. Within this lived-in lifeworld, phenomenological method attempts to look for meaning embedded in common practices (Lopez & Willis, 2004).

Merleau-Ponty's understanding of phenomenology also points to placing the researcher in the perspective of the research participants in order to understand their experiences, thus revealing what it means to be in the situation of a NICU team in their experience of working together (Merleau-Ponty, 1962). Merleau-Ponty simply states, "We can only really understand phenomenology by actually doing it" so there is a difference between understanding phenomenology intellectually and understanding it from the inside (Van Maanen, 1984). This approach investigates truth starting from the origin of all knowledge, trying from there to describe the phenomenon, to analyze and interpret it, thus getting a grasp on what is essential. Lopez and Willis (2004) assert that the phenomenological approach and nursing are a good fit because phenomenology seeks to understand unique individuals and experiences. As well, it is a pragmatic process that applies to both the discipline and the professional of nursing and a methodology that honors the importance of nurse's practical understanding of quality, which has the possibility to enlighten practice (Van der Zalm & Bergum, 2000). It allows the researcher to approach and understand the different perspectives of participants who experience nursing as a team in the world of the NICU.

Anne Flood (2010) provides a thoughtful outline for understanding phenomenological research and its implications. Phenomenological methodology can be structured in a sequence or steps to direct the researcher to a discovery orientated approach (Spiegelberg, 1960; van Kaam, 1966; Giorgi, 1970, Van der Zalm & Bergum, 2000). The process begins with a description of a situation experienced in daily life (Giorgi & Giorgi, 2003). The experience or phenomenon is bracketed and its essence is searched (Sadala & Adorno, 2001). The interview is reflective rather than observational

as in quantitative research (Munhall & Oiler Boyd, 1993). Thus, the interview is the central method of data collection: participants' descriptions can be explored, illuminated and then proved (Kvale, 1996). This paves the way for reflection, clarification, requests for examples and descriptions, and listening techniques (Jasper, 1994). Seidman (1991) suggests that it will pass through three structured stages: first, establishing the context of the interviewee's experience; second, the construction of the experience; third, reflection on the meaning it holds.

This perspective enables the researcher to concentrate on the phenomenon that is being studied while the ethnographic perspective allows for the phenomenon to be considered in terms of the participant group and its cultural background (Maggs-Rapport, 2000). Both look for commonalities and shared themes within the narrative data and both distill or reduce data to uncover the essence of participant meaning or to clarify and understand cultural meaning (Maggs-Rapport, 2000). The benefit of combining these methodologies is that the researcher can reduce the data to search for "thinking units" or interview themes exercising ethnographic techniques, while reinforcing this procedure by employing a process of reasoning to understand the exact phenomenon under study (Maggs-Rapport, 2000). This combined methodology can enhance the results of data analysis by using technique of phenomenological data analysis combined with the understanding of "typologies" or themes used in ethnographic research.

Combining phenomenological and ethnographic research methods may also have implications for nursing. As well, nursing is a complex discipline that involves highly skilled techniques and expert, deep, and precise knowledge of medical science. This invites using a method that is not a silo approach, but one that can better embrace the

totality of nursing practices. Combining a research approach that gives voice to the NICU team, without imposing an interpretation, together with an approach in which the researcher assesses the sense-making and impact of the event for the group, appears to have some import with the realities of health care and nurses.

Participants and Context

I used ethnographic methods as a base and guide for my research and spent time within a NICU in a large hospital in a major city in the Midwest. I interviewed 11 nursing members of the NICU team. As a disclosure, during my eight year tenure as a Lutheran pastor in the city where this hospital is located, I made over 100 pastoral visits to newborns in this unit and their parents and family members. Nearly all of these visits engaged the nursing staff who were present and taking care of "their" baby. Through these close interactions and noting that there is not a lot of turnover in this particular unit, I became well-acquainted with many of the healthcare providers. One of the nurses and one doctor are members of my former parish. In this study, I was not previously acquainted with any participants and had not met them before their participation. In the following, I will provide brief information about (a) the members of the healthcare team I will be interviewing and observing, (b) the hospital, (c) the observation and ethnographic process, (d) analysis of data.

The Nurses

This study will focus on members of the nursing team within a Neo-Natal Intensive Care Unit (NICU). This unit is located within the main hospital and close to labor and

delivery and the pediatric unit. There are 68 nurses in the NICU, 5 who are full-time and 63 PRN (at least 16 hours a month) who may work up to 72 hours in a 2 week period. Within this group of 68 nurses, this study interviewed 11 nurses. The nurses were selected by the unit manager and I had no input into the selection process. Currently, all nurses who work in the NICU are female, except for one male nurse who started in June, 2014. The average experience for .4 Full Time Employee (FTE) or greater is over 20 years. Nurses are usually assigned two patients during a shift, however, this can change if a patient has unusual needs and demands upon the nurses' time. While there are routine tasks that a nurse has with each patient and each day, because this is an intensive care unit, some patients are "feeders and growers" who are born prematurely yet need the expertise of intensive care and others are in distress and their condition may be considered "serious" and anything but routine.

NICU nurses are in a pool and are assigned to the NICU because of their specific skill sets and training. During each of the 3 major shifts (0700 – 1500; 1500 – 2300; 2300 – 0700), the number of nurses assigned depends on the census of the unit. For example, if there are 20 patients, there might be 10-12 nurses assigned for that shift, depending on the acuity level of the patients. Nurses also may work 12 hours shifts and others may work part-time or 4 hour shifts. Nurses are part of an interdisciplinary team that includes NICU physicians, other physician specialists (i.e. cardiac and ophthalmologists), nurse practitioners and respiratory therapists. As well, the must interact with the pediatric unit and labor and delivery teams.

While there may not be a constant in terms of the nurses that work each day and nurses must interact with many other health care providers, there is still a strong sense of

the concept of "team" among the nurses, who have the most contact with the patient. Nurses in the NICU count on each other for help with admissions, when there is a "code" or complications in the delivery room that require resuscitation, mentoring each other, offering both nursing skills and emotional support during a time of crisis with a very sick baby or death, offering additional presence and teaching caretaking techniques for parents of babies, covering for lunch and breaks and providing detailed and accurate information when the shift changes and the "hand-off" of a patient occurs. There is no permanent cohort group that works together regularly for each shift, however, all of the nurses know each other because they have either worked together for a while and/or because the unit capacity is 30 beds, which makes for close connections, even if they rotate shifts and nurses are not consistently sharing the same hours or shifts.

The Hospital

The hospital where I conducted this study is a private hospital in the Midwest that I will call "The Hospital." In data collected for the 2011 year, there are 376 beds in The Hospital, 22,869 admissions, 7,413 annual inpatient surgeries, 919 outpatients surgeries, and 43,450 ER visits. The purposes of this study deal with the nursing staff, which at The Hospital include 340 Full-time RNs and 728 Part-Time RNs.

This hospital is tied to the Roman Catholic Church and is "committed to the philosophy of the Franciscan Sisters of Mary. (The Hospital) recognizes the sacredness of life and promotes the dignity and freedom of each person." It is noteworthy that because of the strong ties to the Roman Catholic Church, The Hospital must follow the "Ethical and Religious Directions for Catholic Health Care Services" issued by the United States

Congregation of Catholic Bishops, issued on June 17, 2009. To stray from these directions or dismiss them in any way that could be interpreted as disregard for their intent could mean losing status as a "Catholic" hospital.

Observation, Ethnographic Process and Data Collection

The exercises that will provide the structure for my research comes from the practices of narrative medicine that is currently being utilized in several medical schools and hospitals, among them are Dartmouth Medical School, Johns Hopkins Medical School, Strong Memorial Hospital of the University of Rochester, Harvard Medical School, Kaiser Permanente, Henry Ford Hospitals and Clinics and Virginia Mason's Medical Center. It is founded on the principles of narrative practice and the general concept is outlined by several authors who may have small tweaks in their methods, but follow the same basic approach (Charon, 2001a, 2006; Engels, et. al, 2008; Frank, 1995; Martin, 2011). The primary method of collecting data for this study will follow the patterns and lead of Charon, Engels, Frank and Martin. This study was done through several participant observations, one individual meetings/interviews, and three group meetings of 11 participants. There were 60 - 70 nurses from which to choose and they were randomly selected by the NICU unit supervisor. The unit supervisor provided recommendation of team members, identifying team members with different levels of experience or those who have either ease or trouble with communicating and/or teamwork. Those who worked different shifts and hours were included, because most of the nurses interact with each other at some point. The kind of sample that makes sense in this study was that the members of the nursing team included members that focus on

team communication and collaboration that is critical to providing good care for patient. The semi-structured questions are not atypical for qualitative study and reflect a qualitative technique that also is appropriate for phenomenological methodology. The "field" for this project was in the NICU at The Hospital.

Themes I am examining are primarily organized as they related to specific research questions that this study seeks to answer and are tied to the theoretical perspectives that I have chosen for this study. As well, the phenomenological approach allows for being open to capturing themes that may emerge during the research. I created an initial code list, which captured words (codes) that act as labels for important concepts that emerged as the process unfolded. The coded data was then clustered together to form cohesive categories and themes that the group constructed, which once again, was placed within the research questions. These were be naturally shaped by my own assumptions, experiences, and interpretations. I consulted theories from organizational behavior, healthcare communication and dispute resolution to shed light on the themes. Lastly, I looked for links and relationships between themes to eliminate or confirm themes.

I used "realist" ethnographic methods in this study. I took field notes and kept a journal of observations and conversations. Following the methods described found in *Writing Ethnographic Fieldnotes* by Emerson, Fretz, and Shaw, I "wrote up" my notes during those times I was not in the field. Notes will be detailed, describing scenes and conversations. There will also be extended entries and my own reflections. The time span for this study was a single academic semester. Three primary sources of data were collected.

I first met with the 11 NICU nurses to complete 3 rounds of a narrative exercise. Groups ranged from 3 – 5 people and participants varied according to their own schedules. Because this was a fairly homogenous group, this provided an opportunity to explore similarities and differences in perspectives as well as expand participant's views. This exercise involved me reading a poem or short story together, discussing its meaning, and then inviting the individuals in the group to write a poem or narrative about some aspect of their work as a nurse in the unit. The session time of their own writing began with a basic phenomenological and narrative question of "think about a time when your team was working well together…" or "tell me about your worst or best day at work because of your team…" or "describe what it means to be a nurse for you…." Various themes were offered as starting points, which were used to access the nurses' perceptions of the impact of teamwork: e.g. biomedical ethical issues, palliative care, intimacy and bonding with their patients, parental joy and sorrow, friendship and mentorship and job sharing with other team members. After 12 minutes of writing, I invited team members to share their poems and reflect on their work as a group. Sharing their own work was up to each individual and although no one was required to share their work, each participant shared at every session. The confidentiality of each participant was protected by changing all names, places, and other identifying information. I took field-notes and taped the sessions.

After these three group sessions were completed, I interviewed each participant in semi-structured interviews one-on-one. The semi-structured interviews were an open process, which allowed the opportunity to understand the experience of the narrative medicine exercise for people within the team and reflect and on perceptions they wanted

to share as a result of the exercise. I needed to interview individuals in the team to become acquainted with their interests and probe for characteristics of their perceptions and understandings as a team. The semi-structured interview method enabled me to investigate their stories yet at the same time provided me with the freedom I needed to respond to them. These individual interviews were used to assess how nurses make sense of teamwork and how the narrative medicine exercise impacted them as individuals and a team. In the individual interviews, which lasted from 1 - 2 hours, the conversations were taped, with permission from the participant, and then transcribed and coded for patterns, recurring themes and compared to the constants that are present. I used an open-ended style of questions and covered topics cogent to the research questions: e.g. team cohesion, leadership, communication and how nurses find meaning and make sense of their work as individuals and as a team.

After participants were interviewed one-on-one, I observed each participant in the unit as they worked their shift for a total of 15 hours and was present for all 3 shifts (day, afternoon/evening, and night). This observation was done in 1 to 2 hour segments each time with the members who were assigned to be in the groups. I spent time with nurses while they were alone with their patients doing their “cares”, with family members, with other nurses and staff, and during what is called “the huddle,” when one shift hands off to another. Observation was done alongside the entire nursing staff during that shift and within the NICU unit. Since each baby has their own room in this unit and the rooms are rather large in size, I was able to be present in the room, yet not intrude on nursing care of the patient. If parents were in the room alone, there was no need for me to be present in that room. I informed each nurse I was working with that I was going to be with them

for some of their shift and checked-in to get permission for spending time with them, which I continued to do throughout my time with them. I was aware that this consent could change during my assigned time with them, because patients have varying degrees of acuity from hour to hour and a nurse may not want to be observed if she is under considerable stress or involved with an intense situation with a patient. My involvement with these nurses was as an observer only, I was not be a participant-observer or involved in any medical care, however, some observation time was spent in conversation about issues with the patient, family members, or issues within the healthcare NICU team. This usually happened while they were feeding their babies, which is a normally quiet time to have a conversation.

The central question of this study addresses how NICU nursing teams can be impacted by the practices of narrative medicine. Thus, this study engaged in the sense-making of nursing teams and revealed understanding of the NICU team and how their work is meaningful in their daily lives, individually and as a team. In the findings and conclusions, this will be reflected in conversations and their own stories, or narratives, which will be analyzed by examining recurring themes and the constant comparatives.

I had conversations with 12 nurses in the NICU at The Hospital about this project in August – October, 2012. I wondered if the project was feasible and if the nurses would be willing to engage the concept of narrative medicine and how it might be reflected in a meaningful understanding of teamwork in a prolonged study. At the time, I was also doing some training in understanding of the work of nurses, which would inform my training, so I did this pilot study with this group of nurses. I did not accept any remuneration for these sessions. None of the nurses who were in the pilot study

participated in this study; they were excluded. I did not I use any of the material gathered from meeting with them; it was excluded.

CHAPTER FOUR

RESULTS

Introduction

Although there is a large amount of research on nursing teamwork, the subject of narrative medicine's impact on nursing teamwork has not been considered. Patient care and safety are the underlying reasons that nurses are involved with their work. Yet, focusing on patient care and safety by itself does not offer a comprehensive way of recognizing the important aspects of how nursing team functioning provides a way to accomplish these goals. My research identified that narrative medicine offers a way for new perceptions and actual practices to emerge and enhance team functioning.

Results of my research on narrative medicine and health care teamwork will be presented through three research questions. The focus of the results centers on three themes:

1. How narrative medicine influences nurses' perceptions of how healthcare teams function.
2. How narrative medicine builds understanding between nursing team members and helps them make sense of their team interactions.
3. How nurses make their meaning out of their role as a healthcare professional and team

   member.

Research Question 1: How Does Narrative Medicine Influence Nurses' Perceptions of How Healthcare Teams Function?

The findings in this section illustrate that the research team found impact on team functioning with respect to offering and asking for help, feeling less isolated and more bonded with other nursing team members, and being able to communicate more effectively. The results show that communication realities for nursing team members are sometimes compromised and can create considerable barriers. However, through participating in the narrative medicine exercises, the participants made some significant impact on the way they communicated with each other and their perception of how their teams functioned.

I begin addressing this research question by considering three themes that emerged from the data that demonstrate how narrative medicine influenced team functioning. First, I examine the nursing team practice of offering and asking for help with work tasks. Second, I turn to how team members felt more bonded and less isolated in their teams, creating a feeling of "comradery" and working collaboratively as a result of narrative medicine. Finally, in this section, I analyze the communication patterns and improved conflict resolution skills as a result of narrative medicine. Through participating in the narrative medicine exercises, personal and team goals became sharper and participants believed work with their patients was enriched. Specific techniques or skills through narrative medicine encouraged stronger teamwork functioning. This was exemplified by enhanced conflict resolution, communication and giving feedback. Narrative medicine may be a new tool in the organizational development toolbox that could fill a gap for nursing team members to develop deeper sense-making of individual work as well as teamwork.

Teamwork emerged as a prominent theme in the research and as a theme for this study. Descriptions of how participants' daily work played a prominent role. When considering the effects of this study, participants often considered their "routine" work, where they "routinely went about their work and were giving cares," "were bed side with a patient," or "teaching parents." Although much of this routine work is individual, when reflecting about their work, this was often accentuated with the awareness that they were part of a team, and, most profoundly, with their team of nurses in the unit during their shift time. The interview data establishes dominant themes suggesting that nurses in this NICU are mindful of how their team is functioning within the nursing group and the wider aspect of all those who work in the NICU. This wider group includes NICU unit physicians, nurse practitioners, specialists such as cardiac physician and ophthalmologists, respiratory therapists, physical and occupational therapists, social workers, chaplains, and the housekeepers. Organizational development behavioral features are recognized within wider aspects of healthcare research on teamwork and they are specifically investigated in nursing team studies, which makes this study relevant (Wittenberg-Lyles, Goldsmith, Ferrell, Ragan, 2013; Wittenberg-Lyles, Goldsmith, Ragan, Sanchez-Reilly, 2010; Longo, 2010; Krause & Hidley, 2009; Dauer, 2005; Gerardi, 2004; Lebed & Mills, 2002; Weick & Sutcliffe, 2001; Reina & Reina, 1999). The support within the nursing team during everyday procedures and especially during stressful times, such as a baby's death or coming to terms with compromised social situations in which the baby would be sent home, keenly demonstrate the lived-in contextual team realities and challenges of their work. Research participants revealed that it was within the day-to-day realities where they most needed each other's clinical skills,

as well as the emotional support. I argue that narrative medicine offers a way for new perceptions and actual practices to emerge in team functioning within the daily practices of nursing care.

Team Functioning in Asking and Offering Help to Team Members

Research into healthcare teams suggests that sound teamwork practices within the healthcare team are essential to functioning well. One of the central components of healthcare team functioning is the ability and comfort level of asking and offering help to other team members. When healthcare team members are on friendly terms and share appropriate aspects of their lives, connections are built and they become more approachable to each other, which is beneficial for team building. During the initial group sessions in this research, I asked participants how effective the current functioning of the nursing and all team members was in the NICU with respect to asking and offering help and, if so, how it was perceived.

Several research participants noted the significance of team support that was evident before the narrative medicine group exercises and talked about it in an animated way. Baily said: "Just coming to work and getting support…being surrounded by great teamwork. People are supported and supporting. They're caring…they want to make sure you do the best." Sandy said: "There's definitely good teamwork here. A lot of people go around and say, 'Do you need anything? Are you OK?' They check up on you. I do see that people lend a helping hand. They'll stop by and say, 'What can I get you? Do you need anything?'" Donna noted: "I've found people to be really, really helpful because I've always been able to go to someone to ask for a second opinion…." Barb said: "Some

people come to help out – and extend themselves." These remarks display that nurses in this study experienced a sense of reaching out to each other before their participation in this research.

While interviewing, I found that the nurses viewed their work as a connection not only with the patient to be important, but to each other as well. Their inter-team relationships were a significant part of their work that gave meaning to their tasks and allowed for professional and personal growth to happen. In forming closer relationships, the ability to ask and offer help was enriched, which dovetailed with the sense that their work skills were heightened as well.

Knowing specifically who to go to in order to obtain help was an important aspect of reaching out. Alison said: "If I were giving advice to a new person, I'd say, 'Know who your go to people are,'…. It's extremely, extremely important that you won't feel like a burden when you ask for help, versus the alternative that would be scoffing or reluctant…." The aspect of feeling safe about asking for help from others was valued and created a trusting relationship. The broader implication of this also means that when the "go to" people are identified for individuals, there is a sense of openness to ask for help without hesitation. This concept considers that the relationships that are formed within the team are as vital as the attitude and degree of sharing that occurs.

Though teamwork was strong in this unit before the study, being able to ask and offer help was not as robust as it could have been in this unit. Evidence of the lack of give and take in terms of asking or giving assistance to other nurses is provided by Sandy. She said:

> …typically when I have time I go and ask other people what I can do for them. Some people are not so helpful. They don't offer but they expect it themselves.

This comment demonstrates an unbalanced relationship in terms of giving and asking for help within the team. For a team member to be on the receiving end of help and then in turn not offer help created a sense that the equilibrium of extending a hand and receiving help returned is uneven.

Alison, who was not new to nursing but in the NICU for less than a year, stated that she believed there is a need to be qualified to offer help. At this point in her experience, she doubted that she could have the knowledge base to be able to reach out and offer advice: "I don't necessarily dislike helping, but I'm not at the point where I feel I can readily give advice." Her unwillingness to extend assistance is not based on a harsh self-assessment of her skills, but rather built on an honest self-awareness about her own skill capacity in her relatively new position as a NICU nurse. It might be tempting for anyone who is new to a unit to exhibit some self-aggrandizing behavior, however, with Alison, she is honest with herself in such a way to realize what skills she has and is willing to accept that she needs to grow in those skills. Although she values reaching out, she understands that she needs to become more experienced and confident in her skill level before she extends help to others.

Asking for help is important for nurses and for sense-making in their work. Knowing that the channels of communication are open between team members on the shift means a lot to them. Donna, who also had less than a year in the NICU, said, "I've always been able to go to someone to ask for a second opinion…." This was echoed by Baily, who said, "everyone here is very supportive and answers your questions and they want to make sure you do the best." The principal sense of providing good patient care is reinforced by the help that nurses in this unit offered and the way in which they asked for

help from each other. As Alison said, “knowing who your go to people are” then not only means knowing those who will be respectful of your questions, but also have an adequate knowledge and skill base to answer a question in an accurate way. The twin aspects of demonstrating a respectful attitude with co-workers and possessing skilled nursing knowledge with regard to asking and offering are linked.

Although many team members in the research group believed that the ability to ask and receive help was at a beneficial level before the narrative medicine project began, all of them noted that after participating in the narrative medicine groups these qualities were increased. While they are assigned a patient or a few patients and are individually responsible for their care, it is evident that the shift team members work together and count on each other for help. In some cases, this captured the participant’s sense of team and individual functioning in a considerable way.

Reflecting on how the research participants were asking and giving help after the narrative medicine exercises, in an individual interview after the group narrative medicine exercises were completed, Sue said: “It was like getting a booster rocket under us. We are all (in the research group) reaching out a lot more. It’s significant and made a huge difference. I am much more confident to ask for help now.” In this comment, Sue reflects on the group’s dramatically enhanced and heightened, “booster rocket,” ability to reach out to each other. Participants felt that narrative medicine helped to remove walls that were built on intimidation and reluctance to ask for help, even though the nurses knew that asking for help was a valued aspect of their work. Sue’s comments that she is “much more confident to ask for help now” reflect a belief that narrative medicine helped

foster a deeper knowing of other team members, resulting in her individual self-confidence being elevated so that she felt better about asking for help.

In a post-narrative medicine group exercise individual interview, Donna echoed Sue's comments that asking for help was enhanced after the narrative medicine exercises. She said:

> It was good before, but now it is just so much better, especially with people who were in our group. And you know, you don't have to feel dumb about asking. So that's made me a better nurse and it's great to have that little edge of nervousness off the table to go and ask for help.

Donna's comments reflect a sense of "feeling dumb" about not knowing something and needing to admit that to someone else, which is manifested through the act of asking a question. An outcome of the narrative medicine exercises for her was not only being more comfortable asking for help, she directly correlated this to the understanding that it "made me a better nurse."

In a one-on-one interview after that group sessions, Randy reflected on how the narrative medicine group sessions changed any of his thinking or actions with regard for asking for help. He said,

> The exercises and conversations were beneficial to me. I know I'm repeating myself but it's so good to hear and talk about what matters and what matters to them when the team was stretched and it would make me feel and think a little more that when I hear that there's an admission – it made me think about, OK, finish, get your kid situated and see if there's anything they need. Anything.

These comments emphasize that Randy is giving more thought to reaching out to nursing peers. This description also demonstrates that he is exploring his own sense of personal boundary and independence, yet realizing that he is connected to a team. While he may not need help at certain times, the group exercises raised his level of awareness of colleagues, "(the group exercises) would make me feel and think a little more" during

busy times in the unit to reach out and "see if there's anything they need. Anything." After the narrative medicine exercises, Randy's sense of bonding with other team members was deepened and became more personal. The heightened sense of the "other" is evident and represented in a significant way that gives acute meaning and significance to his work. The participants in this group appear to understand that their initial responsibility is to their patient. The narrative medicine exercises raised a level of awareness about the rest of the team's stressors, which developed a sense of extending care from their assigned patients to thinking how to help other colleagues, particularly those who might be under some strain in their work.

Baily sums up her experience, noting as others had, that while the ability to give and ask for help was at a good level, she believed that the narrative medicine exercises made her better acquainted with colleagues, which deepened her sense of being comfortable to reach out to them. Baily said:

> …even if you need to bounce an idea off them and say, like, "Hey, this is going on with my baby…" and get what they think. And I'm not less afraid, but more apt to go to people and say, "What do you think?" and get their opinion. And before I was like, "Who should I ask? I really know this person…so I'll go to them first." This group has helped break down those walls and reach out to other people and it never hurts to get to know more people on your floor.

Ellen also noted that after the narrative medicine sessions, she was reaching out to people more and seeking out people who may need help. She also talked about how reaching out to offer help was a way of personally breaking through some of what she described as a "Teflon coated" barrier that she had erected to protect herself. As a result of the group work, she believed she didn't have to keep herself in such a protected position in her work. The group work suggests the creation of an opportunity for developing team connections that were not present before. Some of this came through

some introspection that had repercussions in deepening her sense of team and reaching out to ask for and offer help. Ellen stated:

> Ellen: Mostly, we all have to keep trying to make this a team. I know this one person is trying to make it better and maybe I should say – what can I do to help? I want people to feel that they can ask questions and that they will get an educated answer and they won't get blown off…then I have to step up to the plate and do that all the time.
>
> SB: Has the group work affected that at all?
>
> Ellen: Last night, (as a result of the narrative medicine group) I talked to an IV nurse who had a question. So, I'm trying to look for opportunities. My goal is to try to be present and, you know, ask them if they have questions from me. The things I know, share them, because I have experience. A lot of the people in the groups I was in, we all work together. So, you know, I was more afraid what I was sharing with them. …I guess in the last couple of years, I had to be Teflon coated myself, I had to for survival – but I have to let some of that down. They don't have to know everything, but I can share feelings and thoughts and get to that level with other staff too so we can be closer. These group sessions helped me hear about some of the way to help them. I always want to be helpful. I really do I have a friend that says, "Be of service" – and I try to do that and this group helped me think of how I can do that for my team better.

This lengthy comment acknowledges the sense of vulnerability that Ellen describes about herself and how she is making personal changes to impact team functioning that would provide support and thereby increase team functioning for the sake of providing good patient care. It is significant to note that these comments imply that the narrative exercises worked for participants in a way that deepened their connection to each other and that this was a meaningful issue for them. The conversations that occurred during the narrative sessions created an environment of trust and respect between team members, which fostered a norm that understood that not only was it acceptable to ask for help, it was important. Asking for help increased their skill development and enabled a collective competency to be established among the team.

Donna reflected on the "vulnerable spot in me that has opened up as a result of participating in the research groups. I feel safer to open up. It's made me stronger and more confident asking for help, which is in a way more vulnerable, but it's a good vulnerable I think." This suggests that asking for help places one in the vulnerable position of admitting that one does not know everything and that there may be gaps in training or skill expertise. When a person asks for help, he/she may be viewed by others as not being completely competent or have the independence to figure out issues on their own. Although asking for help is considered a beneficial action for healthcare professionals, it also creates the possibility of viewing the person who is asking for assistance as unskilled or unsure of their work. Donna's word choices of being "more vulnerable" set alongside of being "stronger and more confident" has a kind of paradoxical consequence of laying groundwork for a "good vulnerability." This "good" vulnerability creates a strength that considers asking for help as a positive force within the team encouraging better team functioning.

In a one-on-one session, Randy reflected about the group sessions and if it had changed any of his thinking or actions with regard to asking for help. He said:

> "Yeah, actually after you left last night, I initially had just those two babies and I picked up another baby who was in withdrawal from heroin. It was a really busy assignment and I really didn't feel that I could ask for help. Although maybe I should have. I'm the type of person when somebody says, 'Can you do this?' I say, 'Absolutely. I can try.' And I ended up giving a med late and that really bothered me. I was just stuck in a room and couldn't run out – I couldn't just set the baby down and run out, so you know, I probably should have called somebody and said, 'Can you do this for me?' And then I started to think, well, maybe I should have just spoken up. And sometimes I don't speak up in those situations. And I felt, it wasn't like a life-saving med so it was, you know, not going to set the kid back but I was feeling that, 'Oh, sometimes I should speak up and sometimes…' and you know, talking to some nurses this morning, they said, "Oh, you shouldn't have had that assignment because the twins you had were busy enough."

These comments appear to emphasize that Randy is giving more thought to asking for help and that he is more comfortable reaching out to colleagues. This description also demonstrates that he is exploring his own sense of boundary and independence, yet realizing that asking for help is necessary for the patient and is an appropriate reality in the nursing task.

Ellingson (2005) notes that when nurses and healthcare team members are on friendly terms and talk about their lives, connections are built and they become more approachable to each other, which is beneficial for creating strong teams. When team members want to be left alone this usually discourages collaboration and teamwork (Ellingson, 2005). This understanding of offering and receiving help places an accent of approachability and comfort level with the nurse's own skill levels as well as trusting others' abilities within the unit.

Using Charon's framework of affiliation, attention, and representation, the group work helped participants get a shared understanding of themselves and each other. Through the narrative medicine method of a close reading of the text offered in the group exercises and then writing their own shared narrative, participants engaged each other with closer attention. This allowed for the tacit issues of their work to come to the surface so that they were now audible and visible as well as shared among participants. Through studying "how" the text in the group work was written and participating in what the text is asking of its' readers, participants were invited to not only provide an answer to the text but to be present for each other. Through the narrative medicine tasks, participants experienced a heightened supportive understanding, nursing team members indicated that their comfort level with each other increased. As team members increased the ability to

be present to each other in richer, more affiliated ways, participants noted that there was a deeper sense of vulnerability that allowed for greater ease in asking and receiving help. The following statement exemplifies this. Donna said:

> Before (the group sessions), they (nursing colleagues) were just awesome, but now we have with the people in our group – we are more supportive and we are less isolated and there for each other. And these open discussions can only make us better. It helps us as a unit and pulls us together a little more. It could change a culture too. I know go and seek those people out more and in a better way, well, deeper way because we know each other more so I've found over the past few weeks, we're just seeking each other out if we're having a problem or need help with an IV – or they need another (help with a care). So that builds the team and you work together better because we know each other better.

These comments point to the ways in which nurses felt these experiences and identified the changes these practices made within their work. This parallels Van Servellan (2009) finding of the functioning of health care teams being increased by improving communication that not only includes knowing yourself and others but asking for help and extending yourself to others within the team. This was not a planned outcome of the group work, but naturally emerged as an outcome that was welcomed. In the group work, participants did not discuss how they were going to reach out more or indicate the methods they would utilize, rather it was an unexpected product of exploring their work together. During my time observing in the unit, this was a strong theme that was oft times repeated by those in the group. These comments demonstrate their development.

> Kim: Overall, I just feel so much better about asking for help because I got to know people more and can trust them and their nursing skills. I know where they are coming from and who they are, so I can feel free to come to them. And that's because of our time in the groups. It impacts our team functioning in this important way – to be able to ask for help is something that is critical to nurses and for their patients. … the feeling is one of trust…it's even good to do it now. It's so great.

> Ellen: Now I look for more opportunities to help. To be honest, I've been doing this over 30 years so my need to ask others for a hand isn't so great. Not trying to brag or anything, but there's not much I need. But I have realized through the group work that others need help and are not comfortable asking for it. I guess I was like that too, when I was new. So now, I just go around, especially to people who were in the group, but also to others, and ask if they need anything or how things are going. And that's new for me.

The research group attributed this fact that during the group exercise they came to know each other better and deeper and therefore trusted that they could ask questions of each other and that their help would be received in a beneficial way.

Asking for and offering help within the nursing team is s habit that can be developed and is appreciated by those who share the nursing shift even if they are taking care of individual patients. The experience of nurses feeling more comfortable with this seems also to be enhancing their skill sets and empowering them by a more profound sense of being valued by their co-workers. Although the general sense of this nursing team was comfortable asking for and giving help, the narrative medicine exercises enhanced their willingness and comfortability to practice this habit. Another of the outcomes of this practice that affects team functioning of this practice is that the team became more bonded and felt less isolated in their work.

Team Functioning in Bonding and Being Less Isolated

Social bonding among nursing team members can help contribute to team functioning. In the process of this study, team members had the opportunity to become better acquainted with each other's stories and this enhanced their sense of feeling less isolated and more bonded to each other as team members. The issue of isolation for these research participants was a theme that emerged in the group and individual sessions. The

individual patient rooms and overall expansive physical lay-out of the unit, as well as the nursing assignments of a single nurse to two or three patients, can promote a sense of isolation in this NICU. Although being emotionally closer to coworkers can help nurses make sense out of their team, it is also an important characteristic of nursing the teams that function well. Frank (2004) suggests that care can only be provided in a relationship, which can be enhanced and fully appreciated through the practice of a deeper understanding of patient's story. From this understanding, it follows that the relationship between nursing team members can be augmented through the understanding of each other's stories. In the narrative medicine exercise, the research group experienced each other's stories and grew to understand not only the stories, but each other in a richer way.

The nurse's comments suggest that being bonded to the people with whom they work is an important part of their work. In one-on-one interviews following the group narrative exercises, participants provided illustrations of how they felt more bonded to each other. Baily offers an insight into this bonded result:

> I have to say, the happier you are at work with your coworkers and the more you bond with them, then that happiness show through to your patients. I know people have said that too and other people who come to our departments have notices that, and are like, 'you guys are really in a good mood.' So, we're bonding.

Baily talks about when she is feeling more bonded with the people she works with she believes her "happiness" will be shown to her patients. As well, the spirited climate projected a positive environment that others could detect, which affirms those who work in the unit and perhaps offer renewal to others as well. Barb also noticed how the group exercises created greater bonding with her co-workers:

"I feel I can talk to those people [who were in the group] about things better. I

feel that I have a bond with them now. 'Oh, you're feeling the same way…'"

Knowing that feelings are a shared experience leads participants to the understanding that they are not alone in their thoughts and feelings. This creates a sense of normalcy for individual team members as they recognize that their concerns and emotions are shared. This gives team members a sense of a more common understanding about their feelings, which gives them a comforting sense that they are natural and even somewhat conventional.

Architectural features are an important part of hospital unit design and have a lot to do with reinforcing healthcare team communication and overall functioning. The architecture and design of unit in a hospital can foster an emotional sense of being more bonded with others and less isolated. The nurses who participated in this study were working in a newly designed unit, where the patient rooms are individual, situated off long hallways that had two nursing stations strategically positioned, with two nursing stations located about equidistant from each other. This is known as a decentralized architectural scheme in a health care unit.

Most of the nurses in this study had an appreciation of how architecture played a role in their sense of isolation and how that impacted the importance of being bonded. The physical space played an important role in pulling the group together and allowing them to feel more – or less - isolated. This was exemplified in a persuasive way. In the former unit, the patients (babies) were all located in one large room, which allowed doctors and nurses worked very closely, in proximity, to each other. Each of the research participants talked, sometimes at length, about the advantages this had for giving and receiving instructional opportunities, being able to ask questions of each other, having

parents view care-taking procedures with babies who were not their own, and give and receive support – not only nurse-to-nurse, but for parent-to-parent support as well.

The physical lay-out of the old unit had a blanket effect on bonding, not only for nurses, but for parents as well. Becker and Sims, (2001) note that when work processes benefit from a better understanding of other's skills and knowledge-base, and a free and open exchange of information and opinions can flow easier, more open work areas with a notable degree of visual contact are shown to be more effective than closed-in offices and workspace. While this might bring up a violation of HIPPA laws and seem to break boundaries for patient confidentiality, participants stated that they never heard parents complain about the architectural arrangement in the old unit.

Participants also mentioned that not only in the old unit did they feel more bonded with each other, they felt more bonded with the doctors as well. In the new unit, doctors now had a separate room do to their charting, and in the former unit, they were in an open space that was within the nursing station. Although the NICU unit in this study has been in its new location for over two years, some of the nurses who worked in the old unit were clearly missing some aspects of what the old unit had to offer. They spoke about the old unit with a longing for the connection that many of them felt was present yet also noted how the narrative exercises helped them recapture the close feeling they were missing.

> Barb: In the other unit, you knew a lot more: about your co-workers, the parents, the babies, and it was such an excellent teaching environment. And now there is more of an isolated feel. So getting to know people is an underlying thing than came from the groups – and being connected.

Barb's comments highlight the "underlying thing" that came from the narrative group work, which is "being connected." The connections that emerged from the group work

seem to be a valuable aspect of created links that engage both the emotional and professional life of the team member. While spatial layout in the new unit was hampering a feeling of bonding, the narrative medicine group exercises created new ties between participants.

Rose noted the influence the narrative groups had on bonding and how that directly affected work functioning.

> Rose: I am so grateful for this study because I feel so much more bonded with people. More than I have ever and I've been working in this unit for many years. This will help our operations, working together, you know? I mean it's a nice feeling too – but it will have impact on our ability to work together, which is really, really important.
>
> Kim: I am so much more bonded to the nurses who were in this group and that is important in many ways, but now I believe I can trust them more and I don't feel so isolated, which help our tasks, our work, you know? I think being closer makes us better as a team because we can perform better if we're working closer as a team.

Although being bonded emotionally is "a nice feeling" and could provide a boost in workplace morale, Rose and Kim notes that actual work performance is also impacted through the narrative exercises, and this is paramount to their tasks. The twin aspects of feeling more emotionally bonded are important, however, Rose and Kim wisely observed that this affects their work functioning, which is the foundation of nursing.

Donna reflected on the isolation she had felt before the group exercises and how that isolation became apparent in a new frame after she participated in the group.

> Donna: I can't even begin to tell you how much less isolated I feel as a result of the groups. I mean, I tried to sometimes reach out and I can't say I've had a terrible time here, but I did feel isolated. And the realization that I was so isolated is even greater now that I have been through these groups because for those of us who were in the groups, we are closer now and that will definitely have an impact on how we do things, perform as a team. I can see it already and it's not even been a month. I feel that I am performing at a better rate, not that I was bad

> before, but this will make me better as a nurse in my skills…to be able to feel less isolated. It's not something you think about right away when you think about skill sets, but it's definitely there.

For Donna, the result of the narrative group work not only impacted her sense of feeling less isolated, but also affected her skill performance. The fact she draws a correlation between feeling less isolated and how that influences her nursing skills implies that these two aspects of her work are linked in a significant way. Perhaps, as she notes, this is not something "you think about right away when you think of skill sets," but is a certainty for her.

Bonding in nursing teams enhances communication, listening, problem solving and trust among members. When team members feel more connected with each other, team skill functioning is enhanced as well. Although the feeling of being bonded may not be strong in a team, it can be developed and is greatly valued by team members. While team bonding creates improved team functioning, communication practices play an important role in this aspect of teamwork. The features of effective team bonding are created and enhanced by thoughtful communication habits, which seem to provide a crucial role in team functioning.

Team Functioning in Communication

> Donna: "I've been taking more time, the little bit of time I have, to sort of talk to people and try to figure out more about people I'm working with."

In the group and individual sessions, research participants explored how communication helped to make sense of their teamwork and functioning. The research revealed that participants improved the communication and felt freer to seek out other team members, especially those who participated in the group, to ask for "anything." This

improved confidence in communication also noticeably assisted team members when there was a conflict between them, which meant a lot to them both personally and professionally. As the literature review in this study noted, a significant number of medical errors result from poor communication among healthcare team members (Tchannen, et al, 2013). Van Servellen (2009) describes common group communication problems, which can manifest themselves in such ways as conflict that is not resolved, isolation, apathy, and the inability to make a decision. Van Servellen (2009) further notes that the way to improve healthcare communication is through creating a sense of understanding the self and others. This reflects what the narrative medicine group work exercise offered to the participants: an opportunity to increase a sense of their own work and selves as well as those who participated.

Nurse's statements on this topic support how important healthy communication is for teamwork and several themes emerged. First, many of them noted that some communication patterns in the unit were abusive and tended toward bullying other nurses. This was in the category of gossip, which was viewed as harmful to not only the individual who was targeted, but to the team as well. Team members who overheard or knew about the inappropriate conversations were bothered by this form of communication and expressed this in pointed ways. In one narrative group session, the following conversation about gossip and poor communication habits took place among the participants.

> Baily: I recently heard stories about how someone was talking and said something really bad about a nurse and I think, why can't we be adults? Why all the negative talking? Say if Donna would do something wrong – there's a right way to say to her, 'Hey, this is happening so maybe we should try it this way…' instead of being so condescending.

> Sandy: Well, sometimes they do intend to be very judgmental and rude….
>
> Donna: … I've seen people cut down people and their personal life and their RN abilities and decisions they've made where it's kind of like I don't really like that. …I don't think we should have that in our professional world….
>
> Alison: It's kind of sad. I guess I've only been a nurse, but I guess it happens in offices and it's all over the world and in all kinds of careers. But I feel that nursing is particularly vicious.

Although this exchange did not mention that mean-spirited communication affected team functioning, I believe that these kinds of examples of communication could affect team bonding and trust building and that effective functioning could be compromised. These thoughts about rude and improper communication can lead to the sad reality of poor functioning teamwork. Good communication means more than passing key technical information between healthcare providers, it also means using civil language that creates trusting bonds between staff. While nurses did not express this exact sentiment in this conversation, there is a desire on behalf of the nurses in this group for their teams to communicate well and in a way that is constructive. Teamwork is affected by this kind of inappropriate conversation. Ellen said:

> I don't want to talk to other people about others. Like, "You'll never believe what so and so did to me." Instead of talking to the person about it. But sometimes, I tell someone else what somebody else did. And that's detrimental to teamwork.

Ellen links badly mannered dialogue to ineffective teamwork function. The narrative medicine exercises opened a channel for discussing the topic of communication and provide a means to offer participants an opportunity to reflect on the sense-making and importance that strong communication can have on a team.

Dispute Resolution in Teamwork

Communication in teamwork also involves resolving disputes and expressing thoughts that are difficult to convey. Research participant team members considered their overall communication practices and how they made sense of their tasks and teamwork within communication practices. While discussing the challenges, dispute resolution within teamwork emerged not as a subset of communication, but rather as an important key for enriching and promoting beneficial communication patterns. Dispute resolution skill sets are something the nurses in the group sessions noted as difficult for some of them and not difficult for others. This depended on the comfort level of the individual with the ability to have a hard conversation or confrontation. Participants reflected on how they became more secure in their ability to confront others as they became more experienced. As well, perhaps they also acquired skill sets and maturity to be able to challenge inappropriate behavior. Although for these participants, they note that they had to grow in their ability to handle difficult encounters head on, they understood that it was important to do this for the sake of patient safety. This connection was a crucial one for them.

> Donna: (where I used to work) I remember, there was this one girl that just hated me. Just hated me. And we had PSA's there – and I was on the floor and had to break the PSA's to get lunch. The room wasn't turned over when I came back and this NA that hated me came on and like, just freaked out at me and was pretty verbally abusive. So, I waited a few days and then, heck, I pulled her aside and thought, - well, I said, I did it professionally and was nice, but I said, "I don't want this to affect our ability to work together. I like working with you," which is a little bit of a lie (Laughter). That's a patient safety issue and you didn't let me tell you what happened and she really didn't know what to say. It was funny. She's like, "No, I wasn't mad." And she never did it again. And it was just annoying….her attitude was still annoying, but….

> Baily: I would have just been crying….
>
> Donna: Once I confronted them, always, I feel it helps. I feel that they feel stupid.

In another group session, Rose said: "Nurses will throw each other under the bus and put down another nurse. It's confusing and non-professional." Verbal abuse is costly to individual nurses, the hospital, and patients. Nurses who experience verbal abuse from nursing peers may be more stressed and feel less satisfied with their work. The result of this may be that more work is missed, which may lead to providing substandard quality of care to those they serve (Rowe & Sherlock, 2005). In the above exchange, participants stated how team functioning is affected by rude behavior. As further research comments note, participation in the narrative medicine research groups helped them deal with these difficult conversations by opening a possible place for developing an essential bond and deeper understanding of each other.

The understanding of the how healthy interactions between co-workers fits with current research reveals how important being able to resolve disputes is to team functioning. Gerardi (2004) reinforces this comment noting that nurses learn a holistic, patient-centered approach that includes physical emotional, and spiritual components of healing, which are reinforced during nursing education that include patient advocacy and quality of life. Ironically, that same advocacy and quality of life that is instilled in nursing education with respect to the patient sometimes does not translate into the workplace among nursing peers. This creates a culture in the nursing team and unit that undermines functioning, creating unresolved rifts between nurses and habits and practices that keep the unhealthy culture in check (Gerardi, 2004; Dauer, 2004). This is important to consider, because as cultural conditioning is difficult to change. Yet the nurses in this

study were hopeful that with the level of support they were offering each other and the closeness that was being fostered, they might be able to talk to each other in healthier ways and feel safer to confront each other when issues arose. The process they experienced in the narrative groups revealed the communication issues they faced. From this process, the groups also reflected how they felt the narrative method offered avenues for change. Cheryl said:

> I just feel now that I can go to the people, especially those who were in the group, and talk to them about anything. I mean sometimes we lose our tempers, we're under a lot of stress, but it will be easier to apologize and talk to someone who was just out of line. It's because I feel closer to them and I want to get things squared away. And I don't want to work in a place that it's OK for people to talk to each other like that. It's like we are all accountable now and can't get away with that – and we can hold each other to it. I swear, I mean I really do swear, when I get dissed and I know it has a bad effect on my work. So being able to talk to each other will help the way I work too, which is really important.

This comment gives the impression that to take up the understanding that tempers will sometimes be lost and things will be said that will be hurtful, however, as Cheryl implies, suffering in silence is no longer an option with the participants who were in the group sessions. As a result of the narrative group work, participants know each other better and this difficult issue has been discussed. "As a result of these conversations and the fact we have discussed this issue, we are now accountable to each other, because we have discussed this." Cheryl also draws the understanding that not only have these conversations helped to "hold each other accountable," the research participants also need to maintain healthy conversations. For Cheryl, this will affect the way she functions at work, "which is really important."

Another aspect of communication that emerged was how the team functioned when they were they were stretched with high acuity patients and over a period of extended

overtime. Participants noted that this work related stress "took a toll" on them and that they were "at a breaking point." This conversation presents the reality of understanding the foundational aspect of their work is that "the babies need the help," yet it is a stressful work situation when the pressure and exhaustion levels are so high. It is interesting that this conversation emerged in a group session about a lengthy period of high stress in the unit and how many members of the team extended themselves to "be part of the team." Although this does not mention team communication and functioning per se, it does emphasize that "working together in a crisis situation" is a theme that is important to participants, which involves healthy communication.

During an observation, I asked Randy to reflect about some of his comments on how conflicted team communication gets resolved and how the group sessions affected his thinking about this. He said:

> Randy: Since the group meetings, I have been thinking about this conflict issue and what I said in our one-on-one session. I have to say that I think it will be so much easier to have these kinds of discussions about things we don't agree on because of the group sessions, especially with the people in the group.
>
> SB: Why easier?
>
> Randy: Because, our communication is better. It's more open. It's more trusting and we "get" each other better, which will make us more honest. We are all talking about this now, which is creating better communication too.

Because team members know each other better and trust has been established, Randy's comments draw a correlation between the group work that enhanced communication and how this will help out when conflicts or disagreements arise. Being able to resolve conflicts is essential in clinical teamwork. To confront another team member and be willing to engage in a conversation about something that is difficult was challenging for team members, yet Randy's remarks suggest that the group work will make it easier to

engage each other. Approaching another team member in a more confident manner about difficult conflicting issues was a welcome feature in teamwork functioning.

Interdisciplinary Teamwork

Communication between doctors and nurses was also an area that emerged during this study. Ellingson's (2005) research on interdisciplinary health care teams makes a distinction about the "gap" between communication with the doctors and nurses and how this can affect the whole team. The notion of specifically identifying that gap came out most clearly in Rose's comments:

> Rose: I've been thinking that the docs should be involved. That's where I think the biggest gap is between the physicians and the nurses. Have you thought about extending the study? I've been thinking it might be so helpful.

This suggests that the perceived gap between nurse and physician communication is a critical one to negotiate and that perhaps by both sets of team members participating in the narrative medicine exercises, this might help breach the space between these two groups. The nurses in this research study perceived the need for healthier interdisciplinary team communication and stressed its importance for team functioning. The following research group exchange indicates this understanding.

> Sandy…It's a combination of lack of communication and they are not getting their own numbers….there's a breakdown in communication there. There's no communication with the night shift nurses anymore, they used to be in on that conversation. And even now on the day shift, usually, there's no conversation on that shift between docs and nurses. No communicating there.
>
> SB: How does this breakdown the team?
>
> Sandy: There's no teamwork. Yeah, whatever, I'm just the peon following orders. But at least when you feel that our voice has been heard and you

> have input about decisions that need to be made – and that's how it used to be.
>
> Sue: I completely agree with you. The thing missing from the team is the team itself.
>
> Sandy: This is very serious.

These comments about the communication gap among nurses and doctors indicate that the nurses speculate how closing this gap would affect team functioning. In a one-on-one interview, Alison offer comments about collaboration, comparing her work in the NICU with her teamwork in the Emergency Department. Her comments support what Propp (2010) and Wade (1999) state about the positive effects of good team communication being building team morale and relationships, assisting each other with team tasks, which facilitate patient care, and promote collaborative decision making. Although the following comments do not refer to the outcome of the group sessions, they do highlight the importance of strong teamwork, which the narrative group exercises developed. Alison notes her desire for better communication and teamwork among all disciplines within the NICU and how it affects her work. Her frame of reference from working in the Emergency Room compared to her work in the NICU emphasizes the benefits of strong interdisciplinary communication and how it relates to team functioning.

> Alison: I think it would be awesome in your research to find out how docs and nurses could work like a team. To made it interdisciplinary.
>
> SB: That's important to you?
>
> A: Very. It's pretty widely known that the nurse to doc relationship in ER room is one of the only nurse to doc relationships is one of the healthiest ones in the hospital.
>
> SB: So, you had that experience here at this hospital, but it is different in this unit?

> A: Oh, God. When we were down there, working with the docs was like working with your peers. There was never a situation where they didn't feel that they had your back. I felt closer to some of the doctors than I did to some of those nurses. And everything in my career that I missed, in terms of decisions that I made, I miss that relationship more than anything else.
>
> SB: Why do you miss it?
>
> A: It elevated care in an amazing way and it elevated my work as a nurse to be able to talk to them in a way that wasn't intimidating and we were able to collaborate and make decisions together.

Although this conversation is making note of the better interdisciplinary communication practices that nurses and physicians had when she used to work in the emergency room, it expresses the desire to have those practices in her current location. The narrative medicine exercises did not appear to enhance this in her current location, however, it did provide a space for her to think about the communication gap and note the significant difference it made in her work. From a nursing healthcare team member's perspective, this type of team experience is not only an important part of work life, but one that helps honor the individual's sense of communication.

The manner in which doctors and nurses "talk to each other" promotes a desired leveling effect on the power and status of each that can cause divisions between these two staffing groups. Rose and Ellen talked about their experience as nurses in other hospitals and compared it to her current work in the NICU with respect to interdisciplinary team communication, which, like Alison notes, had better collaboration and communication in the past.

> Rose: I've been a nurse for nearly 30 years and I have seen that lack of confidence here. And from where I came, it was a real team. You could always ask questions and they [physicians] would rely on what you said and we would collaborate. They would help you think it through. It was like we were part of a team. We were more autonomous. We were in charge. We had parameters – and we knew how far we could go and made the decisions.

> My first 18 or 20 years of NICU experience was so awesome and this isn't the same. I do know that hospitals are different and things change – but this feels like a bunch of personalities and everybody trying to be…a lot of individuals working in the same place.

These comments note the difference between the lack of a collaborative relationship between physicians and nurses in this particular NICU and in other settings where communication and skills sets were honored. The narrative medicine group sessions provided a place for naming this gap and becoming aware of how central interdisciplinary communication is for the team's functioning. Rose's comments also express a longing for this kind of relationship with the physicians, which demonstrates respect for her skills and provides a more interdisciplinary sense of the team. It also emphasizes the decline in the nurses' understanding of teamwork when teams are perceived as being too individualized instead of working together to create an interdisciplinary team.

Teamwork Hospitality

Hospitality in nursing teams is another aspect of communication that effects how teams function. When new people join the team or when a person comes on another shift and works with new people, offering welcome to that person is an important part of helping people feel part of the team. In an individual session, I asked Barb how the narrative medicine exercise helped her teamwork communication and functioning. Barb said:

> I feel it (the group sessions) impacted, like we've got a lot of new people…. So one thing I thought about was to get to know the new people and I feel you need

> to get to know them so they feel included and they feel that they can come and ask you a question.
>
> I liked the way we started out sessions with reflections. (When our regular work starts for the day)…we have our morning huddle where we go through the babies and what they need – but it would be good to take a 10 or 15 second thing to remind us why we're here. So, hopefully, I can bring some of this stuff to the huddle. Knowing (this from the sessions), I did have one or two conversations with Kim and Randy – and I feel I can talk to those people about things better – I feel that I have a bond with them now and oh, you're feeling the same way.

Barb's comments offers a reflection on how communication was operating before the group sessions and how she is reaching out to nursing colleagues after the sessions in a way that has not only deepened communication, but cultivated a sense of close teamwork with her new coworkers. Barb believes that certain aspects of the narrative group sessions could be brought to some of the current routines and may increase communication within the whole team. Her remarks also note that she is able to communicate with her teammates better and that has created a bond between them. This is interesting to see because Randy and Kim are new to nursing and to the unit where hospitality is perhaps at its most critical time for those who are entering the profession and working with people in a new place.

Kim discussed how it felt to be new in the unit and how important it was to her when people extended themselves to her in a thoughtful way to welcome her.

> You see, we have all these new people. I know I felt not too long ago as a new person. Eager. Excited. Scared. Not terrified, but still scared. I still remember those people who reached out to me and made me feel comfortable. And I remember those who didn't too. I want to reach out now even more to those new people because of our discussions in the group. I want to be one of those people, to these new people, who make a positive difference. It matters to them because it will make a difference in their work.

Kim explains that she remembers those people who reached out when she was new and made her feel comfortable – as well as those who did not. This memory for her is an

important one and as a result of the group sessions, she has a strong sense of wanting to offer hospitality to new people. Kim views this as an individual responsibility to make a positive difference for others. This sense of thinking of the other, not only to extend a welcome to new people, but to posit oneself as someone within the team to be present for others, can increase the capacity of sense of team and create collaboration as well as a thoughtful welcome. Reaching out to new people may involve taking a professional as well as a social risk, and will surely involve communication practices that appear to have improved in the group sessions.

Although developing and reinforcing communication within teamwork seems to be important for participants, it is significant for them because it leads to better functioning. In the next section, I will review the effects of the narrative groups on team functioning and how participants reflected this in thoughts they had about functioning as well as new methods they may try as a result of the group work. The group work provided a structure for them to not only think about and share things that had been on their minds, but emboldened them to bring it to a functional level for the sake of their teams and those they serve.

Functioning Benefits of Narrative Medicine

The narrative medicine exercise assisted nurses to share their thoughts and feelings about aspects of their work and discuss where team issues were compromised and how this impacted their sense of functioning. As participants shared issues, they noted that most of them had not had the opportunity to discuss these issues before the group sessions. The main themes of offering and asking for help, being bonded as a team and less isolated, and communication were central themes that emerged from the data. After

the group sessions, I talked to each of the nurses in individual interviews and observed each of the group members while they worked, as well as talking to them during these observation periods. The nurses were eager to share what they considered to be the outcomes of narrative medicine on their team functioning. The following one-on-one conversation with Donna articulates this:

> Donna: I think an advantage would be to take this to the rest of the unit - some of the things that people do or say that affect a large group of people – maybe those individuals don't realize how big a problem it really is – and so I think that making things a little more transparent and I think when things are a little more transparent, that it's more like people are required to do them.
>
> SB: Like, they're busted if they don't?
>
> D: Yeah, I find it's in the air – and if the expectation and transparency says we're not going to do that behavior anymore – and we just talk about it, then it's tough to go back. That's a really big thing in nursing, I mean, the culture in a unit. What the culture is willing to accept and what the culture is unwilling to accept. And what they'll put their foot down on. And I think when things are more transparent people are more apt to stand up for things. Like when things are hush-hush, then it's pretty easy to let it go.
>
> SB: So, when it's more transparent, then it like saying, "This is our expectation now. We're not playing this game anymore. This behavior is not acceptable in our unit."
>
> D: Yes. Definitely. Exactly. My biggest thing is transparency. Tweaking the culture and raising our expectations of each other – more socially. If you raise the bar, by raising the social expectations of each other – skills and everything will improve. Because if you're so worried about what other people are saying and what people think, I think it can cloud someone's mind and it can make them actually worried about am I doing this right? So creating a culture of expectation.

For Donna, by drawing together the topics of transparency and expectations, which for her creates a culture of accountability, skills would improve. This was something that participants noted many times in their group work and individual interviews. I asked Kim specifically about how the narrative medicine group work affected teamwork and individual functioning. Kim stated that taking the group narrative sessions to the rest of

the group would have benefits and discussed how she and the other nurses in the research group noticed changes and what she hoped would happen within their team:

> Kim: I've been thinking about the groups a lot. Thinking about how it would work it is was something we did all the time. If this was something routine. I think it would help – I think you'd always get people who are sticks in the mud. But I think getting people in a room to talk about these things and that people would know we're ALL feeling this way – it would give us more of a voice….
>
> SB: What impact did the group have on your teams?
>
> Kim: Yeah, I think it's that people who have been in the study have gained better understanding of not only each other but of the system and the teamwork itself. And I think that they are starting to act in a different way, which is more positive. Whereas people who have not participated in the study continue to act in the same ways they normally do but it has become more blatant and apparent and obvious to the people who have been in the study that that's not the correct way to operate – or be together as a team.

Kim observes that the participants in the group discovered that individual understanding as well as teamwork functioning developed through the narrative exercises. The group participants were viewing themselves as functioning in a more positive way. They note a wider gap with themselves and the behavior in unit members who did not participate. Kim found this gap troubling and believes that using the narrative group technique would have impact on functioning for most people – except the "stick in the muds."

The data demonstrates that bringing more of the team members into the narrative group processes would enable more members to know each other better, be more bonded, and raise the level of teamwork and communication. For Kim, noting that the group participants are functioning better and are experiencing a greater accountability to each other is not enough. She understands that this group practice may enable the unit to function better – and she stresses that now that she understands how it has changed the

group participants, she realizes that it has the possibility to affect the entire unit. Ellen also echoed this thought in her individual interview and observation:

> SB: What impact did the groups have – if any?
>
> Ellen: I thought there was a huge impact. Knowing how people feel. Knowing they want to make this a better place. knowing they really need to work for it – some people sit around and say, this unit is whatever…but now I can say what are you going to do about it? The people that were coming to this group – want to do something about it. You know, they want to put the effort in to do this and I want to do this. …We really need to keep working on this. This is a work in progress. This is the start of something that would be really good for this unit. I am so grateful to you to bring this to us, you know.

Ellen's comments reflect recognizing the significance that the outcomes were having on their teamwork and individual functioning. The following comments reflect this understanding and impact:

> Donna: I think it even makes me a better nurse. I've been thinking about our group work so much and now that it's been a month or so out, I can honestly say it has made all the difference with my own functioning. I didn't realize it would have that much of an impact. You know, nursing skills, I think I'm getting those and feel pretty good about those. But now that I reach out and ask for help and offer it a lot more, it's huge. Believe me, that's a big thing and the people who were in the group – we are doing it a lot more. It's noticeable. And we all feel less isolated – we talk about it all the time. It's like, the sessions, they weren't that long or anything and there was no formal instruction about how to get closer or less isolated or feel tighter as a group, but it just made it so. I believe I'm a better nurse because of it. And I feel so much better about my work.

Donna outlined the benefits of the narrative group exercises specifically in terms of functioning by reaching out and asking for help, which she notes all of the participants are doing more. Perhaps one of the most surprising outcomes from Donna is that the impact was large, yet the sessions were not that long and no specific instruction was given about functioning or becoming closer. In that sense, the topics that emerged were unplanned and unanticipated. These topics surfaced as a result of the narrative exercises and were named by the research participants.

Rose discussed how the group work provided unexpected yet particular benefits for the team:

> Rose: I think it helped define what are goals are for us as a team. …I think this is what this process has done – it's helped us identify parts of the team that are really not part of the team. …hearing what people want this to be a great place to work. This makes me think we can do it….

This is another example of the group session team topics surfacing out of the discussion, which were not specifically introduced or discussed in the introduction for the day. And yet, through them, Rose had a new perspective on teamwork. She also expresses a hopeful tone for this team. This is a new quality is something that was sorely missing from her when she entered the group process. Her comment, "I think we can do it" represent not only hope, but places a firm foot in the realm of possible better functioning through action, or "doing it."

Sue casts a broader net when she describes how the group exercises increased functioning for her and also notes an emotional and mood change for her in her work.

> Sue: It (the group) has changed everything for me at work. I know that sounds a little crazy (laughs), but I am working now better with the babies because I'm happier and feel that I know other people more in an important way. In a way we understand each other better. You asked about functioning and I will definitely say that this has made me a better nurse and I know that means I am functioning better. Relationships really matter. I went to nursing school at XXX University and they have a 100% pass rate for the board, so I felt good about being in that statistic. But I know the way we get along and feel less isolated is as important to our work and impacts our work significantly. About our work together, I want to scream, "Yes" (laughs), but I'll keep my voice down because, you know, we're in the unit and I don't want to wake the babies.

The findings in this section illustrate that the research team found impact on team functioning with respect to offering and asking for help, feeling less isolated and more bonded with other nursing team members, and being able to communicate more effectively. These results show that communication realities for nursing team members

are sometimes compromised and can create considerable barriers. However, through participating in the narrative medicine exercises, the participants made some significant impact on the way they communicated with each other and their perception of how their teams functioned. While some nurses in the group indicated that the levels of team and individual functioning were at a good rate before the research project, all of them discussed the influence that the narrative medicine exercises had on them and their relationships. These findings suggest that the narrative medicine method may serve as a new technique for enriching nursing team functioning. While functioning in nursing teams is critical for job satisfaction and patient care, this research study will now turn its lens to explore how narrative medicine helped participants to build understanding between them and make sense of teamwork.

Research Question # 2: How does narrative medicine build understanding between nursing team members and help them make sense of their team interactions?

Introduction

The central theme of this research question explores the link between forming relationships between nursing team members and making sense of their team interactions. The research data reveals that the group narrative medicine exercises made a constructive impact on team inter-personal connections. Becoming better acquainted with each other as team mates emerged as one of the distinct benefits that also helped participants make sense of their work.

For the second research question, I begin by considering two themes emerging from the data that demonstrate how narrative medicine increased understanding among team members and helped them understand the interactions among members.

1. Sense-making for teams in forming relationships, knowing each other better, being more aware of each other's stories.
2. Impact of narrative medicine on team feelings of isolation: You felt that way, too?

Sense-making for Teams in Forming Relationships, Knowing Each Other Better, Being More Aware of Each Other's Stories

Unit nursing teams in hospitals have a high level of stress and are usually challenged with little time to spare. Becoming close to another person takes time and conversation, something that is not at a premium for most nurses. When there is time to come together and know each other more fully in order to become more aware of each other's life stories and form relationships, nurses appear to value this and believe it helps them make sense of being part of their team.

Research participants signified how much it meant to them when they did have time to become closer and viewed that even interactions between teammates about work issues were perceived as caring and welcomed. Baily's comments emphasize this:

> There's definitely good teamwork here. A lot of people go and around say "Do you need anything? Are you doing OK?" They check up on you; there's a lot of support coming off orientation, which is really nice, especially when you just come off orientation and it's busy, they're still there for you to make sure you're doing OK.

This conversation highlights that taking time to check in about each other's work has value and is perceived as thoughtful.

If time spent sharing emotional issues makes sense in recognized meeting times, the research data from this study demonstrates that the sense of team also is impacted when nurses can spend some time together in a casual way. Knowing each other better emerged as one of the benefits that helped participants make sense of their work. Yet

there was also a stronger sense of wanting to be together as workplace friends and finding the meaning that these kinds of professional friendships can bring. As Barb said in her one-on one meeting with me:

> Hopefully, I can bring some of this (narrative medicine) stuff to the huddle or facilitate better. Getting to know everyone – and having a way to do that. And doing something in the huddle.

The "huddle" is the time before the shift begins when the charge nurse goes over the charts of all the patients with the on-boarding staff. The narrative medicine exercise was valuable for Barb and was a way for her to experience how making connections could take place in the unit, but also in the midst of the huddle, which is the start of the work period for nurses. The fact that she mentioned the huddle is significant because it shows that she sees a gap with making sense of her team in that time period.

The meetings were run efficiently, with extreme care, given to the tasks of patient, medical and family updates. In this NICU, I observed 8 huddles, which lasted about 10 minutes. During this time, there was no time taken for any deep interpersonal relationship building or sharing because there was a lot of clinical information that needed to be shared. If there is any conversation, it is about clarifying issues about the specific care of the patient. People did not greet each other when they arrived and the charge nurse made no effort to have any personal conversation with them. The non-verbal communication also indicated that eye contact between charge nurse and shift nurses was almost non-existent.

Ellingson (2003) notes the important work on backstage communication. Ellingson defines "backstage communication" as conversation in clinical teams that occurs in the hallways of units, before, during, and after unit meetings, or over breaks and

lunches/dinner times. The nurse's station appears to be the normal site for these conversations, however, nurses in the NICU note that when they are feeding a baby quietly in the patient's individual room, that it is a valuable time to engage and communicate on a personal level with other staff. These conversations within the group sessions were noted as healthy and promoted closer interpersonal connections with team-mates.

The central theme of this research question explores the link between forming relationships between nursing team members and making sense of their team interactions. This includes supporting each other. Nurses noted that the supportive community they were seeking to establish was a central value for them to make sense of their teams and essential to target impact in their work together. They noticed that the narrative medicine group sessions made their work more enjoyable and they believed they were more effective in their tasks as well. Wittenberg-Lyles, et al (2003) note that a supportive community can nurture working relationships. Conversations within the group sessions were noted as healthy and promoted closer interpersonal connections with team-mates.

The themes of caring, support, bonding, and building comradery were central for them. The following excerpts demonstrate appreciation for time spent in the groups and what impact it would have in making sense of their team.

> Sandy: This is good. It's so good to talk about it and get closer to each other and think about what we can do to support each other. We might not be able to change the system, but we can help each other.
>
> Donna: This helps to talk about it. Because a lot of time people just talk about things and, it's like, goes nowhere. But, finding out about each other and how we can help each other is excellent.
>
> Baily: I think it would still be nice to talk to each other. It builds a sense of comradery.

These comments show how a sense of friendship is important for these team members. Through creating meaningful relationship and building a sense of community, nurses possibly could experience restorative support. As well, these participants note that developing a sense of community in the workplace may provide emotional balance in their work, which at times can be traumatic and stressful. By creating the sense of belonging in a team through getting to know each other better, talking about their work, offering support and how they can help each other, these participants note that this may not only improve team work, which may benefit better clinical patient-centered care. The feeling that nurses have to be connected and valued was important to them. Creating time for staff to get to know each other better could help build community, learn more about each other and share what is important to them in their work.

Finding time to gather to talk was usually not in great supply. In my observation data, I found that in those times when the patient census was lower and the acuity rate was not as high, nurses made time to meet casually and informally at the nursing stations for short periods. During observation in the NICU, I noticed that nurses did gather at the nursing stations for short casual conversations and used this time to check in with each other, relax for a few minutes, and be playful. Some nurses were not able to be away from their patients because of the acuity, so for them, they were not able to join in any relationship building conversations. From my observation, nursing stations did have the positive benefit of promoting a space for some healthy interaction and time spent in them, which was not task oriented and did help create community.

Another aspect of deepening relationships that contributed to making sense of their team for nurses in the group exercises was noticing that understanding a person's

backstory was helpful to creating greater support for each other. For the participants, this could only happen through taking time for some conversation among team members.

> Donna: I've had people who were initially – or I thought they were mean, but not mean to me, but just gruff personalities, and then find out what they're dealing with at home and some people, I didn't find out until a long time later that they've been going through something really horrible.
>
> Baily: It really puts it into perspective.
>
> SB: Knowing someone's backstory you mean?
>
> Baily: Yeah. It's everything.

Kim describes the way the group narrative process helped her learn more about her team's backstories and, in her words, "what makes them tick."

> Kim: You know, I feel like in these sessions, people have said things that…now I know that's why you're like this or I didn't know about that or now I understand you in an entirely different way because I know the aspects of your life. I didn't know that about you…there's a reason for their crunchiness or their over-sentimentality…. I didn't know about things and now I understand. …I've been taking more time, the little bit of time I have, to sort of talk to people and try to figure out more about people I'm working with. Some of these people really have it rough in their home life. Really, been through some stuff and you think, "Wow." I always want to know what makes people tick.
>
> SB: So now you're taking time and hearing people's stories.
>
> Kim: I also think there was a yearning to share and I wonder since going through this process it brought things out of the woodwork that normally would have stayed in the woodwork.

While understanding a person's backstory may help build a sense of team and community in any context, it is especially important for a nursing team. Nurses have to work together to share life-saving information about their patients and must be able to work together in a trusting way not only during routine daily operations, but especially in emergency procedures. To underline the import of this, Kim's story about her first day of work in the NICU as a new nursing school graduate demonstrates how deeply building a sense of

team can either foster community or compromise it. Other nurses in the group attempted to help explain rude teammates' behaviors and offer a little backstory about this person.

> Kim: The first time I met XXX she made fun of what I was wearing.
>
> Barb: Something's wrong in her life and so she's going to take it out on us.
>
> SB: What do the rest of you think?
>
> Kim: I just brushed it off and made a joke of things. It makes sense that she feels bad about herself.

In an observational time with Kim after the group sessions had concluded, I brought up this interchange in the group to her in our individual session and asked if she had any more to say about her first night on the job and how this nurse had mocked her outfit and how the group responded in our sessions. Kim said:

> It was so belittling and rude of this nurse to make fun of my outfit. I've thought about this since we talked about it in the group and it felt good to hear them rush to my defense and try to explain her (the rude nurse) behavior. But I did like hearing from our group about it. They have my back in more than just my clinical skills and for that reason, it felt good to hear their comments. It really helps to know a person better and hear their backstory.

Kim's comment is an example of how the group validated and supported her through knowing this backstory about her first night. She also emphasized that the participants in the group sessions helped her identify the person's character traits and personality, which gave Kim a stronger sense of team: "They have my back."

This next exchange probes the importance that understanding a person's history can mean to the team members so they can offer personal support and operate in a sense of security and trust in the team. Alison expressed her need for support and demonstrated vulnerability when discussing a painful event that happened to her in a prior unit.

> Alison: In previous units I think I had someone come and tell me, "This person, you know, is saying this or trying to do this." And in that particular situation, I

> was grateful because that person was literally trying to get me fired. So, for completely unjust reasons and so I think that the thing that I ask for the most of anyone is exactly that: if you have a problem with me, come to me. Because it's really hard not to know and then, like, be completely blindsided. … It was pretty awful what happened, they set me up, they lied about me – and it was allowed to happen.
>
> SB: …The fact you shared this, means that you've kind of, really opened up your heart and you can all pay attention to this and be there for each other in a new way now. Now your co-workers know something where you could use some support.
>
> Sandy: Knowing is good. Like we are really good at helping out and supporting – if we know about it. To care and offer support. Now we know. That was good to let us know that. I take that seriously.
>
> SB: (turns to Alison): How do you feel about that?
>
> Alison (in a soft, slow voice): Bring it on (quiet group laughter).
>
> Sandy: I'm glad I know this now. Not glad it happened to you – but glad I have this insight.

This spontaneous interchange in a group session illustrates how support from fellow teammates

is welcome and helps to shape future care for each other. Whether the team is a small group of people who are charged with a specific task for a short period of time or a larger team that maintains its working relationship over years, participating in a team means a lot more than just showing up. For healthcare teams, working in a healthy way means that support is genuine and fluid, collaborative practices are evidenced by honoring each other's skills and wisdom, trust and respect are high, there is a sense of shared purpose and values, and although problems inevitably come up, there is an ethos of creative problem solving and conflict resolution (Opie, 2000; Cheney, Christensen, Thoger, Zorn, 2011).

While all of these issues are considered important to create a healthy working team, there are unique challenges for teams within a healthcare setting (Ellingson, 2005; Van Servellan, 2009; Brown, Crawford & Carter, 2006). By openly offering emotional support in the future, team members can not only make sense of their work in a deeper way through the insights of others, but become a stronger community as well. Learning another's backstory becomes an exercise in deepening relationships and understanding a person's present behavior. Alison also expressed a relief and gratitude for the support and for being able to share her story in a safe place.

Nurses in this study believed in the values of developing their relationships and becoming closer to each other. In her work on narrative medicine, Rita Charon affirms that the action and movement of "attention" demonstrates that the "teller of an illness needs a listener" and it is in the act of listening that influences routine clinical practice. By establishing attention, Charon believes that not only will the practitioner hear about the clinical aspects of the patient, but about the things that *matter* to a patient – what the illness made of the person, what it did to the person, how the person fought back from it, and whether this person will be the same person as before the illness. This depth of understanding is a way for the physician to obtain the backstory, the inner life of a patient, to find a path or way of establishing a relationship.

This construction can be incorporated with nurses reaching the same level of appreciation for each other through this practice of "attention," which extends the narrative medicine model in a sanguine way for the sake of the healthcare team. Discovering the things that *matter* between members of the nursing team involves getting the backstory and the inner life of team-mates so that authentic relationships can be

formed. In this framework, listening is also important and good listening takes time. While time is at a premium, the need for developing Charon's idea of "attention" is something that is keenly sought in these nurses, even if it is making some space for it in the tight context of the huddle or in the more expansive times that can be fashioned in unit.

After the three group sessions, the individual interviews with research participants noted an increase in forming relationships, becoming closer, and learning each other's backstories. Wittenberg-Lyles, et al (2013) write that as Childs (2007) notes in Kabat-Zinn's (1991) work, personal preference and critical thought are suspended when one is mindful. As well, the feeling of bonding and being present for each other is increased. Although "presence" in this literature exhibits a mindfulness that is attentive to the "now" aspect of awareness, Wittenberg-Lyles, et al (2013) also emphasize that it brings a personal awareness and attentiveness to interaction between people.

This sense of being with another and being present was increased for the participants after the group sessions. In one rather striking instance, the interpersonal relationship between two nurses was healed in the group sessions. This was a remarkable event because the distance between the two was sharp and particularly emotionally distressing for one of them. It is also interesting that their relationship was mended, although the specifics of it were never formally or openly discussed or addressed with the group sessions. It was only after the group sessions were completed that the details of the history of their relationship surfaced for me and subsequently the constructive impact the group sessions had on their relationship. The following one-on-one conversation revealed that the narrative group sessions created a more comfortable sense of self and team for

Sue when she had the chance to be in the group with a team member she had formally had a lot of inter-personal discomfort.

> Sue: One thing in particular. I always felt that Ellen did not like me. But she seemed like a normal person this weekend and I feel like what made the difference was our group meetings. It seemed like she was always annoyed when she talked to me. But this weekend, she came down to the room where I was feeding a baby we had a conversation.
>
> SB: Had that ever happened before?
>
> Sue: Never. Ellen is not that easy. But now Ellen is a more pleasant team member. It's fun to see a change. So, there was impact. And one that is making work so much better for me because of my relationship with Ellen. It's great. It makes me so happy to think about and less tense to come to work – in fact, no tension at all.
>
> SB: And it wasn't that you both sat down and talked about that particular thing…just as a result of us getting together, reading the poem, and then writing the poems….
>
> Sue: And right, it wasn't that we necessarily talked about our relationship or anything, but as a result of the interaction we had in our group, she seemed to see me as a person, a human. It opened things up for me. And now I feel like I have something to contribute to the team. All of my work felt better. It's been so great. The non-verbals were better too – the tone of voice and her posture. It was like, OK, she doesn't hate me anymore. She was the main person I've had trouble with and when I saw that she was in the group, I thought, "Oh, great, she's going to take over all the time," and almost wanted to leave. But now I like working with her and it's great. I think it'll last too. There's a real positive change.

This shift in Sue's experience of Ellen had a major impact with her work. One of the interesting features of this was that the group sessions did not specifically address interpersonal relationship in general or Ellen's and Sue's in particular. There was a meaningful change in their interpersonal life, one that had made a noteworthy influence for Sue. It could mean that because of the group interaction, Sue and Ellen had a chance to become acquainted on a more personal level. This created an appreciation for each other. This new ease that Sue has with her relationship with Ellen has made a large part of her work experience more comfortable and enjoyable. It is curious that one person

could make such a negative impact on Sue to the point that it was having such a large effect on her work life. However, Sue was feeling like she was Ellen's target and perhaps being new, she was not sure how to handle an experienced nurse who was not afraid of being rude and using her influence in a somewhat negative way.

In our one-on-one session, Ellen also expressed having a better relationship with Sue after the groups. She noted some history with Sue and how her perception of her had changed as a result of spending time with her in the group and going through the narrative medicine group exercise.

Ellen said:

> The laughter still bugs me. But I am more understanding of it now. I think it's born out of her being so new. So, I figure now that I know her better, and I do know she went to a great nursing school and is very skilled, it's up to me to step up and make her feel more comfortable. I guess the groups helped me think through that she is a lot more than that annoying laughter. And if that comes from her being nervous, and I am so positive that it does come from that, then it's up to me to make her feel more at home.
> SB: Did someone say something to you? Or was a self-imposed slap?
>
> SB; Do you think it helped her?
>
> Ellen: She still laughs too loud, but she does seem calmer around me and so that's good. And I'm working on it. It's kind of a mission now for me. I see it as my duty and I want to help out. So, yeah, I think it's helped...a lot. Now, I've thought about this and that's amazing considering we never really talked about it in a focused way in the groups, about us or about the laughter.

While not all of Ellen's perception of Sue has changed – she still thinks her laugh is too loud and that she is anxious, through the group sessions she came to see that there is more to Sue than her laughter. Ellen now has framed the laughter as an outcome of Sue being nervous as a new nurse and Ellen believes she can help her calm down and has taken it on as a "mission." Through a growing sense of who Sue is and a deliberate sense of reaching out, Sue and Ellen have formed an effective working relationship. They have

advanced their working relationship from acrimonious to being caring members of the team. Although it may be said that narrative medicine is merely basic relationship building, it does provide a focused space and intentionality about conversation that contributes to health care team members developing their relationships. Their connections are an important element to the whole of the team and could serve as a model for establishing better working capacity and genuine care.

A shift in perspective about individuals is also illustrated by Sandy as we discussed this aspect in an individual session after the group work:

> SB: So, does narrative medicine, the exercise we used, have impact on teamwork? What do you think?
>
> Sandy: The people that participated in this really enjoyed it and got to know each other better, which makes you understand them. It also gives you other perspectives that maybe you didn't think about before.

Many of the participants said they came to this new understanding of a colleague because they heard some backstory about the person, but also because they got a new appreciation for their skills and dedication to their work. Knowing the backstory of a person gave participants deeper insight and appreciation for the person. Backstory also reveal who a person was and created a deeper understanding that would not have emerged unless this was known. Sandy understands this as a revelation about those things about a person that "you didn't think about before," which re-constructed who a person is in a new way. This instilled a sense of teamwork among them that was intensified and appreciated.

For participants, feeling closer to co-workers helped foster making sense of their place in the team, and this was an important result of the group sessions for them. Several participants commented on the impact the group sessions had on their sense of team.

> Baily: Yes. I think it's helped. Reading the poems resulted in us bonding over things, like poems, that we never thought we could. I feel closer to my co-workers now, especially the new employees – at least the ones in the group. …I feel that without having met, this stuff wouldn't have happened. Now we have these relationships with our coworkers
>
> Donna: …so yeah, I think I feel more emotionally supported. The bonds that I have now with people in the group have grown and those ties have been strengthened as well. It builds and pulls us together a little more; it could change the culture too.
>
> Alison: I feel like it made me more aware and open of the idea to sharing personal stories. I think the group exercises did that for sure. I think it makes you a little softer in your inter-personal relationships.
>
> Cheryl: I really learned things about people who are in the unit and my team. It's neat to have a venue to learn those things and the poignant story of their life.
>
> Rose: I think it's good that maybe to know that's there's comradery – we're on the same page. So at least tonight, we have each other and we'll help each other as a team. I feel closer to my colleagues than I ever have here.
>
> Kim: The groups were so valuable on so many levels. With the people who were in my group, it feels like I had hoped it would feel when I started here – more as a family, more bonded, closer to each other.

It is interesting that the responses in this section to the issues of the participant's sense of teamwork do not really comment about skill level, but focus more on a personal and emotional basis. The challenges of working together seem to be centered in relational challenges. The group exercises not only brought the participants closer together, but allowed for team sense making to be recognized and discovered. The unique method in the narrative exercises of reading poetry and participants telling their own stories through poetry brought this team together. Ellingson (2005) indicates that getting to know members of the nursing team has beneficial team-building effects, fostering feelings of connection among team members.

Several participants described ways that feeling closer to colleagues goes beyond the functional aspects of nursing. Feeling close creates a sense of friendship and attachment that is important their work as a team. Based on the group sessions and my individual interviews and observation with research participants, these nurses had a strong desire for establishing a bond with their team and wanted to have a closer relationship. The narrative medicine exercises helped to establish this through the practices of listening to each other's narratives where challenging and complicated experiences were shared. This echoes Rita Charon's observation that listening to patients is fundamental to clinical practice and that individuals frequently use narrative to relate difficult and complex experiences. The methodology that Charon suggests that creates a social and relational event between physician and patient is something that also is important to these study participants. The group exercises, which involved listening to each other's narratives, deepened and develop their relationships and created more social experiences, which increased their sense of team.

Impact of Narrative Medicine on Team Feelings of Isolation: You Felt That Way, Too?

The second theme of team sense-making is exploring how emotional isolation emerged as a prominent subject for all of the nurses in this study. Isolation was defined in two principle ways. First, there is the isolation of being physically distant from other staff due to the architecture of the unit. There is a deliberative choice made by a nurse not to congregate with the rest of the group. This was because of possible repercussions from supervisors or simply not wanting to spend time with other staff who they did not like, trust or wanted to be associated. Whether this isolation was because of unit architecture

or by choice, it led to an emotional distance from others in the group and increased the lack of knowing other nurses on a personal and professional level. Each nurse who spoke about this sense of isolation framed it as something that disturbed them and made their work more difficult and less satisfying. Two of the unfortunate outcomes of this type of isolation were triggering lack of trust among nursing staff because they did not know each other's clinical skills or personal values, which created a feeling of loneliness during the shift. When team members were present and supporting each other, they found great value in being able to share skills and be in the presence of another person on the team.

The second dimension of emotional isolation was articulated after the group sessions and was heralded as a constructive outcome of the group sessions: the nurses overwhelmingly designated that the stories they shared in the groups let them know "they were not the only one who felt this way" about various issues. These feelings and thoughts of isolation were usually found in several ways: the fear about clinical skills or specific nursing procedures not being up to speed, a desire for being more deeply connected with their shift members in a personal way, and being lonesome in their work.

The first examples of this isolation were expressed in the group sessions and participants targeted the fact that being linked with another nurse during specific events was an essential piece to them feeling comfortable with their work.

> Cheryl: …I'll never be alone during an admission.
>
> Barb: That's why I don't' like transports because you're all by yourself. I'd take an admission any day. Randy and I went on a transport even though he was a student – I was still so happy he went along.
>
> SB: It's presence – having somebody else there. What does that say about teamwork?

Barb: You're not alone; it's scary to be alone.

Randy: Support – for clinical decisions.

Barb: Can bounce ideas back and forth.

Cheryl: Comforting.

Barb: Especially in a tense situation.

These comments demonstrate how essential support is to each team member and how support can assist with clinical decisions as well as enhance the emotional life of the team. The narrative medicine exercises wove the themes of both clinical and emotional lives of the team members and built support during high tension times as well as the day-to-day routine procedures. Sandy described how team support can make one feel less isolated, which offers a way to view herself and her team. She stated:

> Sandy: Even when it's busy here or chaotic, or if a baby gets really sick, everyone comes together and it makes it not as stressful. It's (working here) is not as scary as I thought it was going to be. So, I credit that with the support. There's always someone there for you.

During the narrative group sessions, participants were invited to write a poem or narrative about a topic. In the following session, participants were asked to recall a noteworthy moment in teamwork, Cheryl shared the following ideas during a written exercise in the group work, which reflects her thoughts on feeling more bonded and less isolated on the team:

> Cheryl: The baby was dying, we all knew this. He was a micro-premie working hard to live, but his fight was ending. Alarms rang continuously as he just couldn't keep this tiny heart beating. The Nurse Practitioner, nurse, respiratory therapist and myself surrounded his isolette, the top raised and the lights bright. The code cart was nearby but not quite needed yet. We all felt on edge, dreading what his parents would soon feel. Adrenaline pumped through our veins, even though it was the end of a 12 hour night. In a moment, the baby opened his mouth in a weird, large open-mouthed smile. We all laughed out loud. It was an odd response in the middle of such a horrible situation, but sometimes you separate

> yourself from the emotion and it becomes your job, kind of self-preservation. After the laugh at his grim smile, I felt a relief. We were all in this together.

For Cheryl, the team helped her not only get through a tense and heartbreaking moment of nursing, but helped her make sense of the team and their sometimes distressing tasks. The picture that she portrays of the specific team members around a dying baby's isolette is significant as it captures a sense of the whole team and does not focus only on her reaction.

The following discussion in the group also maintains that support from nurses who have experience to newer nurses can make a difference.

> Randy: Nice when obviously the team works together, but having a bit more experienced and respected nurse gave you that compliment at the end of it, I think that's really beneficial. Especially as a new nurse, they say that people in my generation need a pat on the back but I think that's true for any job that you're relatively new at – you need once in a while some affirmation that you're doing an acceptable job and your work is solid.
>
> Barb: That being said, I just want to say recently and they are more experienced nurses and me being in charge of the unit and that's a little more daunting and when they tell me "good job" – I feel a little bit better about that because they're more experienced. Means a lot.
>
> SB: What does supportive teamwork look like and mean to you?
>
> Sue: It means, just being there. Even though I didn't do anything to help.
>
> Rose: You did. You were the cheerleader and gave her confidence.
>
> Ellen: We all need confidence and support from other people. You gave her support and erased the separate feeling we have too often.

Although conversation is also noted as a means of support, this exchange expresses the impact of how being present can make a difference. This creates a feeling of less isolation. Presence offers comfort as well. These comments also feature how experienced nurses can have a meaningful impact on newer nurses not only by sharing clinical skills, but in providing interpersonal teamwork support as well, which also affirms clinical

skills. This discussion also implies the distinctive experience between generations, the more experienced and older team member offering support that increases confidence in the newer team member. This validation does seem to be asked for, and when it is offered brings awareness to not only the individual who is receiving it, but makes sense to the whole team. In an individual session, Baily expressed appreciation for Sandy's experienced perspective and framing issues that newer nurses were having trouble thinking through. Her comments speak to the way within the nursing team that individuals may have different roles to play. Baily said:

> I liked that there were times when Sandy said, "I know. It's OK guys. It's fine. This just happens when you work in a NICU." She sort of brought to light to some things. It was nice to have someone who has been here a while saying, "You'll be all right."

In later observation times, this was also noted and Sandy's thoughtful comments got nicknamed "benedictions." Several participants who were newer nurses joked about how now they were seeking Sandy out to receive a "benediction" and how significant it was to have a meaningful conversation with an experienced nurse who was open to their concerns and would receive them in a hospitable and caring way. These research participants' comments suggest that the encouragement that is offered makes an impact on their sense of feeling less isolated.

In the individual and observational sessions conducted following the group sessions, I explored the theme of isolation the participants experienced from the team. A common and significant result of the group work that emerged for participants who were new to the NICU and nursing was that the participants were grateful to know they were not the only ones thinking and feeling somewhat anxious and unconfident about their

work. This theme of knowing that "I'm not the only one thinking or feeling this way" was a dominant subject in their one-on-one sessions and conversations.

The shared understanding that some of their thoughts about work were found to be in common with other team-mates was an important result that participants gained through the narrative medicine experience. The following comments from newer members of the NICU team expressed this in often adamant ways.

> Baily: …it's nice to know that it's not just me and that every new employee feels this way and that you are doing a good job and it's just a learning curve and that you'll get through it.
>
> Donna: Well, honestly, I think the group meetings have been an ease on my mind. I guess it soaks in a comfort that it seems that all of us have similar experiences and similar thoughts and feelings so it makes you feel less isolated and crazy. You know, "Do I feel that I'm the only one who feels this way?" or "Am I the only one who stresses out about these things?"
>
> Barb: I feel I can talk to people about those things better – I feel I can talk to them better – I feel that I have a bond with them now and oh, you're feeling the same way.
>
> Randy: One of the most valuable things for me to come out of this process is that I don't feel so isolated with what I am thinking about, what's important to me, and what's bugging me. It was comforting to know that the issues I care about are shared by everyone really in the group and that we share those things. So, I'm not the only one. I told my wife that has meant the world to me to know. It has lifted my spirit and gives me hope for the unit because now that we know those things are important for everyone, we can start to make the changes we need. And it only happened because we talked about them, you know, discussed them in a safe place.
>
> Alison: I am comforted to know so many people share the same thoughts as I do. That "I'm not the only one" was an amazing thing to realize. So beyond connecting with the group, which I believe is very important, I know I'm not the only person who thinks about these things.
>
> Sue: That being said, I just went to days recently and they are more experienced nurses and me being in charge of the unit and that's a little more daunting and when they tell me "good job" – I feel a little bit better than about that because they're more experienced. Means a lot.

All of these comments from newer nurses center on the idea that the group work created a way for them to come to understand that what they were going through as a new nurse was not unusual. It was encouraging for them to know their fears and uncertainties were common experiences that were collectively shared, which made them feel less isolated.

As the nurses must be highly skilled in specifics for their nursing tasks, the way they make sense out of their team comes from the support they receive from each other. This was expressed in the individual sessions in a clear way by Randy:

> Randy: I mean, it just gets us talking about the important things that are…that make our team work well together. Or, what we find good qualities in the team and we get to talk to each other about that. It's just more helpful to know your team member and work that much harder for everybody else. Because you know, from talking to everybody else, you know that mattered and was important.

Achieving the "good qualities in the team" that Randy distinctly expresses in this comment serves as the essential standard of team sense making and is at the heart of this research question. First, for participants, the good qualities in a team were marked by knowing they could receive support from each other and being able to trust that support. This support came in the venue of interpersonal support**.** Second, the group sessions helped participants name those good qualities of teamwork and were surprised, in a relieved way, when other participants felt the same way.

This shared experience in the groups was apparently something that had not been openly discussed by participants before. The revelation that others felt the same way was a kind of wonder to them. The implications again created a sense that they were not abnormal to be feeling this way, which not only validated their identity, it also created a kinship among participants. Although these perspectives about teamwork may have emerged in a setting other than the one provided in this study, the group sessions

provided a particular place and opportunity for meaningful conversation to take place. This understanding was supported by many of the participants. They talked about how the groups helped them form relationships and how that formation made them more supportive of each other.

This research question asks how narrative medicine helps to build understanding and sense making among team members. Through the specific actions of forming stronger relationships, knowing each other better, and becoming more aware of each other's stories, participant's expressed a deeper connection and sense of each other. Participants also disclosed that they were encouraged to know that they were not alone in their thoughts about their work, which alleviated their sense of workplace isolation. These connections, as one participant called it, were often noted as the main impact of the group work. The following comments from Barb represent mutually shared thoughts by other participants:

> Barb: So getting to know people is an underlying thing that came from the groups – and being connected. People wanting to connect on a personal level – on a human level.

The research data reveals that the group narrative medicine exercise helped boost team inter-personal connections in a robust way. As well, it gave pause for some participants to question how they might be responsible for undercutting healthy teamwork and how they could assist in making it better. While these thoughts about team support and interpersonal closeness are not new to the understanding of teamwork communication, the raised awareness of this as a valued shared good was striking and is a central key to their work. Participants often talked about how the group work was the venue that made the connections deeper for them, which implies that the technique and

method used in narrative medicine in the groups created impact on their sense of team. These issues suggest an underlying question that the team may had not considered as a group before this study: "What might I be learning about myself and each other?" Participants in this research study strongly show that caring for each other is an activity that they long for and is something that is important to their team. Although the word "community" was not specifically named as such, I believe it is an apt word that describes what this nursing team was searching for and found a footing for it within the narrative medicine exercises.

Through building connections within the workplace, these participants realized a stronger sense of team and each other. This next research question considers how narrative medicine facilitated these participants to create a deeper understanding of their own work. Additionally, this next question demonstrates how the group work gave them an opportunity to deliberate about their sense of calling to their profession.

Research Question #3: How do nurses make meaning out of their role as a healthcare professional and team member through their experience of narrative medicine?

Introduction

> "There's that component of compassion that you can't teach. There are some people you can't teach. They're focusing on the skills to say they're a successful nurse – but the successful nurses are the ones who can communicate and work well as a team. I think it's harder, much harder, than the skills." - Rose

The nurses who participated in the narrative group work frequently described their work using language and descriptions that represent vocational principles. This study pursues how narrative medicine affects nursing teamwork within a NICU. In this chapter,

I explore the third question that directs this study, "How do nurses make meaning out of their role as a healthcare professional and team member through their experience of narrative medicine?" A prominent theme that participants talked about in group and individual sessions was the lived in experiences of being a NICU nurse. While they also discussed the importance of interpersonal communication and relationship building as essential elements of their work, the concept of the meaning of their work, even when it was routine, was an explicit and sometimes underlying theme. These descriptions capture the vocational aspects of nursing and although only one person used this word to describe it, the marks of vocation were evident in their conversation. As I reviewed comments of the participants and listened to them throughout this study, I began to hear the ways that nursing practices for them went beyond skill sets. This research question explores that sense of vocation and how it was strengthened by participation in narrative medicine groups.

Exploring the Nursing Vocation in Group Narrative Medicine Exercises

The NICU participants in this study clearly express that the narrative medicine exercises

created a framework for reflection to strengthen their sense of work and renew and fortify a stable, sustainable change in their sense of nursing as a vocation. The group narrative medicine sessions, dominant themes emerged that suggested how vocational aspects of the participant's work were rooted in their choice of profession. The first theme lifts up reasons for working as a nurse in the NICU instead of working in other medical units,

especially those units that work with adults. This exchange helps to explain how NICU work is meaningful to them:

> Alison: I was just starting to get really burned out with adult issues and adult patient dynamics, so, I felt that I needed to reconnect with why I wanted to take care of people. There is nothing that compares to how innocent a baby is, how helpless, how vulnerable. The flip side that I'm finding in this unit is that caring that much is really hard. It was actually as much the technical side of working in a cardio-vascular ICU is definitely a little bit more, like, there's more machines, there's more drugs, there's more technical skills that are required. This job feels harder because I feel harder, because I feel so much. The other job, it was so much easier to do to and I could turn it off and go home. Whereas this job doesn't feel like it turns off as easily, at all.
>
> Baily: I so agree. It's like when you go home and you're home for a few days and you think, "I wonder how they're doing. I spend time thinking about them."
>
> Sandy: I have had times when I've called in to see how someone's doing – I want to hear. So no, you don't turn it off when you go home my husband will attest to that. (Laughter from group).
>
> Baily: It's just a different thing. I mean with a grown up, they're grown up and have a lifetime of decisions and now they are sick and in the hospital, but they've had a life and they have their family to support them and they have, you know, a little bit more control over their circumstance. Whereas here, for many hours of the day, we're it for this babes. So…it's kind of…a little bit more intense than I expected. But in a good way. I definitely did what I sought out to do, which is to turn back on my little sympathetic nursing heart, which I got back.

The way that Alison conveys that working in the NICU was a way for her to "reconnect with why I wanted to take care of people" indicates that her work as a nurse is centered on helping patients and being attentive to their needs. However, that renewed sense of taking care of patients and being connected to them came at a price for her because "the job feels harder because I feel harder, because I feel so much…." Baily expresses the same sentiment when she says that taking care of this population of patients is "a little bit more intense than I expected…but in a good way." The result for Baily of this intensity and working with this extremely vulnerable population is that it "did what I sought to do,

which is to turn back on my little sympathetic nursing heart, which I got back." Sandy noted that she calls in from home to check on her patients, because she "wants to hear" how they are doing. Intensity of the tasks in the NICU for these participants matched their need to be connected with their work and patients in a way that helped them make sense out of their work as nurses.

This sense of calling takes place in a community of nurses in their working units, a community that also includes the patients and their families. A culture is formed within the unit and lived out in the specific habits and rituals of being together. For these participants, the narrative medicine exercises gave them an opportunity to reflect how the work was personally experienced and also think about what value it has for them as members who work within the complex constructs of the life of a NICU unit. There is a relationship between the participant and the work that has a kinetic sense to it: it is always changing, in motion, and fluid. It is within the connection between participant and work where meaning is found

With the rise of technology in the healthcare setting, Alison captures the idea of work meaning of her former work in the cardio-vascular ICU, with "more machines, more drugs, more technical skills required," yet she "feels harder" as a nurse in the NICU. For Alison, "feeling harder" means that working with high risk newborn babies taps into some intense emotions for her. Participants talked about the experience of their own humanity and how it was engaged in their work and was tied to their work with their patients. Although this might be a subjective understanding for each nurse in each unit, the participants in this study identified that for them, the NICU was the place that provided meaning. They shared that they had a draw or call to be in this specific unit.

These nurses expressed their desire to work with the specific NICU patient population because of the patient vulnerability, innocence, acute needs and newness of a life, which may imply that these are essential attributes in the patient population that give their work profound significance.

One group participant, Donna, a nurse who had graduated five months prior to this study, talked about being drawn to work as a nurse in general and specifically to work with babies when she was seven years old. She described this in a narrative she wrote as part of the narrative medicine exercise during a group session. A portion of her poem that represents this is the following:

> When I was 7, my aunt had a healthy pregnancy and then her baby had a twisted umbilical cord and then passed away. I remember sitting in the waiting room being in anticipation meeting my new cousin. I had already been told that she was sick, but you're so young, you don't really understand. After she passed first thing I did when I came in the room was give her a kiss on the forehead. I remember being so innocent about it. I remember the situation and I remember crying and there were also smiles so it was kind of a poetic thing to be there to meet such a beautiful, young girl but to lose her so soon. And I always remember that and I wonder, you know, is it full circle and why I do this now?

In Donna's story, she captures the innocence of her newborn cousin, the harsh, tragic reality of death, and her own movement to draw near and kiss the baby and "being so innocent about it." This could be viewed as a vocational moment in Donna's life, one that she remembers clearly and gives her a sense of understanding why she is a nurse. Although she wrote this piece in our group exercises, it is something she has thought about before. It is interesting that she chose to share this with the group and talk about how this event causes her to ask if this is the reason why she is in the NICU now: "…is it full circle and why do I do this now?" Donna was open in her conversation with the group about what this moment meant for her. She repeated something that she said in her

narrative that again asked if this incident is why she is doing work in the NICU as a nurse.

> Donna: Actually, I think it's kind of funny how I came full circle –and I've always remembered that. And I don't know….

In the phrases from her narrative that asks the question "I wonder…is it why I do this now" and in the dialogue with the group "I don't know" that prompted the group to respond. It was in this narrative medicine group discourse where the group steps in and offers an affirmation to Donna of her choice to be a NICU nurse.

> Sandy: Doesn't seem like too far of a stretch.
>
> SB: Yeah, I was thinking that too.
>
> Alison: Me too. It came to my mind right away.
>
> Kim: Front and center.

Although Donna had thought about this incident for many years and understands it as a central reason why she was in the NICU as a nurse, she still had questions about this. The group responded to Donna's hesitancy and uncertainty by sharing their thoughts affirming that this event impacted her life's work. This implies that the narrative group exercises helped Donna make meaning out of her role in a way that also confirmed her understanding of how she chose to work in the NICU.

Alison wrote a poem that reflected about what it was like to be a new NICU nurse and work with a patient and the parents. Although Alison had been a nurse for over seven years, she had been in the NICU for about a year. In this poem that she wrote during one of the narrative medicine group exercises, she reflected how the newness of the work was a powerful experience for her and how her initial learning curve with a particular patient and his parents made a lasting impression.

> A baby boy number one was born perfectly tiny. His perfect tiny little hands and feet with tiny little nails. Everything went flawlessly with his entry into the world. Albeit too early, he honeymooned with the best of them. We all learned together, his parents and I. returning from the beach is a long arduous journey, filled with tubes, needles, blood, medication. And so much work and effort from such a perfect tiny boy. He worked to breathe, eat, and grow every day. He used his perfect tiny little might to survive. And it did it all perfectly. Now he gets to laugh and play and eat and grow. He has become a perfect big boy at home.

She says, "We all learned together, her parents and I" capturing the shared connection of learning with the parents that demonstrates how they absorbed the illness of the baby together. This narrative expresses how Alison learned alongside the parents and how she honed her skills as a NICU nurse. The group reacted to her story by confirming that is the way they learned as well and that this gave depth to their sense of work.

After the poem, the group continued reflecting on Alison's experience. They said:

> Sandy: He had a lot wrong with him.
>
> Alison: Yeah. He was my first premie here. He was my first delivery…ever.
>
> Cheryl: Really?
>
> Alison: Yeah.
>
> Donna: How early was he?
>
> Alison: He was 25 (weeks). And, I just, I learned so much with him and his parents. I learned really what it means to go through a honeymoon. It was insane. I feel I was right there with the parents…you get your hopes up because he's doing so well at first. Not realizing the pitfalls that can happen after that. Not having seen any of this before it was just…I was reading the same "How to get through a NICU experience" books that the mom was reading because I was in orientation when he was through it. And I was like, "Oh, you should read this chapter." (Laughter)
>
> Sandy: Did you talk about that roller coaster ride and those deep valleys….
>
> Alison: Yeah. Yeah.
>
> Donna: I think when you're new, the first time you see a honeymoon, it's kind of crazy because it's like, "But you were doing so great yesterday…what is wrong?"

(Laughter)

Cheryl, Alison, and Kim: Yeah. That is so true.

> Alison: It was devastating to see his honeymoon end. It was so hard. The first time he had to get re-intubated, I was like "Oh my God." I honestly think I might have been mourning…it was so hard to understand that this is just the way it is. It's just premies.

For Alison, her first NICU patient left a memorable impression on her understanding of not only coming through a rite of passage with respect to her nursing practice and skills, but also how she developed her sense of being a nurse though this patient. The group participants understood this phenomenon and were able to affirm the awareness of the value of her work in a warm and thoughtful way. Although her role as a nurse was not confused with that of the parent, however, she reflected on her thoughts and feelings as a nurse and realized that she had definite feelings that were in line with the parents. The group validated her perception of being unsure of her skill sets as a new nurse and also how overwhelming it is to experience this rapid change in how a patient is doing. The "roller coaster" experience is not only evident in the arc of a patient's illness, but in the learning curve of a nurse. Through this exchange, Alison, as well as the group, experienced an opportunity to discuss the meaning of their call as a nurse.

The group continued to discuss their reflections about being new to the unit, the care of their patients, and becoming acquainted with the sometimes anything but normal expectations of this particular patient population and how it impacted their sense of being a nurse. They said:

> Donna: I think that's been the hardest part of working here, it's like, "What can I do to make it better?" And, you can't. There's nothing…especially when you have to leave the shift, it's like, they just started turning and you have to give report and you're like you know, it kind of…it's hard and you kind of take it

> personal on yourself and it's the hardest thing of working here, it's like you know….
>
> Alison: Yeah.
>
> Kim: It's like you prepare the parents for a honeymoon and a crash and then it never happens…. That's OK. I'll take that. The whole thing of wondering what will happen next completely baffles me. Waiting for the other shoe to drop.

As Donna noted "taking it personally" when something happened to a patient suggests that the nurses are genuinely engaged with their patients and their patient's welfare is important to them. When a "honeymoon" for a patient ends and things go badly for the patient, Donna describes it as "the hardest part of working here." Kim expands this idea when she notes that preparing parents for a "crash" that never happens and naturally is something that is welcome, yet she expresses that "wondering what will happen next completely baffles me. Waiting for the next shoe to drop." These comments indicate an involvement of the patient's welfare that extends itself beyond simply doing a task but finding a shared sense of identity in work. For these participants, this was evident by the way they expressed that they wanted to be able to have a voice in caring for their patients and trust their own voices as well. Meaning was also found by providing solid learning experiences for them to develop their skills. They often articulated that the group work they were doing was worth doing and had enormous bearing on the life of a vulnerable patient as well as the anxious parents.

Cheryl used these comments as a jumping off point to talk about when something goes well and how proud this made her feel, illustrating an engagement with the patient that goes beyond merely performing a job task. Cheryl states:

> Cheryl: The other side of what you are talking about is, like, when you extubate them and you take the lines out and mom gets to hold him for the first time, like, you can kind of take that personally too. I feel like, "I did an awesome job today."

(group laughter)

Cheryl: (throwing her arms out wide) Check me out. I am an awesome person.
(group laughter)

It is interesting that immediately after these comments, the group returned to narrating their stories of the patients who were not doing well and how this affected them personally and professionally. The distance between personal and professional merged into a unified entity. Keeping a balance between a personal and professional life is important for many people. This distance is something that many consider to be something to strive for and, if possible, ultimately achieve. It is possible to turn the lens around and see value of how we think about joining the professional and personal life in a way that might speak of our lives being seamless and having a kind of flow. Linking the personal and professional in this way could allow us to locate our whole selves in every aspect of our lives, without a gap or separation. Lischer (2005) explores the concept of how the personal and professional life is difficult to separate because they encompass the totality of a person and making a distinction between the two entities difficult. In this study, this is relevant because it expresses a vocational aspect of the participant's work.

Through the group sessions, participants were able to give voice about the meaning they found in their work. It is *through* the work of the nurse, performing the acts that nursing demands, that the value in their work is found and renewed. The nurses in this study occupied their roles and saw them as having deep impact when they were able to help others physically and promote healing.

The meaningful aspects of nursing can be challenged by becoming "cut up" in a way that consumes them whole and does not nourish either themselves or those for whom

they care. This may also lead to burn-out, which can tear at the heart of even the most substantial work moment. Technology can remove nurses from their point of contact and create distance. Stripped of the time to be with patients, the nursing life can have aspects that may cause its disintegration. Without the central principle of hands on, a nurse's calling relapses into the chaos of busyness. The conversation below demonstrates the job related stresses that affect NICU nurses and how this impacts their calling. Sandy, who has over 15 years as a NICU nurse offered some sage advice to her group during one discussion of the stresses of their work and how it affected them personally. She said:

> Sandy: But, we have the opportunity to change a baby's life forever. Whether that being holding G when he's screaming and crying and not just leaving him crying in a room all by himself. Or the other baby, the K babies…or teaching parents something that they didn't already know and sometimes that comes from parent being open to learning those things, which can be a challenge. But, I think our job is unique and for the most part, yeah, we have stressful days and stressful time and it's stressful times in our field, but we love what we do. I can't say that about everybody else who does what they do in other jobs, you know.

Sandy's expression of "changing a baby's life forever" holds up the awareness that the nursing work in the NICU goes far beyond their own lives and has great impact on another life. Based on the group sessions with the research participants, it is clear that these nurses consider their work with their patients and families as a joining experience, one that is crucial to their sense of being a nurse in the NICU and making consequence in their work.

Living in work in such a deep way has its consequences and can be emotionally difficult. Alison and Ellen expressed the vulnerability in her work, which is characterized by understanding that they are human. In a group session, they noted that this is a reality they have to live with and they are willing to live in that understanding of the experience of their work.

> Alison: Working on this unit has opened a vulnerable side to my nursing that I hadn't experienced so intensely yet. I feel so much more intensely the sense to want to do everything perfectly, or even more than perfectly if possible. It is constantly questioning, am I missing something, not seeing something, saying the right things, doing everything, not doing too much? I feel like I need more from my peers than I ever have because of this. I need to pull from their knowledge and experience. Being a nurse here means checking and double and triple checking that I am doing the best that can be done for my patients, while knowing that I am fallible and not all-knowing and having to deal with that reality.
>
> Ellen: …it hurts me to see a baby suffering when it might be avoided.

These comments suggest a personal commitment to work that is characterized by being vigilant and attentive to the tasks of nursing and coming to terms with the fallibility of being human. This understanding represents the strong desire to serve the patient and emphasizes that this work is not about themselves. The narrative medicine exercises were a place for participants to talk about this aspect of their work and be affirmed about their shared understanding and how it shaped their identity as a nurse.

The nurses acknowledged an understanding of being willing to step into uncertainty in their practice and noted the unpredictability of their work. This understanding goes beyond merely checking the boxes with patients because they recognize that there are mysteries when working with a patient, a human life. Ambiguity can also take on the perspective of surprise. Nurses confessed to the surprising events that can happen in nursing as well as the involvement they feel with their patients. The following conversation illuminates this point:

> Donna: …we never know what's going to happen. I'm really new to nursing, but one of the newer people was like, "Do you feel like you know when a baby's going to make it or not?" And, I'm like, I have no clue. Like the times I feel that this one's not going to make it, then, they turn around and do awesome. And with others, they're doing great right now and then they don't make it.

> Baily: I think for parents, too, it's kind of a mystery and they just have to go with this plan, which is not the plan they had – no one ever thinks they're going to have a baby to be in the NICU. So the whole thing is kind of a mystery.
>
> Donna: You can have little things. You can have babies born at the same week gestation and one can have spells and spells and spells and the other can start nippling. I'm so proud of a pleasant surprise though. You just don't know and it's kind of crazy. Like the other night, one of mine started eating and I was like, "Yay."

Nurses stand in the midst of mystery, surprise, wonder, unpredictability, and ambiguity. They realize this is a large part of their work. These conversations acknowledge the complexity of being in this role and how it affects them, for the work is personal and their involvement is total.

The sense of meaning can be undermined by fellow professionals not recognizing another's skills sets or valuing their training. Participants spoke out against this practice in this specific NICU and indicated that when their competencies were not acknowledged, even in a basic way, it undermined their sense of professional well-being and calling. NICU nurses who had been in the role for over 25 years noted that they used to believe in their work and had little separation between the work and themselves. However, over time and perhaps because of the dynamics in this NICU, these two very experienced nurses believed that through steady dismissal of their skills by the physicians, they did not have the same respected experience of their work they once had. The following conversation exhibits just how deeply the sense of meaning as a nurse is affected by not being regarded for their skills and their passion for their work:

> Rose: We're techs. We're not nurses, we're techs. We do the feedings.
>
> Ellen: We're trained monkeys…
>
> Rose: Sort of.

> ALL: Agree.
>
> Rose: This is just our job, it is not our life. It is just what we do to be able to afford what is important to us. So, I've gone from feeling that this is my vocation, something, I love, love love…I have pictures of preemies in my pocketbook, wallet, and on a wall…but not anymore. Because of this (being treated as if we're trained monkeys) – it doesn't feel … our opinions are valued, our experience isn't valued.

These comments address the context of their work within the interdisciplinary team. Participants note they not only need to be part of the interdisciplinary team to feel valued, they also need to be validated for the specific skill sets they bring to the job and significant amount of in-depth time spent with each patient. Because of their immediate and frequent contact with their patients, they believe they have a valued perspective. This group session brought to light how they shifted from feeling that nursing in the NICU was appreciated to noting that "our experience isn't valued," provided a time for them to reflect on this change and name it with colleagues. This awareness of shared experiential worth was an understanding that was affirmed. Being dismissed for their evaluation of patients was crushing to these nurses and undermined their sense of personhood as well as their value as a NICU nurse.

Participants expressed a self-awareness of the importance of their role and how profoundly it helps others, NICU patients and their parents. Cheryl's poem in a group session reflected this awareness. Kim and Cheryl's response indicates a shared understanding:

> I walked into a patient room to say hi to the mom. The baby was having a spell that just started. As I opened the door I heard another nurse yell down the hall, "You got that one?" I looked up and then it registered that the alarm was ringing on the monitor. The red light flashing, the incubator cover was open and mom's face was panic stricken. I addressed the baby and when the vital were stable the mom asked me what that meant. She was still so scared. She asked if I felt panicked during the spell and I honestly replied no, even though it is completely

> normal for her to. Her eyes brimmed with tears as she asked me if that would cause brain damage. A long chat followed where I explained how common these spells are and how short it lasted. I noticed as she smiled with relief, her shoulders lowered and she realized, thanking me for the help. It's scary when it's your baby turning blue. When you see a little fragile baby's chest is not rising and falling like it is supposed to but here is no normal in that situation. The best I could do was help her smile afterward.
>
> Kim: I envision having the exact same conversation with those kinds of parents, so hearing this – it is kind of crazy. It makes me think how used to it we are and how, you know, when it's your baby….
>
> Cheryl: And I think it's important it is for us to remember how scary it is for the mom and dad because, like your baby's not supposed to do that and like, especially when they're not used to it and they haven't been around when the baby hasn't had big spells and it's even just hearing the alarm is just scary. And we tune out certain beeps, because they don't mean anything really, but the parents are panicking.

This conversation highlights how Cheryl and Kim understand the technical and specialized aspects of their jobs for being a nurse in the NICU, which for them include nurturing an understanding of what parents of NICU patients are going through. Being present for parents to explain procedures and what is taking place with the baby is an important aspect of their work and one that has impact. In the group session work, these conversations about the baby and parents being a unit offered an opportunity to consider this aspect of their work and how important it is when the nurses in this situation understand that part of their professional care is to help families as well.

After the group sessions, I conducted one-on-one sessions that lasted an hour to two hours. I then spent an additional hour or two observing each research participant as they were working with patients during their shift. During these observational times, I invited them to discuss if there was any impact of the narrative medicine group exercises on their views of the vocational aspects of their work.

The understanding that NICU work is "more than work" was noted by Alison. She said that before the group sessions, she made the switch to the NICU because she "…wanted more than just work. It's way more exhausting than I ever thought it would be, but taking care of this population feels like my calling…." Alison said that after the group sessions that

> "… right now, after the group sessions, as a result of them, I'm starting to feel reinvigorated to actually care enough to care enough to push my limits and push the limits in my unit and make sure we're striving for what's best instead of just execute my job in a good way. There's a difference. I no longer want to be just the best nurse with what I'm given. I want to be the best nurse that is possible. It's made me more energized Definitely aware – but now I feel everything more now…."
>
> SB: As a result of….
>
> Alison: I think it has to do with the patient population. I've said this before. They are the ultimate innocence and there is nothing that they have even done that is their fault. They're completely vulnerable and they completely depend on us to figure it out. They can't point, they can't tell us, they can't explain what happening, it's all on us. I think that sense of weight is helping to make me feel that I need to be better. So far, I'm feeling it's a good thing. I've been aware of this since I started here, but because of our work and our discussions in the groups and the sharing, it's pushing me in ways that are really good and for me personally, sometimes not so good. But professionally, re-invigorating and good.

For Alison, the work in the NICU and the vulnerability of the patient population strikes a personal chord. The narrative medicine exercises in the group appear to have resulted in a renewed and re-centering of her sense of vocation and a sharpening of focus for her, both personally and professionally.

For these nurses who work in the NICU, there is a sense that their population of patients required something deep from them. Barb echoed this when I asked if anything came to light about her work as a nurse as a result of the group work. She said:

> I hope you're not just doing your job. …so, all the other political crap going on – you just go in that room and take care of that baby. So sometimes, you've got to

> remember that: why am I here? Why am I here? To see that everyone else struggles with that sometimes, it reminds you why you're here: for the babies. I hope I show that. Some days it's easier to remember it than others. So, in the group sessions, it was good to know that others feel the same way I do – and that's good to remember that we all feel this way sometimes. But we don't feel this way all the time.

This comment suggests that "political crap" that happens in their unit can take hold of them and even when it does, that asking the question "why am I here?" provides a foundation for them to remember that their sense of work stretches beyond any workplace politics.

Working in the NICU for these participants has a depth of its own that transcends nursing skill sets. Participants believed they were engaged in something worthy and of value. Randy's comment reflects this as said in an observational time: "NICU work seems to go pretty deep with people who work here." Rose's comments support this line of thought:

> We want to be good. And we want to be proud of our work and we want to make a difference. And I think there are a lot of us here who are very good nurses – even the inexperienced ones want to do a good job. They're driven.

Randy and Rose offer a perspective about their work that indicates that their work is personal and they want to be excellent in their skill sets to serve their distinctive patients. Sometimes this was manifested by questioning their own capabilities, yet they never questioned their own motives or drive to be completely engaged with their patients.

Sue also stated that she had a sense of renewal in her sense of work and personally after the group sessions. Renewal in this sense is animated by an awareness of the implications of work, the appreciation for what they do for the patients and families, and the consciousness of how this contributes to their identity as a nurse. This conversation

illustrates how the groups made a difference for her. Sue described the way she viewed her work post-group sessions.

> Sue: I don't think it was the poems, but maybe the overall openness of the group in general about the staff and families. And maybe verbalizing the things we talked about vocation made a difference. When we talked about actually what it means to take care of a little newborn who is struggling and what it means to the family. Just talking about what it means. And hearing other people say it, too, was a form of support.
>
> SB: Anything else about teams?
>
> Sue: I think my own sense of calling as a nurse was impacted too. … My outlook was changed and better all weekend long.

The root of Sue's comment does not rest in a confused inner cross examination of why she is a nurse in the NICU or if her skill sets are good enough to handle the exclusive work she does. Rather, they are a crystallization of her receptivity and response to the narrative medicine exercises, which was exemplified through the candidness of the groups and the meaning of encountering a "little newborn" and their families. Searching in the groups for what those daily encounters with patient and family meant were part of the group's principal appeal. This gently raised questions and brought these sentiments to the surface: What does our work really mean to us? This also impacted Sue's outlook about her work. This transpired without a specific instructive exhortation from anyone in the group, but instead the work within the group instilled something in Sue took it beyond a simple forensic exercise.

The narrative medicine exercises provided a space for participants to be able to say what they feel about their work and why it is more than a therapeutic group: it gave specific form for laying groundwork of fostering genuine conversation about their work together. Participants entered these kinds of conversation almost immediately when they

encountered the first group. I found it interesting that although their claims for expertise in their field were evident and they considered them critical to their work, it was not the credentials that took center stage. Instead, it was in service to their patient and finding value and depth in their work.

Donna also believed that the group sessions made her work more personally significant because she felt supported and this made her sense of dedication to her practice richer. She said:

> This group helped me; makes me feel good in what I'm doing and makes me feel I'm right where I should be. I do agree with that the people you work with and the sense of belonging can make or break an experience. And I think another point is that it allows you to deepen your own sense of nursing and not be comfortable, too comfortable. You can have those open discussions and not be in a judging kind of culture or atmosphere and instead have what these groups were – supportive. Or you are able to bring those things to discussions, openly, it makes you more dedicated in your practice as a nurse because you're dedicated and want to learn and do better as a nurse. So the fact you can bring things up, honestly, and share them and get good, helpful feedback.

Donna's comment suggests that she is in pursuit of clinical excellence and through the vehicle of the group work, she was able to experience support that gave her an opportunity to think about her work in a way that made her "feel I'm right where I should be." To be able to say what you feel and what work means to you and why it was valued was important to participants. For Donna, the group experience of "deepening your own sense of nursing," did not come through force, it came through the introspective and attentive conversation within the group. It was as if the group work was teaching participants how to think about their work and how to examine their own thoughts and feelings about it. It is possible that this task could be done alone, however, the presence of colleagues offers something to each participant when thinking about significance in their work: confirmation, encouragement, and perspective. In the group work, it was as if

they were they were able to drop the innately critical streak that can be present in self-reflection. Instead, in an unanticipated way, their eyes were opened by other people who shared their same concerns and joys about their work. What was uncovered was a way to make worth out of their work. Instead of being so alert to exhaustion and frustrations, the group work offered support and shared meaning.

Randy talked about his love of nursing and how the group sessions helped him get back in touch with his work. Talking about "what matters" has propelled Randy into extending himself for the sake of the team and being more aware of team needs. He stated:

> My dad's always says, "You could go back and get an MBA and get into nursing admin." I have no administration – I have no interest in sitting at a desk. I said to him, "I want to do this job and I love it." One kiddo at a time, I don't need to try to change the whole structure. …(the group's) been beneficial to me. It's so good to hear and talk about what matters.

It is interesting that Randy refers to administration and deskwork on the opposite side of the spectrum in regards to what he does. For Randy, this means that self-regard is found in participating in a patient's care, "one kiddo at a time," and this has meaning enough for him. The group provided a forum to think about these questions. It also offered the possibility of how his work has merit.

Although some participants talked about the impact of their work in relationship to their patients, Kim specifically reinforces that the group work increased her sense of herself as a nurse. The group sessions reinforced her understanding of advocating for her patients, yet in this she discovered a strength in herself that was substantial. Perhaps she did not discover the strength on her own, but the group work gave her a way to remember

she already possessed it. And, for Kim, it is a necessary component to being a NICU nurse.

> SB: Has this process helped you make sense of your own vocational life and work?
>
> Kim: I think it makes me see that I'm actually suited for it. It's frustrating and yeah, it's hell in the meantime, but I've got the backbone, the spine, and the willpower to want to deal with it and make it better. Which is what you need in a nurse. You can't have someone who backs down easily – that's not a good nurse. Like, you've got to have someone who's willing to fight. If I were a patient, I'd want someone to fight for me, just speak. Especially here – these kids, they only have their parents and if their parents are losers, well, then, who else do they have? That's what I'm seeing. And that was affirmed for me in this group process.

While some participants talked about their work in terms of how it was rewarding. Kim's perspective generates another compelling view of how her work is important: she has to be a strong advocate for her patients, or as she says in her words, a fighter. This sense of advocacy is a strength that occurs as these participants experience the crucial aspect of being sometimes the central participant in a baby's welfare. Kim is a new nurse trying to make sense of and find consequence in her work in a unit that has intense patient care. The group pushed Kim back to her own sense of worth in her work – and pushed her back to her own strength: a strength she is using in a consequential way – to fight for her patients.

During the individual and observational sessions, participants identified how the narrative medicine exercises helped them think about their work in more rewarding ways and reminded them why they wanted to become nurses. This vocational reflection allowed participants to learn about themselves. Sue said that the group work:

> Made work better. I had a reminder about the things I like about my job and why we do this…. …It was just kind of like a renewing little collecting your thoughts about the job…it made me think about the job in a more rewarding way.

Sue's comments suggest a renewal of the value in her work: she was reminded about the things she enjoyed in her work. In this case, the group did not provide an actual new thought, but a renewal.

Baily's comments discuss how the group work evoked a new appreciation of her job and helped to deepen the consequences of her work as well:

> It's really made a positive impact. It makes me enjoy my job more than I already did. …There's more job satisfaction. This has been a very good experience and helped me learn a few things about myself. I don't know if I'd be the same if I didn't do this. It's really has a very big positive impact and so I think it should be done with other people in our unit.

These comments imply that Baily had a learning curve that offered some fresh learning experiences about herself. The clarity that Baily's expressed about the impact of the group work on her sense of worth in her work draws a clear line that it was the group work that provided insight.

Donna also discussed the maturing of her understanding of being a nurse and how the group work provided an enriching sense of significance in her work. She said:

> I think when people go into nursing, you just picture helping people – working at the bedside, helping people. When you pick your occupation, you don't really think, you're first thought, "How am I going to feel as part of the team? Am I going to feel comfortable there?" You just think about the job you're doing. You don't think about your sense of belonging, because those things grow, like, it's kind of hard to prepare for your occupation I guess because it grows as you're there. So I think the narrative medicine exercises deepens my sense of belonging here. …This group helped me, makes me feel good, in what I'm doing and makes me feel I'm right where I should be. …and I think another point is that it allows you to deepen your own sense of nursing…. This group process we had was filled with great substance.

Donna's comments imply that the group exercise helped her discover her sense of value and belonging as a NICU nurse. It also helped her find her footing in the consequential sensibilities that happen through the tasks of being a nurse. For many of the participants,

the group exercises were the method to discover issues of meaning that would not have been uncovered unless they were allowing a setting such as this for it to happen.

The following closing comments about vocation as a result of the group exercises sum up various aspects of how participants viewed the importance of the work they employ:

> Rose: "Nursing is a big deal for all of us – you honored us as people and our vocation."
>
> Cheryl: "I love being a nurse, but being with my colleagues and getting to know them better, it's made us closer and made me love my work even more. I can't tell you what it did for me – it was great."
>
> Baily: "The narrative medicine exercises gave me a good reminder of why I love being a nurse. It gave me a lot to think about – not just teamwork, but how I am as a nurse and what that means."
>
> Randy: "I felt an over-surging sense of my call as a nurse as a result of these group meetings. I think it's important to have your job be a right fit and do excellent work. That's a large part of what the group sessions meant to me. It enlarged that for me."
>
> Alison: "This renewed in her nursing and life as a nurse" as a result of our group sessions and our one on one time.

After the narrative exercises were completed, nurses were renewed and changed by the experience in their work and personal sense of professional value. I will argue that it was not only the group exercises that assisted this understanding, but their desire for a way to practice their craft through the rituals, practices, habits, and conversations of their work. Their shared experiences in the group work renewed sense of community.

I believe the great virtue in narrative medicine exercise is the method it employed: gathering participants together in a way that would invite them to reflect on some of the more worthy aspects of their work. The results indicate that the usual hedging and filtering that happens automatically – even unconsciously – when any professional group

sets up to talk about issues such personal value in the workplace, were absent. Perhaps if not completely absent, then diminished. By and through this group process, the questions of meaning not only emerged, they were sharpened and evolved. The group almost demanded, in the framework of the structure and colleagues who were involved, that each person wrestle with the questions for themselves. And to that end, as this study demonstrates, each person is invited to fashion answers for themselves that while they are tailor made for each person, they were often supported and shared by the rest of the group.

CHAPTER 5

CONCLUSION

This research contributes new information to the discipline of healthcare team development in identifying how the practice of narrative medicine influences team functioning, sense-making, and meaning. Although there are many techniques currently available for increasing healthcare team training, narrative medicine offers an innovative method. Healthcare teams operate in a complex and quickly paced environment. Strong functioning, making sense of their team and its work, and providing meaning for individuals and the collaborative work nurses do are keys to teamwork. An increased sense of teamwork leads to safer and higher quality of care. Observation of the narrative medicine practices provides insight in several significant areas of healthcare teamwork.

Participants report that they were able to form stronger relationships as they grew more aware of each other's stories. This led to an intensified individual and group understanding of shared stressors and the isolation those stressors bring. When feelings and thoughts about stressors were shared, the common question, "You felt that way too?" provides evidence that this was a collective consideration. Participants sought to make sense out of their role as a healthcare professionals and team members and through the narrative medicine practice, expressed the significance of their work and the appreciation for what they do for patients and families. They also noted that through reflecting on this contributed to their identity, value, and meaning as a nurse.

This conclusion is divided into two sections. First, theoretical implications of this study will be considered. Second, practical implications of the research will be examined. Practical implications will examine the following: first, participants in the narrative

medicine study offer insight into understanding some of the themes of common stressors of nursing teamwork and the need for a range of genuine supportive team practices; second, the narrative medicine practices initiated by Rita Charon provide an opportunity to analyze the results through this framework and explore the possibilities for using this method in healthcare team development. Finally, the study of these participants suggests a discovery of a particular way members of this team applied these practices and how this proposes possibilities for future application in healthcare teams.

Theoretical Implications

The narrative medicine method provides beneficial means to think about teams and identity. Narrative in communication often joins individual identity. However, it is through listening to each other's individual narrative where we become connected to each other. By utilizing the narrative medicine method through the single act of sharing an individual's story or poem, the group became active participants. Individuals and the group processed their work and the meaning of it. Sometimes, participants would simply say something like, "Let me tell you a story…" By parting the curtain on their past, they seemed to be opening a door to a shared future relationship (Lischer, 2005).

It is essential to remember that at the heart of this narrative method is the concept of story. In this reflective method, particular connections could be made through narratives in ways that other methods do not. The stories and conversations fostered the participant's connections and allowed them time and space (location) to reflect on their work and its purpose. For participants, this cultivated consideration about the meaning of their experience at work. Through conversation, participants reflected on their own

meaning of their work experience, but also helped each other imagine what meaning was uniquely theirs as well. Giving voice to those experiences often forms our thoughts and then our identity around issues, sometimes surprising us about things that, until we talk about them with another, we may not be aware. Weick reminds us that the recipe for sensemaking is "How can I know what I think until I see what I say?" In this, sensemaking becomes a matter of identity for it is how we understand ourselves in relationship to the "other." The narrative medicine method allowed participants to join and reflect upon what parts of their lives they were living out in their work – and how these were shared experiences and the connection of the shared sense of vocation and the implications that offers.

Practical Implications

Common stressors within the nursing team participants emerged and revealed that there was a need for genuine supportive team practices. These practices lead to patient care and safety, which were acknowledged in the group and individual sessions. Participants noted that being insecure or fearful asking and offering help was an issue that caused strain in their work and affected functioning. Using diagnostic skills to think through a patient issue involves interpretation and responsibility, which are excellent critical thinking skills to develop as a caregiver. Asking for and offering help can promote a feeling of empowerment for both parties and also may help diminish intra-team rivalry that can create disruptive relationships between staff. The person who provides another viewpoint may see their professional life as valued and trusted through offering this knowledge. Becoming used to this kind of interaction can have benefits.

The person who asks for help may come to realize that it is secure to ask, which also provides a sense that they are self-confident enough to ask. Cognition levels can be enlarged and insight strengthened. Asking for and providing consultation in non-emergent setting creates good groundwork for being able to practice this when the stakes are higher during emergency situations: both parties are comfortable with it. While answers to questions may be unpredictable, if team members can not only ask for and receive the assistance in a constructive manner that is a norm, they may be more comfortable to challenge the input when that input seems to be questionable. The constructive implications of asking for and giving help Baker, et al, (2005) notes that trust is a key component in a health care team, one that sets the foundation for enhanced team communication, openness, conflict resolution, and ultimately better team functioning.

The narrative medicine exercises gave participants a chance to consider how stress affected their communication. This shared knowledge within the group offered an occasion to reflect on their work together during a stressful time and consider the ways that it impacted their work. When the unit is understaffed, the patient census is high and the patient acuity rate is notably difficult, the nurses believed that the added stress affected communication. Although they believed their task work was usually at a high level, it also was apparent that when there was added considerable stress and strain, which they believed affected functioning. Participants noticed that the narrative medicine group work eased some of this stress because they could communicate more easily and trusted each other more. The personal connections that participants made through the narrative medicine group work allowed them to engage each other on a socio-emotional

level, which fostered a sense of deepened personhood. The feelings that were evident in the shared narratives within the group sessions joined participants in important ways, which clearly affected their understandings and perceptions of each other as fellow human beings. The group sessions allowed for a time of collective reflection about their work and also how that worked felt as individuals and as a working team.

Conversations in the narrative medicine exercises helped to remove walls so that relationships were enhanced, which made asking and offering help seem easier and safer. Trust developed in the groups, which also augmented reaching out to co-workers and communicate needing or suggesting clinical support. Participants noted that there was some strain when the team did not communicate well and the group work fostered genuine conversation. The narrative medicine exercises gave participants a chance to consider how stress affected their communication. This shared knowledge within the group offered an occasion to reflect on their work together during a stressful time and consider the ways that it impacted their work. Another issue of stress and anxiety that emerged was when colleagues were new to the team. The group work helped those who had more experience understand and remember what it was like to be new and as a result, reach out to the newer employees in an active and sensitive manner. Those who were new expressed a reduction in tension through these actions and felt welcomed in a meaningful way.

Part of the maturation that is embedded in experience, means a responsibility to aid newer people, with the result that they will function better and be incorporated more quickly in the team. This results in an enhancement of the more experienced person's self-efficacy and competence as well.

Many participants expressed the need to believe they were competent in their work and be seen by others as possessing competency. Participants were also humble enough to realize there

were always skill sets that could be improved, yet the stress of not appearing competent with their peers was something that was important to them – and to themselves. The narrative medicine sessions assisted participants with disclosing questions about their tasks, thus appearing vulnerable and threatening to disclose an deficient in their work. This was particularly true for those who were new to the role of a NICU nurse. The more experienced nurses in the groups made a strong yet compellingly thoughtful case for asking questions. Those NICU nurses who had experience also indicated that through the group sessions, they grew in their understanding of their essential role as a mentor. Through creating a deeper personal connection and relationship, these participants felt more ease with each other to admit their questions and believe that it was the right thing to do for their patients.

Making sense of a team poses a different set of implications that are related to and yet are distinct from functioning. Team sensemaking seeks to understand the team as a whole. It considers those things that create a sense of team such as building relationships and creating trust. In as much as learning to function well individually and as a team, the features in a team that help make sense of that team for participants are deeply valued and appear to be related to helping to create improved functioning. While they are distinctive, they overlap and both functioning and sensemaking in a team are important factors in teamwork that depend on each other. In the group sessions, participants shared their views on simply being able to talk to each other and become better acquainted personally.

Being aware of a colleagues' "story" and becoming better acquainted helped co-workers understand each other as people and professionals, which reduced strain in their relationships. Participants also were relieved to know that they were not the only person who "felt that way" about an issue or event. Through the work in the groups, this understanding greatly reduced a feeling of isolation and created a general sense of deeper bonding and feeling less isolated.

Participants noted that their work was important to them personally and had great value. They also stated that sometimes the stress and busyness of their work impacted their sense of meaning as a nurse. The narrative medicine group work offered a way to provide a forum for participants to formalize and articulate deeper questions of meaning about their work. This was discovered through the introspective and attentive conversations within the group.

The method that narrative medicine utilizes invites participants to tell stories about themselves. These self-narratives are intended to define individual group members to each other in a way that allows them to connect on a professional and personal level. These connections emerged slowly and through each participant taking part in three groups, relationships were able to grow at an unrestrained pace. Three group sessions also provided continuity, stability, and the capacity to build trust. Participants emphasized different strands of storyline when a particular issue addressed something that was relevant to that person. At that moment in the group discussion, specific stories surfaced from participants. Such detailed self-narratives may be dangerous to other group participants when they seem to clash with other experiences. These may also be called into question. However, they also may provide an important link or bridge to another

person. The bonds that were formed were the rule rather than the exception during the narrative medicine exercises and provided some significant outcomes for their work.

The wider reach of these self-narratives also constructed a narrative about nursing teamwork, with its problems and potential. These were expressed by casting a wide net about grand ideas about teamwork. Yet, far more often, ideas about teamwork also were expressed in finer, more precise and descriptive details that exposed the particulars and tailor-made experiences of their work. The greater the specificity, the more profound the commonality. The research questions were sharpened and conversation naturally evolved through the narratives. It created a kind of membership where participants learned about themselves and how they related to each other. They examined their actions in terms of their appropriateness and relevance to their work and in a personal way. Participants held each other accountable to the group in a gentle way and offered a sheltered place for individuals to wrestle with questions of teamwork and self. Through narrative and group process, participants believed that there was a possibility of building a better team. Through the enthusiastic and genuine engagement in the group, participants dedicated themselves to playing a meaningful role within the group and when they returned to their work. This reality of the group work focused their energy and attention in a way that allowed for encountering meaningful change, which they fashioned through the narratives, for themselves. This suggests a sort of openness that had an insistent way of pulling each other in and holding their attention. The risk of highly personal sharing in the group forged a connection that participants took back to their work.

Limitations and Future Study

This research was guided by three basic themes about the use of narrative medicine. First, how does narrative medicine affect nursing team functioning? Second, how does narrative medicine create sense-making for healthcare team individuals and teams? Finally, how do nurses make meaning out of their roles through experiencing the process of narrative medicine?

This study is considered a project of exploring how the method used in narrative medicine impacted a NICU nursing team, which may have wider implications for the promise of other healthcare teams.

Like other efforts to strengthen healthcare teamwork, narrative medicine will offer some limitations. First, not everyone will be enthusiastic about the methodological practices that embody narrative medicine. Reading poetry in a close attentive way, the act of writing, and then discussing a personal narrative may be threatening for some and/or greeted with skepticism by others. Although the participants in this study accepted the method and engaged the process in a total way, getting people to participate may be a challenge.

Second, facilitating narrative medicine sessions will take a well-trained person to assist group participants through the group work. Expertise in the methodology of qualitative research in interview technique and interpretation is not necessary. However, skills in this may stimulate richer data from participants through a focused discussion. Through the leadership of someone who has an understanding in narrative competencies of close reading, the participants have a stronger opportunity in the group work not only

to articulate their own stories, but listen to another's story as well and find connections between each other through their stories.

Third, this study introduced the concepts and practices of narrative medicine to eleven research participants. Each participant had an individual session following up the group sessions to understand how the narrative medicine exercises impacted their work. These individual sessions were scheduled about two or three weeks after the group work. This was the only follow up. It would be interesting to see how participants "took up" the practices after three or six months and if the new practices they named were still being employed. If some of them did fail, it would be good to study why they failed and what could be done to sustain them.

Fourth, health care team work is located within a highly interdisciplinary environment. In this study, there were no physicians, physician assistants or other clinical specialist staff. Besides other clinical staff, this study did not include those who are often considered part of the healthcare team in a unit: the administrative clerk, housekeepers, orderlies, and other staff who provide necessary services to keep the unit and patient care in good working order.

Fifth, there were eleven research participants in this study and about 60 nurses in the NICU. Although this experience had a transforming effect for the participants, the other nurses in the unit were not interviewed. How did this study affect their work? What would the outcomes be in this unit if the entire nursing staff participated in the narrative medicine experience?

Future research could examine patient safety when narrative medicine methods are employed. As well, other markers that could be possibly investigated are retention rates, job satisfaction, team communication, and dispute resolution.

The outcomes of this current study provide a springboard for exploring innovative future work using the methodology of narrative medicine and demonstrate that this method has the potential to transform healthcare teamwork. This study also suggests that future study of the effectiveness of narrative medicine may prove to be measurable in terms of patient care, clinical outcomes and teamwork. The participants in this research study were willing to give a novel method a whole-hearted effort. At the conclusion of the study, each participant experienced strong benefits for themselves and their team.

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