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THE ROLE OF NARRATIVE MEDICINE IN PATIENT HEALING AND MEANINGFUL CLINICAL PRACTICE

By
Gray DuPerier

A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

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ABSTRACT

The patient-clinician relationship is one that relies heavily on trust and understanding—both of which are reached through effective communication. As medicine advances, it is increasingly important to prioritize the human interaction in the clinical encounter. Illness is more than just a set of diagnoses; it is the culmination of one's way of being and interacting with the world while experiencing these diagnoses—it is a narrative. In order for physicians to provide quality care, trust and understanding are of the utmost importance, but oftentimes these are not at the forefront of medical practice due to logistical barriers that the US healthcare system presents.

This thesis aims to explore the arts aspect of medicine as seen through narratives and their integral role in the ability to provide quality care and reintroduce meaning in work. I argue that the integration of Narrative Medicine into one's practice brings the focus back to the patient, allows the provider to be reminded of their initial draw to medicine, and equips clinicians with the means to practice quality care that extends past that singular clinical encounter.

The human body is incredibly complex and interconnected, and a clinician's understanding of a patient's thoughts, emotions, and more can provide important insights into their overall health. By integrating narrative medicine into their

practice, physicians can treat patients in a manner that recognizes the unique experiences and perspectives of each individual. This approach allows providers to connect with patients on a deeper level and provide more comprehensive and effective care while simultaneously promoting clinicians to continually develop their professional identities.

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CHAPTER ONE: WHAT IS NARRATIVE MEDICINE?

Introduction

> Theoretical, scientific knowledge formulated in context-free and value-neutral terms is seen as the primary basis for medical knowledge and reasoning… Science is made human in the sense that its social and value-laden character is revealed.[1]

Narratives have a profound impact on the way we live our lives and experience the world. Whether it is the personal narratives we believe about ourselves, the stories we co-write with the people around us, or the stories we strive to fulfill throughout our lives, the impact each of these has is immense and ultimately helps create not only our lives but the meaning we tie to our lives.

Regardless of the nature of these stories, they help us make sense of our experiences and help us understand how these experiences fit into the greater picture of our being. They teach us lessons that we would not otherwise learn. They provide glimpses into another person's way of being in the world—fostering empathy, promoting understanding, and sparking inspiration. Personal narratives, if not the main source of an individual's identity, are an integral part of them. Through narratives, individuals are able to relay their values,

[1] Lidskog, "In Science We Trust?", 48.

experiences, and what they find meaningful while simultaneously making sense of their story.

Whether an individual is consciously aware of it or not, personal narratives form throughout every experience, no matter how small the experience may be. From failing a test to experiencing the death of a loved one, our lives are ultimately a culmination of every experience, and the meaning we derive from them. Because being human means perceiving the world, learning from experiences, and finding meaning, it would be in our best interest to become aware of the stories we tell ourselves, recognize the hand we have in co-writing stories, and take agency over the stories we are currently writing.

In this thesis I will consider the narratives that are formed around the clinical encounter, the weight these narratives carry into a patient's life and health, and the power personal narratives carry in the creation of meaning in both the ordinary and extraordinary moments for both patients and clinicians alike.

I will begin this section by providing an overview of narrative medicine and introducing the history and purpose of this field, highlighting two parts of this practice that will constantly be referenced throughout this thesis. I will then explain the ways in which narrative medicine is used to employ medical humanities into the clinical encounter. To finish, I will provide an overview on the ways in which the practice of narrative medicine sets out to fill in holes in both the clinical encounter and in the formation of a clinician's professional identity.

Narrative Medicine Overview

> Wouldn't you want someone to tell your story? Ultimately, it's the best proof there is that we mattered. And what else is life from the time you were born but a struggle to matter, at least to someone?[2]

Narrative medicine encompasses both a field of study and a clinical practice that promotes comprehensive and holistic medical care through the use of patient narratives. It sets a high standard for patient-centered care and provides practical approaches to meet that standard of care in the clinical encounter. Narrative medicine emphasizes the humanness of the experience of health, illness, and suffering, with an aim to practice medicine in a way that heals rather than cures. See below (Healing vs Curing & Narrative Medicine).

One component of the field of narrative medicine is the integration of narrative skills into clinical practice. These narrative skills provide the foundation needed to effectively integrate narrative medicine into the clinical encounter. These skills include the ability to effectively communicate, to actively listen, to practice open-mindedness, and much more.

The term 'narrative medicine' was first coined in 2001 by Rita Charon, MD, PhD.[3] Charon developed this field through the creation of the narrative medicine program at

[2] Zaharias, "What is narrative-based medicine?", 177.
[3] Charon, "Narrative Medicine."

Columbia University, where she currently serves as executive director.[4] Narrative medicine is valuable in that it "brings medical practice back to its human core without losing its scientific footing."[5] Narrative medicine provides supplementation to quantitative ways of knowing in order to provide competent and quality care for the patient. Because narrative medicine involves many different components, the way in which an individual clinician practices narrative medicine can differ from one encounter to the next, and from one clinician to the next.

While narrative medicine generally refers to the clinical encounter, there is another essential component in the field that considers the clinician improving their narrative literacy outside of the clinical encounter so that they are better able to effectively communicate with their patients and develop their professional identities. This practice is completed outside of the clinical encounter and is done through reading and reflection. Both reading and reflection not only enhance a clinician's ability to practice narrative medicine, but also has the ability to create dramatic shifts through realizations made in the midst of these practices.

While narrative medicine creates a space for patients to provide clinicians with a holistic understanding of the multi-faceted nature of their own health and illness, it also provides clinicians with the ability to let patient stories shape their understanding of themselves as an individual and as a clinician while also broadening their practice of medicine. Seeing that both patients and physicians are whole and complete people, every encounter they both have shapes them into who they will be that next day. Learning to be moved by the vulnerable act of a patient allowing a clinician into their lives to help co-

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[4] Columbia University, "Rita Charon, M.D., Ph.D."

[5] Lewis, "Narrative medicine and healthcare reform", 9.

write a story in order to promote healing can be lifechanging in patient outcomes and the identity development of clinicians.

Medical Humanities & Its Relationship with Narrative Medicine

Medical humanities and narrative medicine are related fields that employ similar methods to promote the consideration of influential factors in a patient's health outside of the biomedical model. Both of these disciplines aim to humanize healthcare and bring a more holistic approach and humanistic perspective into the clinical encounter to promote patient healing.

Medical humanities is a broad field that houses a vast range of disciplines including religious studies, philosophy, art, literature, and more in order to examine the social, cultural, and historical influences that shape medical practice and form the experiences patients and clinicians have.[6] Medical humanities prompts students and clinicians to reflect on and contribute meaning to the clinical encounter through exploring one of the forementioned fields and its relation to patient healing outside of medical treatment.

Narrative medicine is also considered to be the clinical approach to implementing medical humanities into practice. Through the use of narratives, clinicians are able to gain a greater understanding of the circumstances that shape a patient and their health outside of the biological mechanisms taking place and the symptoms that accompany those mechanisms. Narrative medicine is a vessel for the humanities to flow into the clinical encounter. In order to effectively practice narrative medicine, clinicians must be very

[6] Batistatou, et al., "The introduction of medical humanities in the undergraduate curriculum", 241-243.

familiar with the many ways the humanities shape patients' experiences in the clinical encounter and beyond.

History of Medical Education

Over a century ago, Abraham Flexner standardized medical education, imploring German-influenced and evidence-based practices that legitimized the medical profession through the emphasis of basic sciences and laboratory research.[7] To this day, the Flexner report, published in 1910, still holds as the foundation of medical education. While this standardization was an advancement in its time, Flexner's Report was taken too literally, with Abraham Flexner even commenting on the need for the consideration of cultural and philosophical influences on health only a few years after seeing the ways in which his Report effected medical practice.[8]

With the Flexner Report impacting medical education through promoting a biomedical model as the only model for practicing medicine, medical schools focused solely on disease, disregarding preventative medicine, public health, humanities, and other outside factors that contribute to the health of patients. In the mid-1900s, medical schools solely prioritized accepting students that could successfully complete the medical school program to ensure the school's funds were being invested in students that would eventually go on to practice medicine. At this time, medical schools solely considered quantitative measures of an applicant, seeing that GPA and MCAT had an accurate ability to predict a student's likeliness to complete medical school.[9] While GPA and MCAT were predictors

[7] Stahnisch and Verhoef, "The Flexner Report of 1910 and Its Impact."
[8] Turner, "Medical Education: A Comparative Study. By Abraham Flexner."
[9] Cuca, "An Analysis of the Admission Process to U.S. Medical Schools."

of medical school graduates' outcomes, they were never utilized to assess the long-term performance of physicians.[10] Even though assessing only GPA and MCAT directly aided in the production of technically capable doctors upon completion of medical school, the consequence of using this standardization brings forth the concern that medical schools at this point in time prioritized successfully completing medical school over cultivating their students to become caring clinicians.

The solely biomedical practice of medicine that was implemented based on suggestions from the Flexner Report distanced itself from the people it was supposed to serve. The Flexner Report served as the basis for the exclusion of entire groups of individuals in medical education and research and exacerbated the lack of diversity in medical schools—an issue that is still seen in the medical community to this day. The excessively objective standardization of medical education failed to acknowledge patients as individuals, treating them instead as mere vessels for scientific exploration and research. Because of this, individuals that were drawn towards the medical profession were ones that considered science superior to the human experience of health and illness, increasing the likelihood for the clinician to conduct unethical practices in the name of furthering scientific research. With the medical field being a system that innately promotes mentorship, knowledge and ways of practicing medicine passed from one generation of physicians to the next. This mentorship accounts for the long-standing rigidity of the objective practice of medicine and the breeding of clinicians as scientists rather than humanists.

[10] Ibid.

In the 1970s, the US medical system witnessed the emergence of medical humanities due to the growing realization that medicine's comprehension of the human condition, as previously limited to its strict evidence-based and practical approaches, was insufficient.[11] This introduction of medical humanities was first seen as radical and displaced, as there hadn't been a push for widespread shifts in the medical education since the Flexner Report was first implemented. Arguments in favor of incorporating humanities into the medical sphere went as far as considering the Flexner Report as a "maldevelopment in the structure of medical education," creating "an excellence in science that was not balanced by a comparable excellence in clinical caring.[12]" The incorporation of medical humanities into medical education and the clinical encounter highlighted the importance of considering factors that influence health outside of the biomedical model. This more encompassing way of understanding the human condition has revolutionized medical practice through incorporating the human experience of health and illness into the clinical encounter.

Today, with the growing recognition of the importance in implementing medical humanities into the clinical encounter, many medical schools have begun incorporating humanities-based approaches as a means to educate their students. Although the extent to which these are implemented varies from medical school to medical school, the overall movement from the Flexner's medical education system towards the one that is seen today is marked by an increased emphasis on a more holistic and patient-centered approach to medical education, along with a greater recognition of the importance of incorporating humanities into the practice of medicine.

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[11] Macnaughton, "Medical humanities' challenge to medicine."
[12] Duffy, "The Flexner Report – 100 Years Later."

In 2001, the emergence of narrative medicine as a field officially brought narratives back into the clinical encounter—something that was rarely used for multiple decades after the implementation of the Flexner Report. The field of narrative medicine recognizes the significance of the humanities in shaping patient experiences through the lack of use seen throughout the recent history of medical education and practice. With the current medical system still having the foundation proposed by Flexner's Report, it is important to implement narrative medicine as a means to provide a way to practice medicine that incorporates the humanities while still abiding by the heavily systemized and strong scientific grounds that still characterize the medical field today.

CHAPTER II: NARRATIVE MEDICINE & MEDICAL SYSTEM

Introduction

> Medical errors cause more than 250,000 deaths, or 9.5% of all deaths per year, making medical errors the third leading cause of death in the US behind heart disease and cancer.[13]

> 67% of adults are dissatisfied with the quality of medical care in the nation.[14]

Behind every healthcare-related statistic is an individual—a parent, child, loved-one—whose health is affected by the medical system. From heartbreaking stories of treatment being put on hold due to missed diagnosis, miscommunication, medical errors, and much more, it is evident that the US healthcare system needs drastic change.

In this section I will begin by considering frustrations help by both patients and clinicians regarding the US healthcare system. I will then layout characteristics a more ideal system would have. Then, considering these shortcomings and characteristics of the

[13] Johns Hopkins Medicine, "Medical errors third leading cause of death."
[14] The Gallup Organization, "The Gallup Poll Briefing."

more ideal healthcare system, I will then argue that incorporating medical humanities into the clinical encounter can help bridge the gap between our current broken system and a more ideal one. Finally, I will suggest that narrative medicine is an ideal and effective way in which clinicians can incorporate medical humanities to everyday medical practice. Through the clinician's use of narrative medicine, the US healthcare system can progressively transition towards a more ideal system—improving patient satisfaction, decreasing medical errors, and heightening physician job satisfaction from one clinical encounter at a time.

Issues with the Current Healthcare System

The current US healthcare model is one that infuriates patients and burns out doctors. Fragmentation of care, lack of trust, poor communication, and pervasive overuse and misuse of services are a few of the many faults of the medical system. These faults significantly reduce the quality of care patients receive and inhibit a clinician's ability to serve the communities they initially set out to serve. While there are many different opinions on the extent of change and the way that change should occur within this system, the vast majority of people can agree that the current system is severely flawed and needs change in some form or another.

The fundamental objective of healthcare is to improve quality of life by promoting health.[15] However, due to the design of the healthcare system, providing care that enhances a patient's quality of life is more of a theoretical understanding rather than something that is systematically implemented. The current US healthcare system is designed to create

[15] Berry, "Reclaiming Health Care's Fundamental Purpose."

revenue for insurance companies, hospitals, and pharmaceutical companies.[16] Although finances are an essential component in a clinician's ability to provide care, the healthcare system's design places an exponentially larger emphasis on financial aspects of medicine than on delivering quality, patient-centered care. Many patient experiences provide examples that speak to the healthcare system's failure of accomplishing its fundamental purpose. When the design of the healthcare system in the US does not match or even compliment healthcare's fundamental purpose, problems begin to emerge.

Shortcomings from the Patient's Perspective

Medical advancements have increased life expectancy, allowing the general population to live longer. Around half of all adults in the United States have a chronic medical condition and around twenty-five percent have multiple chronic illnesses.[17] With individuals living into older age, there is a growing space to develop chronic conditions. The healthcare system has not shifted quick enough to keep up with the growing needs of the general population – it has not fully shifted to adequately provide long term care for the individual that suffers with these chronic conditions. While acute medical interventions are necessary, it is imperative that the medical model begins to adopt a more long-term model that encompasses multiple facets of life to accommodate the growing needs of the population. Shifting the system brings the fundamental role of the medical system—to enhance quality of life by enhancing health – back into the forefront of clinical practice.

While exceptional delivery of care should be the experience most patients have, this is not the case. A study out of the University of Georgia considered the struggles and

[16] Gross, "How U.S. Health Care Became Big Business."
[17] Gazmararian, "Health literacy and knowledge of chronic disease."

needs of people living with chronic conditions and how these not needs being met are symptoms of the larger problem that is the entire health care system. Around seventy percent of patients with chronic conditions in this study had at least two of the following frustrations with their care: being frustrated repeating the same condition over and over, wishing the doctor spent more time with them, leaving the clinical encounter feeling confused, feeling alone when it comes to managing their health, feeling their doctor doesn't fully understand what they are going through and how they manage their condition at home, and wishing they had someone who could go to the doctor with them.[18] These prevalent and valid concerns seriously inhibit the care the patient receives and negatively impacts their life outside of the clinical encounter.

Shortcomings from the Clinician's Perspective

Many clinicians bring forth their concerns about increasing loss of autonomy and respect, finding themselves demonstrating qualities that do not embody the type of clinician they had once hoped to become. Sandeep Jauhar, M.D., explains this, saying, "… I realize that in many ways I have become the kind of doctor I never thought I'd be –impatient, occasionally indifferent, at times dismissive or paternalistic."[19] He further explains that it is very common among his colleagues to feel as if they are losing or have already lost their professional identities and that they are "a pawn in a moneymaking game for hospital administrators."[20] In working for a system that generally fails the individuals it sets out to serve, clinicians begin to lose meaning in their work, realizing that they are limited in their

[18] Smith, et al., "Factors associated with healthcare-related frustrations."
[19] Jauhar, "Is Physician Autonomy Dead?"
[20] Ibid.

ability to change lives the way they hoped. Medical students are attuned to these feelings and frustrations clinicians have—taking note of the narratives their mentors discuss the ways in which their hands were tied in a clinical situation, deterring them from applying to certain specialties.

These concerns are reflected in the trends in residency applications over the past three years, with Emergency Medicine having 14 unfilled positions in 2021, 219 unfilled positions in 2022, and over 550 unfilled positions in 2023.[21] The US is expected to face a shortage of primary care physicians from 21,000 to 55,000 in the next 10 years, with "lower salaries, higher ratings of burnout, and a growing feeling that their job is generally impossible and thankless on all fronts.[22]" This is an issue in that 98.8 million people in the US are already living in a primary-care health professional shortage area,[23] ultimately placing further straining emergency departments due to this becoming the only option for some individuals to receive care.

A More Ideal System

Creating systemic change on the level of a national healthcare system is no small feat. The incredibly difficult challenge of making any type of change on that large of a scale is nearly impossible especially when the individuals pushing for that change are already burdened by the system and its demands. But incorporating the humanities into the clinical encounter can change healthcare one clinical encounter at a time, resulting in

[21] Fiore, "Over 550 EM Positions Unfilled in This Year's Match."
[22] Grinspoon, "Why is it so challenging to find a primary care physician?"
[23] US Department of Health and Human Services, "Second Quarter of Fiscal Year 2023."

drastic changes of a physician's experience of and attitude towards practicing medicine and can have positive life-altering effects for their patients.

During the Committee of Health Professions Education Summit whose committee consists of medical program directors, researchers, deans of medical schools, clinicians, and many others believe the ideal medical system is one whose structure promotes continuous healing relationships where physicians are able to communicate effectively and accommodate patient preferences while administering care in an individualized manner.[24] Physicians in this ideal system should be able to encourage shared decision making through communicating effectively with patients and their families—both of which can be accomplished through incorporating narrative medicine into clinical practice. While these changes can be made by physicians on an individual bases, they oftentimes find themselves falling subject to the fast pace of the medical system and its demands, placing these ideal ways of administering care on the back burner while administrative duties are forced to the center of their practice.

A more ideal medical system is one that combats fragmented care and focuses on disease prevention, promoting clinicians to place the health of the patient at the center of their practice. It is one that considers dimensions of health outside of the clinical encounter and allows clinicians to use services in an appropriate manner. It is a system that fully encompasses the different knowledge each member of the healthcare team has to offer, considering all options for treatment and targeting underlying issues rather than treating symptoms. It provides access to affordable quality care despite location and socio-economic status, ultimately changing the structure of the system from one that sets out to

[24] Greiner and Knebel, "Health Professions Education: A Bridge to Quality."

make money for large corporations and industries to one that aligns better with the fundamental goal of healthcare.

This ideal medical system cannot be reached any time soon. There are restrictions in place that clinicians must abide by and hoops that patients must jump through. To combat this system that impersonalizes healthcare, a clinician may take different approaches to their individual practice that creates movement towards this aforementioned ideal system from the clinician's perspective and the patient's perspective.

Bridging the Gap Between the Current Broken System and a More Ideal One

For healing to take place, the personal aspects of a patient's illness and the clinician's scientific knowledge must come together. Knowledge acquired through schooling and scientific literature equips clinicians with the tools to diagnose and suggest impactful interventions. This knowledge in conjunction with the patient's personal experiences allows for a productive and effective clinical encounter. Combining these two perspectives in the clinical encounter creates a space to combat both patients' and clinicians' frustrations with the greater medical system. This merging of the objective aspects of medicine and the subjective feelings and symptoms patients hold is the responsibility of the clinician. This requires the clinician to consider ways in which they can obtain this information from the patient and productively use it to treat the patient in a way that best adheres to the patient's needs and the clinician's concerns and values.

Practicing medicine in a way that intentionally brings forth the humanness of illness and incorporates non-medical factors into care is an art. It is an art that requires intention, mindfulness, reflection, open-mindedness, and much more. Considering the clinical

encounter as an extension of life—something that is multifaceted and complex—rather than a two-dimensional person in a room at a specific moment in time is imperative in the art of treating patients. Incorporating medical humanities into the clinical encounter allows the clinician to get a glimpse into the larger context of the patient, helps them understand the patient's values, and integrates both of these into their medical interventions for the patient.

Medical humanities consists of humanities, social sciences, and arts. Each of these three categories houses fields of study such as philosophy, ethics, history, sociology, psychology, literature, and more. Bringing a multidisciplinary approach to the clinical encounter also creates a space of intimacy to build the foundation of trust that is needed to promote a continuous healing relationship between clinician and patient. Medical humanities implemented in practice through the use of narrative medicine has the power to promote the healing of the patient and restore meaning in work for the physician through their continual healing relationship. It has the power to make meaningful differences in patient lives and combat physician burnout. Narrative medicine possesses the potential to truly revolutionize the medical system from the group up. It goes beyond mere theoretical concepts, providing a practical framework to cultivate and integrate the skills needed to reach that ideal system, ultimately changing the experiences the patient and clinician have of their healthcare system.

Importance

Incorporating narrative medicine into the clinical encounter allows the clinician and patient to experience the current broken healthcare system in a way that feels more similar

to the ideal medical system. In practicing narrative medicine, a continuous healing relationship between patient and physician is observed. Through the practice of narrative medicine, clinicians are urged to intentionally move through the clinical encounter, to be present, and to use reflective practices that promote meaning in work. Narrative medicine creates a clinical encounter where the patient feels they are heard, understands treatment plans, and feels less alone in their illness. In addition to these benefits of integrating narrative medicine into clinical practice, there are other positive outcomes that result from adopting these approaches.

When assuming their respective roles, the clinician and patient generally have contrasting understandings and experiences of the patient's human body and its functions or lack thereof. The patient's comprehension of their ailment is often subjective and tied to their emotions. The patient's experience can have a significant impact on many aspects of their day-to-day existence—ultimately leading to the possibility of emotional distress and disengagement from activities that once held personal value and significance. The physician's understanding of the patient's ailment is one that lacks these personal components but considers the science behind the human body and possible medical interventions. These different understandings can lead to confusing and unsatisfactory clinical encounters, but this does not necessarily have to be the case.

The current US medical system fails many of the people it sets out to serve and promotes practices that contribute to physician burnout. Many of the suggested ways to improve the healthcare system call for the human aspect of care to be placed more centrally in the clinical encounter. Emphasizing the humanness of illness and care means using medical humanities to form a fuller picture of the patient. Bridging the gap between the

current medical system and a more ideal one is possible by incorporating medical humanities into the clinical encounter. In doing this, the healthcare system has the ability to improve drastically one clinical encounter at a time.

CHAPTER III: NARRATIVE MEDICINE AND MEANING IN WORK FOR CLINICIAN

Introduction

> Man's main concern is not to gain pleasure or to avoid pain but rather to see a meaning in his life. That is why man is even ready to suffer, on the condition, to be sure, that his suffering has meaning.[25]

> Meaningfulness is derived from feeling personally immersed and alive in the experience of working.[26]

In this section, I will discuss the capacity narrative medicine has to change clinicians' practice and combat burnout. I will first explain the importance of finding meaning in work and the ways in which narrative medicine can sustain and promote this meaning throughout one's education and career. I will walk through a few of the most common reasons why individuals pursue careers in medicine and will explain the importance of medical students creating and constantly developing a professional identity

[25] Frankl, *Man's Search for Meaning,* 106.
[26] Rosso et. al, "On the meaning of work", 109.

throughout their career. I will then consider different explanations for some of the reasons behind medical students once having above-average profiles in terms of mental health and resiliency scores and what might lead them to eventually develop significantly below-average ratings and experience increased levels of burnout during the course of their medical education.[27] I will propose that the use of narrative medicine as a resource to build a professional identity and promote resiliency in both medical students and medical professionals is valuable and attainable through bringing back into view the initial reason one pursues a career in medicine. I will finish this section by explaining why clinician resiliency is necessary both in personal and professional aspects.

Personal Narratives, Meaning in Work, & Pursuing Medical Careers

Time spent working constitutes a large portion of an individual's life. While it is necessary to avoid placing one's entire identity in the work they do, it is just as important to find work that is meaningful and fulfilling—especially because it is the way the majority of an individual's life is spent on a day-to-day basis.

Meaning in work is constructed through an explicit awareness of one's own values, motivations, and beliefs about themselves, the world around them, and how they see themselves fitting into that world. Deep introspection is central in finding work that allows these values to be carried out. To find work that aligns with what is important and valuable to the individual, the individual must be able to articulate what is important and valuable to them. While this seems fairly straightforward, it is oftentimes missed. Deep and necessary introspection cannot take place unintentionally.

[27] Hill et al., "In their own words: stressors facing medical students in the millennial generation."

Critically reflecting on one's values promotes the conjunction between the inner voice that pushes towards a certain way of being in the world and the outer call that is pulling in a direction where they may be needed.[28] Placing a vocational decision in the hands of an external source is a certain way for meaning to disappear (or never appear) in the workplace, causing burnout to ensue. This is shown through the following possibility that, "Some students drawn to medicine are avid fans of televised medical dramas and are nonplussed—some of them even bitter – when they find that most of medicine's actual patients have chronic problems, as well as tangles of physical and social afflictions, that cannot be resolved in an episode or a season (if ever)."[29] If an individual (like the one in this example) fails to delve into their own personal motivations and truly understand what a medical profession entails, and how these factors intersect, it can result in a mismatch between their expectations and reality. This can ultimately lead to an unsatisfying career, with patients suffering as a consequence.

Becoming a clinician is a challenging process that demands significant investment of time, resources, and energy. This dedication is exemplified through the expectation of resident physicians to spend "up to 80 hours a week in the hospital and endure single shifts that routinely last up to 28 hours—with such workdays required about four times a month, on average."[30] Because of this, it is important when considering a career in medicine to have a clear understanding of one's desires and how a medical career can align with an individual's values. When clinicians reflect on their personal narratives, they can explore their limits and understand themselves better, leading to a positive self-

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[28] Hill et al., "In their own words: stressors facing medical students in the millennial generation."
[29] Mohrmann, "Vocation is Responsibility", 35.
[30] Park, "Why So Many Young Doctors Work Such Awful Hours."

concept and improved patient care. The way clinicians view themselves impacts their practice and patient outcomes, as the narratives they tell themselves shape their thoughts, emotions, and behaviors.

Resentment of one's profession ensues when an exorbitant amount of time and energy is given to a job that ends up being a completely different profession than what was initially expected. This buildup of resentment overflows into and negatively impacts the patient care practiced in the clinical encounter, creating an unfulfilling career. Using self-reflection as a means to continually establish a narrative that promotes the growth and development of a strong personal narrative directly influences one's positive self-concept. Being a clinician means that patients are coming to you in a vulnerable state, asking for help in the upkeep or restoration of their health. When a clinician uses personal narratives to explore their limits and their understanding of self, they are more confident in providing care because they are aware of which areas they excel in and which areas they might need outside assistance. Thoroughly investigating an individual's reasoning behind certain actions will help them understand their goals and who they currently are in relation to who they want to become.

Personal narratives and critical reflection ultimately provide a safe space for an individual to determine if and why this career path is what they want. Being able to explicitly lay out the reasons for going into a career in medicine allow the student to align their career goals with their personal values. When these align, career goals and personal values are able to influence and further develop one another.[31] As seen in the following

[31] Wear and Zarconi, "Meaning in work."

section, the ability for an individual to critically reflect and continually create their personal narrative is an essential component in the making of a competent and caring clinician.

The Type of Students Medical Schools are Looking for and What This Insinuates

According to the American Association of Medical Colleges (AAMC), there are fifteen core competencies for entering medical students that are placed in four different categories. These categories are listed as interpersonal competencies, intrapersonal competencies, thinking and reasoning competencies, and science competencies. With interpersonal competencies housing the most qualities, AAMC recognizes and emphasizes the importance of these personal attributes in promoting a humanistic approach to healing rather than strictly a biomedical treatment of disease.

Interpersonal competencies include *service orientation*, writing that applicants should have "a desire to help others and sensitivity to others' needs and feelings," *social skills*, with the applicant demonstrating "an awareness of others' needs, goals, feelings, and the ways that social and behavioral cues affect peoples' interactions," *cultural competence* through showing "appreciation and respect for multiple dimensions of diversity," *teamwork* by sharing information and knowledge with others," and *oral communication* through "listening effectively and adjusts approach or clarifies information as needed."

Considering the drastic change from the 1910 Flexner Report to today's holistic consideration of an applicant, it can be inferred that a physician's role is one that requires an individual to have the capacity to care for an entire person, bringing together public health and medicine as one entity rather than two separate fields. The AAMC considers

these humanistic qualities as integral to the identity of an applicant that has the ability to practice culturally and socially competent medicine in a way that meets the set standard.[32]

Incorporating the Humanities Through Practicing Narrative Medicine Combats Clinician Burnout and Restores Meaning in Work

> In 2021, 62.8% of US clinicians experienced at least one symptom of depression compared to 38.2% in 2020.[33]

> One in five physicians intends to leave their current practice within two years.[34]

Burnout in the workplace is a specific type of stress that is characterized by exhaustion, increased mental distance from one's job, and/or feelings of cynicism related to the workplace.[35] While the term burnout has been thrown around in casual conversation about areas of life outside of one's job, it is a serious condition that deeply affects an individual and their ability to perform well and find meaning in work. Burnout is prominently seen in the clinical space due to the nature of the work and the demands of the broken system. Burnout negatively impacts the patient-clinician relationship, the quality of care the clinician is able to provide and increases the likelihood of the clinician making medical errors.

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[32] AAMC, "Core Competencies for Entering Medical Students."
[33] Shanafelt et al., "Changes in Burnout During the First 2 Years of the COVID-19 Pandemic."
[34] Henry, "Medicine's great resignation? 1 in 5 doctors plan to exit in 2 years."
[35] WHO, "Burnout an 'occupational phenomenon.'"

Due to the predisposition a clinician has towards developing burnout at some point during their medical career, taking preventative measures to combat the onset of burnout is of the utmost importance. Dr. Tait Shanafelt states that there is a growing body of research showing the effects that cultivating meaning in work have on physician satisfaction and burnout reduction, suggesting that "…enhancing physicians' attention to their own experience not only increases their orientation toward patients but also reduces physician distress"[36] Enhancing meaning in work and promoting reflection that brings attention to their experiences combats burnout.

Employing the use of humanities through narrative medicine in the clinical encounter creates a space where meaning in the workplace can be found. Narrative medicine is filled with practices that equip clinicians with tools to better provide for their patients through understanding their patients better. These practices serve as a means for the clinician to deepen self-awareness, promote reflective writing, and provide care that attends to the entirety of the patient. The act of being intentional and present allows clinicians to reconnect with their reasons for going into medicine.

The demands of the medical system and the difficult road one must take to become a clinician calls for students, residents, and clinicians to intentionally take measures to ensure that meaning in work is not lost. Consider the experience of a medical student's initial experience in a clinical setting:

> An assembly line mentality trumps just about everything in clinical settings, prompting a focus on patients' disease, not patients themselves: 'It is easier to shut off your emotions and get through the work as efficiently as you

[36] Shanafelt, "Enhancing Meaning in Work.", 1339

> can… As a result, I started falling into a trap. That is, quick, superficial greetings to the patient.[37]

This natural shift towards dehumanization in the clinical encounter furthers the point of the importance for medical students and clinicians to partake in reflective practices. These practices deepen self-awareness in order to refrain from falling into the 'assembly line mentality', promote meaning in work, and prevent burnout of the clinician.

Forming a Professional Identity with the Help of Narrative Medicine

> Lessons are often learned and perhaps best learned from frequent and systematic processing of one's feelings, particularly regarding conflicting messages. One student wrote, 'The busier we become and the more important we view ourselves, the less time we have for introspection and reflection.'[38]

Forming and continually developing a professional identity is a critical step in becoming an effective and fulfilled healthcare professional. One's professional identity helps them confidently navigate the complexities and challenges of the healthcare system and do this in accordance with their values. A strong professional identity not only improves patient outcomes through promoting a vital sense of self-awareness, but also allows a clinician to actively seek out instances in which personal meaning will be found. Consider the following revelation determining what is of value to them about their job as a clinician:

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[37] Wear and Zarconi, "Can Compassion Be Taught?", 951.
[38]Wear and Zarconi, "Can Compassion Be Taught?" 951.

> What's most important to me as a doctor, I've learned, are the human moments. Medicine is about taking care of people in their most vulnerable states and making yourself somewhat vulnerable in the process. Those human moments are what others – the lawyers, the bankers—envy about our profession, and no company, no agency, no entity can take those away. Ultimately, this is the best hope for our professional salvation.[39]

Through this clinician's reflective self-awareness, they are able to discover what exactly gives their job meaning. In doing this, a stronger professional identity is formed, allowing this clinician to seek out and promote instances in which they are able to find meaning and reaffirm their professional identity.

A strong professional identity allows clinicians to establish and be aware of their perceived purpose in the work they are doing. A well-defined professional identity enables clinicians to articulate their values, goals, and expertise to their patients, colleagues, and the broader healthcare community they are a part of. It allows them to feel comfortable offering their perspective to the care team and to lean on them for support. It provides a means of better understanding their boundaries in practicing medicine, leading to an assurance that their institution's rules and procedures are followed intently and that they are taking part in the ethical practice of medicine. For a clinician to understand their role in the broader healthcare team and their limits in practicing medicine, they are more readily eager to ask for help, opening the door for collaboration with other professionals that ultimately benefits the patient. A strong professional identity and taking part in constantly

[39] Jauhar, "Is Physician Autonomy Dead?"

developing this identity allows clinicians to build confidence not only in who they are individually, but who they are as providers and the ways in which they practice medicine.

Narrative medicine provides the space for clinicians to continually develop their professional identity throughout every clinical encounter and outside of the clinical encounter. Through seeking out stories of patients with different backgrounds and being able to broaden one's understanding of social and emotional factors that influence health and illness, clinicians are able to critically evaluate their implicit biases and assumptions. A clinician's practice of narrative medicine is one that holds an openness to different ways of experiencing illness and health, broadening their understanding of the social and emotional factors that affect the patient. This deepens their understanding of healthcare as a field, developing their perceived roles in the clinical encounter.

Ultimately, narrative medicine aids in the development of a strong professional identity, and having a strong professional identity allows narrative medicine to be practiced in a more encompassing manner. These both influence each other, promoting continual lifelong learning about oneself and the practice of medicine. This results in a fulfilling practice of medicine and better patient outcomes. Taking time to critically reflect on patient stories that stretch the definitions that were once held rigid expands a clinician's ability to practice individualized care.

Literature as a means of Nurturing a Resilient and Empathetic Clinician

> Writing, especially good writing, is one of the oldest methods we have of expressing our humanity in all its glory and all its struggles. Reading allows us to engage with another's message and give thought to the story placed in

> front of us. This is not all that different from what we do every day as doctors. We aren't always good at this, but like all skills, we can improve if we practice deliberately. I propose reading as one way for doctors to practice and develop this skill.[40]

> We read to know that we are not alone.[41]

Literature is a powerful tool in the development of the individual and of a resilient and empathetic clinician. Different forms of literature provide different ways in which a clinician can learn more about themselves, their desires, and more while also providing a glimpse into other perspectives, promoting an open-mindedness that is required to practice narrative medicine. John Harper writes, “Reading makes us better people, and better people are better doctors.”[42]

Using reading and writing as a means of self-exploration and horizon-broadening nurtures and promotes a resilient and empathetic clinician. Literature and reflective practices provide insight into the human experience, providing different perspectives that aid in promoting oneself as a caring provider. Literature gives clinicians a space to explore stories, allowing them to practice the fundamentals of narrative medicine in a safe space without the consequences of a wrongfully understanding a patient’s narrative negatively impacting their outcome. Literature allows the clinician to be aware that it is not the job of the clinician to make meaning out of someone else’s experiences but promotes the

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[40] Schnipke, “Reading Can Make You a Better Physician.”
[41] William Nicholson, *Shadowlands*.
[42] Schnipke, “Reading Can Make You a Better Physician.”

openness of how a patient's experiences might move the clinician's understanding of their patients.

Theory of Mind is an essential component of narrative medicine that refers to our capacity to understand and ability to relay other people's underlying intentions and beliefs about themselves, their situation, and their actions. Literature improves Theory of Mind through revealing third person omniscient information along with one's actions to provide an understanding into a particular individual's understanding of themselves and their situation. In reading fiction, one is prompted to make meaning of the characters, trying to figure out who they are and what their motivations may be. Determining what one's immediate thoughts go towards allows them to reflect on why this might be the case and find ways to be aware of how they may be doing this in clinical practice.

Reading of patient experiences in literary form allows clinicians to identify ways they could better communicate with their patients. Reading perspectives of patients that are struggling with their health and understanding their disease or condition provides the clinician with a means to understand the large gap of knowledge of scientific information that is found between the patient and clinician. Being able to explore what a patient feels, gets frustrated with, and doesn't understand can revolutionize the way that a clinician provides care. This is exemplified through Margaret McCartney MD's work, with her explaining that "reading tells us about other lives that we didn't even know to consider. Books can explain humanness to us, better and differently. This helps, I think, when we're at work, under pressure, and without a clear solution to problems, which is often."[43]

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[43] McCartney, "Reading Makes us Better Doctors."

Literature also has the power to provide inspiration in many different ways. A story that reaffirms one's experiences provides a development in their understanding of themselves and of the human experience. Literature often explores universal themes that allow readers to immerse into characters' understandings and experiences that are similar and different from the readers.

Literature oftentimes provides readers with the bigger context to which one's story belongs while allowing the reader to also experience the smaller mundane aspects of the story as well. This promotes the awareness that the mundane aspects of the reader's life belong to a bigger picture. Small things oftentimes feel large and can be crippling at times and large things can oftentimes be pushed to the side and seen as small but reading and understanding that there is a purpose in both the small and large aspects of life can help an individual appropriately address them and grow from them. Daniel Marchalik explains how easy it is to get acclimated to the incredibly devastating sights and experiences that fill the hospital in the name of efficiently working. This detachment that once felt necessary coupled with little to no time to slow down quickly resulted in the formation of routinely disregarding one's own thoughts and feelings.[44] Through Georgetown University's medicine and literature track and the assigned books that "on the surface have nothing to do with medicine", this routine disregard of one's thoughts and feelings is combatted through the use of literature—with Marchalik explaining how Kazuo Ishiguro's *Never Let Me Go* surfaced a student's need to emotionally process donating an organ to a man he barely knew, how Haruki Murakami's *Colorless Tsukuru Tazaki and His Years of Pilgrimage* made a student address their concerns of becoming a Psychiatrist due to their

[44] Marchalik, "Reading Novels at Medical School."

perceived fault in misjudging a mentor's state of mind after having recently gotten the news that they had committed suicide, and how Jay Fowler's *We are All Completely Beside Ourselves* led him to become a vegetarian.[45] Although these aforementioned examples are not exhaustive, they demonstrate the significant role literature plays in fostering introspection, personal growth, and resilience in medical students and clinicians.

[45] Marchalik, "Reading Novels at Medical School."

CHAPTER IV: NARRATIVE MEDICINE & PATIENT

Introduction

> It is not possible to treat sickness as something that happens solely to the body without thereby risking damage to the person. An anachronistic division of the human condition into what is medical (having to do with the body) and what is nonmedical (the remainder) has given medicine too narrow a notion of its calling. Because of this division, physicians may, in concentrating on the cure of bodily disease, do things that cause the patient as a person to suffer.[46]

> Death, powerlessness, helplessness, isolation… Each is both universal and individual. Each touches features common to all of us, yet each contains features that must be defined in terms of a specific person at a specific time.[47]

[46] Cassel, "Nature of Suffering and Goals of Medicine", 132.
[47] Ibid, 139.

> Persons cannot be reduced to their parts in order to be better understood. Reductionists scientific methods, so successful in human biology, do not help us to comprehend whole persons.[48]

In this section I will consider the clinical contributions narrative medicine has and the ways in which these contributions promote the healing of patients. I will first explain the issues of taking a reductionist perspective during the clinical encounter and explain through examples of different patient scenarios that there is not just one single correct way to medically intervene. Then, I will bring forth the importance of treating the whole person and the difference between healing and curing. From there, I will explain the arts and humanities that are central to the clinical encounter through discussing a brief overview of the history of medical education and practice. Finally, I will elaborate on current medical practice and how treating all aspects of the person (mind and body) equates to healing and is emphasized through the use of narrative medicine.

Incorporating Humanities into the Clinical Encounter and Patient Healing

Individuals in every context are whole people that see the world through the culmination of their experiences and their beliefs. The humanities promote an understanding of the patient as a person and allow the patient and provider to form a relationship built on trust. A common understanding of the goals of the patient, and the provider results in better patient adherence to the devised care plan. Understanding patient healing on an individual level is difficult as it varies across patients and across diseases.

[48] Ibid, 138.

This fact alone emphasizes the importance of dropping all preconceived notions about the patient and their situation, allowing the patient to give information that is needed to provide quality care.

Importance of Incorporating Narrative Medicine in the Clinical Encounter to Combat a Reductionist Perspective

To show the importance of incorporating the humanities into the clinical encounter in the healing of the patient, I will use different theoretical patient situations and different barriers to care that play a large role in a patient's ability to manage their diabetes. While diabetes is just one example of a disease with many plans for care possible, this application can be implemented on a wider basis. There is not a single correct way to treat a patient in any case. Not considering the patient as a full person with many different stressors outside of the clinical encounter is doing the patient a disservice and could leave the patient in a worsened state than when they came in. For healing to occur in the clinical encounter, a patient must be understood, and their stressors and worries must be made known to the clinician. In providing care, the clinician is making a promise to provide the best care they possibly can. Doing this requires the job of the physician to incorporate questions about the patient to determine the best course of action based on the individual person's goals and stressors.

Looking at diabetes from a purely scientific standpoint, this disease results in blood glucose levels that are above average. This can lead to many severe complications like losing a limb, blindness, kidney failure, and more. So, keeping blood glucose levels at an average level is of the utmost importance for someone with diabetes. The purely scientific

form of treatment for diabetes is to lower blood sugar while making sure that it stays in a safe range and doesn't dip too low. This is done by regularly checking blood glucose levels many times throughout the day and then determining the amount of insulin that is needed to keep the blood glucose levels within a normal range. While this is the general mechanistic way of treating diabetes, there are different interventions to do so. This is where incorporating the humanities to better understand the patient and their situation comes in.

While it might seem straightforward to check glucose levels then administer insulin to combat the expected rise of blood glucose, there are many more factors that contribute to a person's ability to do so. The clinical encounter is only able to account for a small portion of a diabetic patient's symptom management, so it is imperative that the clinician knows about the patient's situation, caters the treatment to their situation, and adequately educates the patient on how best to treat this disease keeping in mind the limitations imposed by their situation.

For simplicity, I will make a fairly straightforward and significantly generalized statement to serve as an example of the financial burdens associated with some forms of care. The cost of insulin is outrageously high in the United States with the average person spending almost $17,000 a year on their treatment. A single person with no dependents making $55,640 a year (United States average salary[49]) approximately takes home $42,000 after taxes.[50] This means that insulin therapy alone would account for forty percent of their income. A clinician must understand how much of a financial burden this would be to the patient and propose other effective and more affordable ways to manage their blood

[49] Indeed, "Average Salary in the US."
[50] Pacific Service Credit Union, "Simple tax calculator."

glucose levels. It is imperative to intentionally manage diabetes but doing this in a way that threatens a patient's financial security is imposing new stressors into one's life that deter them from adhering to treatment.

An elderly woman that lives alone has Parkinson's and diabetes. Although her Parkinson's is not very advanced, she sometimes experiences small tremors. Her primary care provider is aware that she has Parkinson's but has not seen her tremor. Only through asking is the clinician then able to understand that she has anxiety around the possibility that she may have a flare-up at a point in time when she would need to administer insulin. Insulin therapy would not be the best form of treatment due to her inability to confidently use needles when needed. Managing diabetes in a way that threatens the patient's security and comfort imposes new stressors that could result in higher levels of anxiety and non-adherence to the treatment of diabetes.

Healing vs Curing & Narrative Medicine

While healing and curing are oftentimes used interchangeably, these have two different and distinct meanings in relation to the clinical encounter. Healing takes into consideration not only the patient's illness and their physical symptoms, but also their emotional, social, and spiritual needs associated with their illness. Healing promotes the use of holistic care to address all of the needs associated with illness to understand ways to help the patient through each of these factors. Curing relates to medical interventions in treatment of diseases and/or illnesses with the goal of eliminating all physical components of disease/illness. Curing is limited to the physical symptoms of the body with medical

interventions such as medications, procedures, and surgeries target getting rid of the biological markers of their condition.

While one of the goals of medicine is to cure the patient, it is also the responsibility of the clinician to promote healing over curing. When a patient experiences a traumatic event where their health is immediately at stake and their lives are called into question, the way the patient sees themselves, the world around them, and the ways they attach meaning to their experiences changes drastically. It is important to address and guide the patient towards merging their previous life (where they fully functioned in a healthy way) and the diseased one. Healing looks at factors outside of the physical realm that intervene with one’s everyday life. Understanding and working with the patient to develop a treatment plan tailored to individual experiences promotes healing.

The practice of narrative medicine promotes healing over curing, with narrative medicine considering ways in which to enhance the quality of life their patients have.

CHAPTER V: IMPLEMENTATIONS OF AND ARGUMENTS AGAINST NARRATIVE MEDICNE

Introduction

It is evident that narrative medicine has many benefits that include bridging the gap between the current broken medical system and a more ideal system, improving patient outcomes, combatting burnout through reintroducing meaning in work, promoting resiliency, playing an integral role in the healing of patients, and more. The question then becomes at what point in medical education and training would it be most beneficial to introduce narrative competencies and the field of narrative medicine. In this section I will explore the efficacy of narrative medicine in medical specialties where patient interactions are at a minimum, determining what, if any effect is present considering both patient and clinician perspectives. I will then present perceived barriers to practicing narrative medicine and arguments against the efficacy of narrative medicine, using these arguments to further elaborate on previously mentioned points.

Implementation of Narrative Medicine Throughout Medical School and Training

Undergraduate Education

In one's undergraduate university experience, it is important to begin exploring the role that humanities plays in the medical sphere. The value of gaining a basic understanding of biomedical ethics and medical humanities through studying the social sciences in one's undergraduate education cannot be overstated. Doing this provides a foundation upon which a student understands the importance of seeking out mentors and colleagues that promote the intentional placement of the patient as a person in the center of their practice.

Undergraduates oftentimes feel pressure to study only the sciences rather than a field they might find interesting. Taking extra sciences in undergraduate education might give a fuller knowledge of science in one's undergraduate experience, but at the end of medical school, every will come out with the generally the same level knowledge. Studying the social science fields allows the undergraduate student to supplement their science education with a knowledge base that goes beyond the scientific information and takes into consideration psychological factors that provide a broader look into the human condition.

Medical Education

> We believe that medical students *do* arrive at our doors as thoughtful, compassionate people – with a 'pilot light' burning strongly. It is our [educators] responsibility to nurture this compassion, remaining mindful of students' lived experiences and striving to understand *their* particular narratives and the complex, conflicting messages they receive every day in an environment we create and sustain.[51]

[51] Wear and Zarconi, "Can Compassion Be Taught?", 953.

While the implementation of the components of narrative medicine differ from one school to the next, medical schools have begun to find ways to incorporate patient stories into education. While some schools completing this through creating entire departments dedicated to promoting the use of humanities to medical students,[52] other schools have incorporated the use of patient narratives directly into the didactic portion of medical education. Many schools have individual faculty or students that come together to create a book club that promotes reflection, small group communication, patient empathy, and the practice of using narrative foundations to connect with colleagues. Consider the following response to the implementation of narrative interventions outside of the didactic portion of education:

> At the meetings each student would tell the story of something that happened to him/her in either a clinical or educational context which either enhanced or changed their sense of what is meaningful about the practice of medicine… The range, depth, and intensity of the stories were truly amazing. The experience was evaluated very positively by the students.[53]

The aforementioned indicates the positive experience that processing and discussing stories can promote one's understanding of their education as a means of developing knowledge that can be applied to their future practice. Outside of narrative practice, a medical student being continuously educated on the limits of medicine and the unknowns that accompany the practice of medicine can allow students to consider the benefits that accompany the practice of narrative medicine.

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[52] Case Western Reserve University School of Medicine.
[53] Branch et al., "A Good Clinician and Caring Person", 121.

Duke Medical School

Duke University School of Medicine's incorporation of the humanities into medical their curriculum shows one of the many ways this implementation of the humanities is seen. Their new curriculum serves to educate students on the ways their practice of medicine can be shifted through placing, "the patient at the center of their learning beginning Day 1 of medical school."[54] When students are continually taught to prioritize the patient's needs, they are able to see the practice of medicine as more than just a set of technical skills to be mastered. Duke University School of Medicine created different interventions in each year of medical school that intentionally promote learning the practice of medicine as a multi-faceted entity that must place the patient central to the clinical encounter—creating a positive and continual influence in the development of the student's professional identity.

Duke's first-year medical students begin their medical education with a two-week clinical skills training immersion course to introduce basics that provide a foundation upon which future educational interventions over the next four years will build. It introduces foundations of patient care, the study of cultural determinants of health and health disparities, leadership, education, development, and more. Duke medical students partake in small group sessions with faculty and other students, working towards developing skills that weave clinical skills, cultural determinants of health, and leadership together, helping cultivate their students as competent and caring clinicians.

Duke's medical education curriculum change reflects the larger shift seen throughout medical schools in the US that emphasizes the individualized application of

[54] Duke University School of Medicine, "Curriculum Innovation."

knowledge over the regurgitation of information. This shift is promising—showing the positive change that can take place along with the US medical education evolving to meet the dynamic needs of future patients.

With the fairly recent acknowledgement of the need for the medical profession to incorporate and practice medicine in a way that promotes an understanding of medical humanities, and the even more recent implementation of the humanities into medical education, it is evident that placing medical humanities central to the clinical encounter in practical ways is difficult to accomplish. Studying medical humanities was successful in forming clinicians' understandings of outside influences of illness and health. It gave a broader scope to which clinicians were able to see the practice of medicine through. But introducing medical humanities directly into the clinical encounter was difficult until narrative medicine emerged as a field. Through the use of different practices that promote critical components of narrative medicine, medical students at Duke are able to not only become scientifically competent clinicians, but culturally and socially competent clinicians that are firm in their professional identities.

Internship Year & Residency Training

Students that graduate medical school and go on to complete residencies in areas other than family medicine or internal medicine complete an internship year upon graduating from medical school. The intern year is completed in general medicine before going on to further specialize. Employing narrative medicine in this intern year could promote the use of narrative medicine outside of the primary care specialties. Finding ways to do this is a challenge due to many factors associated with residency that were not issues

in medical school. According to Tiffany Wesley and colleagues, most residency programs do not have the culture to sustain or promote a narrative approach to medicine, the hours the residents work are not constant and oftentimes excruciatingly long and getting acquainted to the complexity of care takes time away from partaking in activities outside of residency.[55] Due to the lack of information found on the applicability of narrative medicine practices in the internship and residency portions of training, they conducted an study that found this information to have overwhelmingly positive results, with interns feeling a significant increase in their mindfulness, wellness, and professionalism.[56]

Implementation of Narrative Medicine Based on Specialty

While narrative medicine is well-respected as a means to provide care, considering the implementation of this practice in specialties that have minimal clinical encounters should be considered. It is generally understood that narrative medicine is an important and necessary tool in primary care, but there are unique beliefs on the drawbacks of narrative medicine depending on specialties.[57]

Narrative medicine has traditionally been associated with primary care specialties like family medicine and internal medicine. While these specialties in the clinical encounter emphasize long-term relationships with the clinician and patient, there are other specialties where long-term patient clinician relationships are placed central to the clinical encounter. Even heavily procedural specialties have clinical encounters that extend for multiple appointments. For example, when a patient goes to see an orthopedic surgeon for a hip

[55] Wesley and Hamer, "Implementing a Narrative medicine Curriculum During the Internship Year."
[56] Ibid.
[57] Fox and Hauser, "Exploring perception and usage of narrative medicine by physician specialty."

replacement, there are initial appointments to discuss if the hip replacement is the best course of action to take. Oftentimes the decision to go through with a hip replacement is based on the severity of hurt the patient feels. While X-rays are taken and quantitative ways of knowing are collected, moving forward with the surgery ultimately depends on the patient's perceived pain and the ways in which their pain interferes with their lives. Follow up appointments are necessary and extend months and even years in after the surgery.

While orthopedic surgeon A might be one of the best out there, a patient can only discern whether the surgery has helped their pain. They are not able to explicitly state the degree to which a surgery was successful or not. This is where narrative medicine has the power to leave a lasting impact on patient experiences. While surgeons oftentimes do the same procedure again and again, this might be one of the first times their patient has ever had any type of procedure done. With surgery being very intimidating from the perspective of someone that does not know much about medicine, it would make sense for surgery to be an anxiety inducing situation. At this point, having a surgeon that has the ability to effectively communicate their expertise, exude confidence and not cockiness, and address all of the worries a patient may have becomes a very large part of the experience of surgery. A patient will remember the way they were treated in the clinical encounter, if they feel like they were properly informed of post-operative care and treatment, and if they felt they were heard by their surgeon.

Implementing narrative medicine in any medical specialty requires the intentional shift in mindset towards one that requires creating and fostering relationships with patients. In nearly every specialty there is room for narrative medicine to be practiced. In every practice of medicine that even partly consists of a clinical encounter, it is important to

provide care that is more personalized, compassionate, and effective, especially when the patient's health/illness is interfering with their everyday lives.

Arguments Against the Efficacy of Narrative Medicine & Perceived Barriers to Practicing Narrative Medicine

> There is a perception, even now, that the idea of the medical humanities is something that appeals only to a fraction of left-wing academics who, in the absence of data or proof, are postulating a change that would take place at the expense of teaching more valuable subject material.[58]

While it was difficult finding recent arguments against the practice of narrative medicine, there were some valuable insights into the limitations of narrative medicine that raise important questions both clinicians and educators should take note of and encourage their students to consider. The current United States medical system is one that is overly systematized and creates many hoops that clinicians have to jump through in order to properly care for their patients.

Narratives have limits and cannot be used as the sole method of knowing. Trust must be present between the patient and clinician, the clinician must know the patient to be truthful, and the physician must have the ability to be openminded. There are also human experiences that stretch beyond what can fit into a narrative, with patients that have experienced traumatic events and oppression not having the ability to articulate influential factors on their health and the ways in which it fits into the larger context of their situation.

[58] Mullangi, "Presenting the Case for the Medical Humanities", 592.

Time

Time constraints imposed on the clinical encounter are only becoming more rigid as time progresses due to patient volumes increasing and the physician shortage growing larger each year.[59] With clinicians' tasks and workload only increasing, time constraints as a barrier to actively listen to the patient are brought forth against the practicality of the implementation of narrative medicine.

In reality, the time a clinician spends listening to the patient is not extreme by any means. A study found that even in a "busy practice driven by time constraints and financial pressure, two minutes of listening should be possible and will be sufficient for nearly 80% of patients", with them also putting forth the fact their sample consisted of a few difficult patients with complex histories.[60] Through a clinician's ability to practice active listening techniques in the clinical encounter, time constraints no longer offer the resistance in practicing narrative medicine than were previously perceived.

Emotional Exhaustion

Working in the medical field subjects clinicians to experience a large volume of illness and suffering. Using narrative medicine as a means to understand a patient's perspective on a deeper level subjects the clinician to an even further amount of exposure to illness and suffering. Clinicians could assume that subjecting themselves to this form of intimacy will create levels of emotional exhaustion that are difficult to deal with, but this

[59] Boyle, "US physician shortage growing."
[60] Langewitz, et al., "Spontaneous talking time at start of consultation", 683.

is the exact opposite of what was found in a study that looked at the decrease in emotional exhaustion scores upon completion of a narrative medicine elective.[61]

Physicians not Willing to Shift from Their Current Practice

Being trained in a Flexner Report-heavy medical system makes it difficult to understand the true value behind narrative medicine. Older and established clinicians may not feel comfortable shifting their practice in a way that focuses on the patient's personal story. Inadequate training in narrative practices and an unawareness of the increased role of medical humanities in medicine may cause clinicians to see no point in changing their practice that has worked for them throughout their entire career. Even if clinicians are able to see the value that narrative medicine provides, after having a way of practicing medicine that has been established for an entire career deter the clinician from adopting new practices.

While this resistance to change is difficult to individually combat, it serves as a reminder of the importance of teaching medicine as an ever-shifting and malleable practice to the medical student so they are able to adopt new ways of showing up in the clinical encounter.

Although there are limits to the practice of narrative medicine in the fact that patient narratives cannot be treated as an all-encompassing portion of the clinical encounter, introducing and practicing ways in which narrative competencies are continually implemented and further familiarized have a great effect on the clinician and their patient.

[61] Lee et al., "Addressing Burnout."

DasGupta perfectly articulates that she is "…ultimately interested in is teaching people to listen critically, to listen in socially just ways. I want to teach healthcare providers to listen not only to comfortable stories, or stories of folks who are just like them, but also stories that challenge them, stories that are from the margins, stories that are traditionally silenced."[62] Becoming comfortable with stories that challenge an individual's thoughts and understandings of the world promote the fostering of a self-aware and open minded clinician who ends up becoming a physician that can better treat their patients.

[62] DasGupta, "Narrative Medicine, Narrative Humility."

CONCLUSION

Narratives are an important part of the human experience and profoundly impact our lives. They play an integral part in promoting empathy, fostering connection, and forming our identities. Sharing personal narratives allows us to connect on a deeper and more meaningful level, helping build a sense of community and understanding. Using narratives in the clinical encounter adds a valuable dimension to care that promotes patient healing and restores meaning in work for clinicians.

In the current US healthcare system, there are many shortcomings that create a barrier between healthcare's purpose and the US system's ability to carry out that purpose. But with the integration of narrative medicine into the clinical encounter, we can bridge the gap between the current system and a more ideal one that values the unique stories, experiences, and backgrounds of both patients and clinicians. Through the practice of narrative medicine, we can nurture a more compassionate and empathetic healthcare system that honors and brings forth inherent interconnectedness of all people.

Through the incorporation of literature into medicine, we can dive deeper into our values and goals, consider things that have never come to mind, and seek out ways in which meaning can be found. This is particularly important in a profession like medicine – one that is often stressful and demanding.

Overall, narrative medicine is a transformative field that celebrates the importance of personal narratives in the practice of medicine. Through the integration of humanities into medical education and clinical encounters, narrative medicine offers a holistic

approach to healing that has the power to combat clinician burnout, restore meaning in work, and enhance patient outcomes.

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