Conceptual article

Narrative Medicine as a curricular activity: experiences and hopes

Medicina Narrativa como atividade curricular: experiências e esperanças

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"With greater or lesser skill, we craft fictions not so that the false may appear true, but in order to tell the most ineffable truths with utmost fidelity through fiction."

Ferrante E.[1]

ABSTRACT | INTRODUCTION: Experiences in our country regarding Narrative Medicine (NM) as a curricular activity are still quite scarce. While we do have over a decade of background in activities tangentially related to educational institutions, these have not been considered curricular, nor even elective, during the formative stage of medical training. In Tucumán, Argentina, for our part, we began two years ago to offer extracurricular workshops at the Facultad de Medicina de la Universidad Nacional de Tucumán (UNT). These efforts led to the creation of the subject "Narrative Medicine" at Universidad San Pablo T, offered to first and third-year students as an integral part of the curriculum.

KEYWORDS: Narrative Medicine. Curriculum. Medical Education.

RESUMO | INTRODUÇÃO: Experiências em nosso país com a Medicina Narrativa (MN) como atividade curricular ainda são bastante escassas. Embora tenhamos mais de uma década de experiência em atividades tangencialmente relacionadas a instituições de ensino, estas não foram consideradas curriculares, nem mesmo eletivas, durante a fase formativa da formação médica. Em Tucumán, Argentina, por sua vez, começamos há dois anos a oferecer workshops extracurriculares na Facultad de Medicina de la Universidad Nacional de Tucumán (UNT). Esses esforços levaram à criação da disciplina "Medicina Narrativa" na Universidad San Pablo T, oferecida aos alunos do primeiro e terceiro anos como parte integrante do currículo.

PALAVRAS-CHAVE: Medicina Narrativa. Currículo. Educação Médica.

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1. Introduction/the problem

This work is originated from the lecture at CAEM (Congreso Anual de Educación Médica) 2024 (Buenos Aires, September 26th, 2024).

Experience in our country regarding Narrative Medicine (NM) as a curricular activity is still quite scarce. While we do have over a decade of background in activities tangentially related to educational institutions, these have not been considered curricular, nor even elective, during the formative stage of medical training. In In Tucumán, Argentina, for our part, we began two years ago to offer extracurricular workshops at the Facultad de Medicina de la Universidad Nacional de Tucumán (UNT). These efforts led to the creation of the subject "Narrative Medicine" at Universidad San Pablo T offered to first- and third-year students as an integral part of the curriculum. Together with Dr. Paula Amaya, who is responsible for the course, we regard this development as both significant and worthy of celebration. Throughout 2024, the course has been delivered regularly, receiving highly positive responses from students, closely aligned with international experiences of a similar nature.

In clinical practice settings, the development of NM has been far more robust and has acquired considerable consistency. Workshops have been held with healthcare professionals in various health centers in Buenos Aires City and its metropolitan area. The Hospital Italiano de Buenos Aires, arguably the pioneer of these initiatives, has held seven Narrative Medicine Conferences to date. Two years ago, the Sociedad Argentina de Medicina Narrativa was established. It has grown exponentially, offering courses, workshops, and a major conference in 2023. Most recently, the Society has launched its most ambitious project yet — a Diploma Program in Narrative Medicine, aimed at training facilitators, workshop leaders, and activity coordinators. The program has enrolled 25 professionals, including participants from Argentine provinces and abroad. We are very hopeful that this promising project will succeed; it is scheduled for completion in mid-2025.

We are aware that interest in Narrative Medicine is currently on a steep upward trajectory. It is time to seriously and vigorously promote curricular spaces in medical schools throughout our country.

On a personal note, I can say that I have fulfilled the dream of building an effective bridge between the dominant scientific–technical model of medicine and humanistic medicine. Both professionals and patients increasingly demand concrete outcomes in the process of humanizing medical practice. It is essential to take solid steps in this direction.

Some years ago, in our teaching practice, we reached the conclusion that if medical humanities are not taught alongside clinical disciplines — if they are instead relegated to the periphery of the curriculum — then the much-desired and frequently invoked humanization of medical practice becomes an impossible mission. This is the reason for my enthusiasm for Narrative Medicine.

As a preliminary presentation, we may say the following: Narrative Medicine is the practice of the health professions by professionals equipped with narrative skills and competencies, including attentive and active listening, the interpretation of meaning in stories. The management of patients' and colleagues' narratives, the ability to process the emotional and affective impact of those stories, and the capacity to act within complex relational contexts involving patients, their families, co-workers, and themselves.

2. Narrative Medicine education: the intervention and the results

This introduction naturally leads us to recognize that the teaching of Narrative Medicine presents at least two distinct scenarios, each requiring slightly different approaches and strategies:

Scenario 1: Narrative Medicine during the formative stage of health professionals.

Scenario 2: Narrative Medicine during the practical phase of health professional practice.

Clearly, these are two very different contexts, each demanding tailored educational proposals. Given the nature of this presentation, our emphasis will be on the first scenario — education — without neglecting the second.

Let us briefly recall the definition of Narrative Medicine offered by the originator of the term, Rita Charon[2] of Columbia University, New York:

> *"Narrative Medicine is clinical medicine practiced by physicians who possess narrative competence."*

This is a very concise definition, one that merits further elaboration and detailed clarification depending on which aspect of Narrative Medicine one wishes to explore. Still, even this basic statement allows us to infer several foundational concepts:

It affirms that this is a form of clinical medicine, thereby upholding the values of classical medicine. It does not reject but rather confirms the importance of evidence and the foundational elements of modern medicine. Clearly, NM is presented as a reaffirmation of academic medicine, and as a coherent proposal for cooperation and complementarity centered on the human value of stories.

NM can be practiced by healthcare professionals as we currently know them, provided they have been trained in narrative competencies and embody them — make them their own — in both their lives and their professional activities.

The complementarity with clinical medicine lies in the fact that professionals must be trained in specific narrative skills, which may be initially listed as follows:

1. Attentive and active listening;

2. Interpretation of stories;

3. Creation of an effective and affective connection with the patient (a principle that can be extended to all human interactions).

Thus, we arrive at the three foundational pillars of Narrative Medicine: attention – representation – affiliation[3].

2.1. Attention

This concept refers to a focused, fair, and compassionate gaze directed at individual reality. It is a gaze that presumes nothing but is instead the result of a discipline whose condition is the abandonment of generalizations, prior judgments, and the pretension of universality — the belief that all cases of a given type are the same and should be resolved in the same way.

Attentive listening cultivates the ability to:

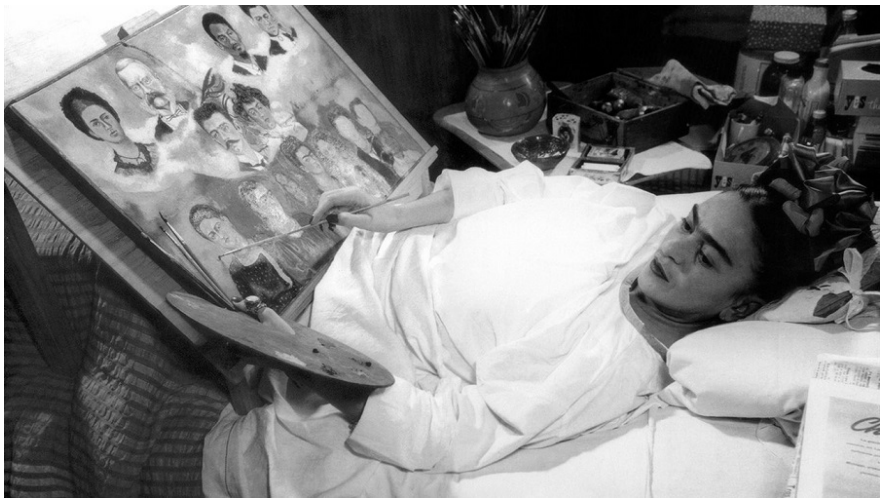
1) Formulate questions that deepen mutual understanding in the clinical encounter.

2) Create a space in which narratives can unfold.

Encourage follow-up questions and invite alternative reformulations of the narrative. This creates an opportunity for all involved to reconsider stories in a new light.

Examples of an exercise proposed for a small group of students:

Figure 1. Frida Kahlo painting "Portrait of Frida's Family"



Source: Juan Guzmán (1950-51)[1]

Figure 2. The Broken Column

Source: Frida Kahlo (1944)[2]

[1]Available from: https://www.alejandradeargos.com/index.php/es/completas/32-artistas/41816-frida-kahlo-biografia-obras-y-exposiciones
[2]Available from: https://www.nationalgeographicla.com/photography/2019/01/frida-kahlo-una-vida-desplegada-en-obras?image=09-frida-kahlo-difficult-women

What does Frida Kahlo appear to communicate about her illness in this artwork of hers? Pay attention to the whole and to the details. Observe it for two or three minutes, and then anyone who wishes may share their impressions.

What are your impressions and feelings in response to this paragraph from Días sin hambre, in which Delphine de Vigan[4] recounts her harrowing experience with anorexia?

> *"Anorexic. [...] Apparently, ten percent of them die. Perhaps through neglect. Without realizing. From loneliness, surely.*
>
> *Sometimes she thinks about it. She couldn't go on like this, especially because of the cold, and the exhaustion too. She's worn out. She now knows that one cannot live at that weight.*
>
> *She's compromised a few kilos to stave off danger, to survive, above all. But she hasn't given in. She doesn't want to lose control. The life before is just an anesthetized memory, and the life after whispers like an impossible promise. She doesn't want to recover, because she only knows how to exist through that illness that has chosen her, the one they talk about in newspapers and conferences—a blind, dark quest she shares with others, anonymous and hesitant accomplices in a silent crime against themselves. It will take time for her to understand why she got to that point. For now, she's retreated into that black hole in her stomach, which draws her in from within. The body has taken over—diminished, reduced like a shrunken hide, denied even its existence, now occupying center stage—she hasn't missed the paradox—breathless, rebelling against the abuse it's suffered for weeks, resisting. And she, wholly focused on that dilation, no longer feels, no longer thinks; her soul has stopped suffering."*

Prompts like these can initiate sessions in which students and professionals reflect on the phenomenological implications of human suffering. It is a way to move from pain described in fibromyalgia or cancer to pain expressed in the first person.

In these examples, together with their respective stories, students, or residents gain direct access to the testimony of a fellow human being's suffering. When listening to these stories (even fictional ones), the same brain areas are activated as are involved in processing real-life events.

2.2. Representation

This component is directly linked to the interpretation of stories and the internal processes they generate in professionals who have listened attentively. Representation refers specifically to the act of writing down, after an encounter, the salient features of what was heard: cadences, metaphors, expressions, gestures, vocal emphases, and narrative details.

While the concept of representation traditionally refers to writing, it is not uncommon for professionals to ruminate over the day's consultations and for new insights or understandings to emerge even if they are not written down. This process reinforces the perception of the other's suffering and connects it with the student's or health professional's self-awareness — an impact that can extend to their professional identity.

Example:

How might the following story resonate with a medical student? What will their interpretation be, and how might it affect them personally? This is a brief excerpt from The Diving Bell and the Butterfly, written in an extraordinary way by Jean-Dominique Bauby[5], who suffered from Locked-in Syndrome:

> *"The second time I went to Paris, four months later, I had grown almost indifferent. The street wore its July finery, but as far as I was concerned, it was still winter, and the scenery outside the ambulance window was a backdrop projected onto a screen. In cinema, they call it 'a transparency': the protagonist's car hurtles down a road that, in fact, runs across a studio wall. Hitchcock films owe much of their poetry to this device back when it was still imperfect. (...) trees assaulting the façades and a bit of cotton in the blue sky. Nothing was missing—except me. I was elsewhere."*

Later, in the safety of a small group under an explicit confidentiality agreement, participants may share emotions, sensations, memories, and reflections prompted by the reading. They may also be encouraged to write personal notes in a fictional "parallel medical chart" (about Bauby's story, in this case) to capture everything that cannot be expressed in a conventional medical record.

It is advisable to break with the habits of past training and to teach students that one day they must stop and write their stories. If they fall into the trap of ignoring what does not fit the conventional medical narrative, it will accumulate within them and may drive them mad. It will estrange them from their patients — and from themselves. Alienation begins when professional life starts to resemble Hamlet's description: "weary, stale, flat, and unprofitable," or, in more modern terms, exhausting.

2.3. Affiliation

Proper attention and representation lead to a stronger affective bond between physician and patient, expressed as affiliation. While the term "affiliation" is not typically used in clinical language, it is appropriate here if one recalls the act of joining a club. To affiliate is to "become part of." In this context, it means becoming part of a unique alliance with the patient and with their family members.

Affiliation also implies bringing professionals closer together and contributing to the construction and consolidation of work groups or teams in healthy environments that enhance the qualities of each of their members. This alliance fosters patient empowerment by facilitating access to information and encouraging joint decision-making.

Example:

The bond or alliance between the prominent judge Ivan Ilyich and his servant Gerasim — who is the only one who truly cares for him, as he has no "conflict of interest." Charged with helping Ivan with his bodily functions and comforting him at night, Gerasim sees his role as offering help to a dying man. In contrast, Praskovya and Lisa, by virtue of their selfish nature, can only exacerbate Ivan's condition. Gerasim consoles and heals the dying man[6].

Ivan Ilyich: "Oh! Oh! Again, again, and there is nothing to be done, but rest and die."

Gerasim (holding Ivan Ilyich's legs to relieve his pain): "Don't worry, sir. Why wouldn't I help you? You are a sick man, and it is our duty — the duty of the healthy — to help."

Ivan Ilyich: "Does it disgust you? Is it a burden?"

Gerasim (naturally): "Not at all, sir. It's fine. God made us all, and we must help one another."

Ivan Ilyich (surprised by Gerasim's sincerity and kindness): "Doesn't it tire you? Doesn't it wear you out?"

Gerasim (with a smile): "No, sir. It's better for you, and it doesn't bother me at all. You are a sick man, and this is nothing to me."

In undergraduate education, literary texts are used to train students in the triad of attention, representation, and affiliation. These activities rely on reading and subsequent reflection, without yet involving real patient stories. Once this internalization exercise is complete, students are encouraged to share their insights in a framework of simple, explicit rules. Absolute confidentiality regarding what is shared is required, and it is emphasized that no one holds the "truth" about others' contributions. This helps foster wide participation. As already demonstrated, the prompts for reflection and discussion may come not only from texts, but also from photographs, paintings, films, or other expressions of the human spirit.

Exemplary passages are found in Dostoevsky's Crime and Punishment[7], where Raskolnikov is cornered by guilt after committing a horrendous crime. His condition is expressed in a classic case of somatization:

"The fever had only increased, and he was so weak that he could barely stand. His physical illness coincided with his moral anguish, exacerbating his suffering. He felt that everything within him cried out to confess, to atone, to free himself from the burden that was destroying him.

"The fever continued to rise, and in his delirium, he saw images of his crime and the face of the old pawnbroker staring at him. The idea of confession began to take shape in his mind—not as an act of courage, but as a necessity to save himself from the madness closing in."

As my grandmother used to say: "Para muestra basta un botón" (One button is enough to judge the whole coat.) Naturally, this applies to many things, including the subject at hand. Nevertheless, I have the impression that much more could be said to provide a complete outline of Narrative Medicine and its incorporation into academic curricula and graduate profiles in our educational institutions.

Someone once said that our graduates are well trained in scientific and practical matters. They are discerning, efficient, and precise. I'd say they only lack a touch of 'fine tuning.' That subtle quality is brought by the patients themselves through their stories filled with real-life content. The experiences recounted in their narratives provide the lived experiences, characters, and plotlines in which physicians must operate—and already do. It is not only memory and lived experience that make a physician a narrative being, a person sensitive to stories. That 'fine tuning' is provided by creative imagination and fantasy. What our doctors lack is the capacity to fantasize, to imagine scenarios, to give voice to characters. That is how empathy and compassion for others become possible.

3. Conclusion

David Winnicott[8], the renowned English psychiatrist, affirms:

"A sign of mental health is the ability of an individual to enter imaginatively and accurately into the thoughts, feelings, hopes, and fears of another person, and to allow that person to do the same with us."

To conclude, I share with you a passage from a testimonial article written by Dr. José Jackson Coelho Sampaio[9], psychiatrist and public health researcher at the Universidade do Ceará, Fortaleza, Brazil. He recounts his experience during a grueling and complex hospitalization for COVID-19:

"Perhaps the best example is the bath. In the ICU, I have no rational memory of how many baths I received or how they were given. But on the ward, that first splash of cold water was terrible. Especially for me, who needs a hot shower even in the hottest cities. I carry in my body memory the chills of malaria and the jets of water used to disperse us during protests in the military dictatorship.

I had no body fat, having lost 25 kilos. I shivered, I protested — displaying not only indignation but also a partial recovery of my lungs. I went on a bath strike until, one day, a nurse technician appeared, sat next to me, and said he would fetch hot water in basins to temper the water he would use in a bucket to bring into the room.

He described the procedure he would follow: he would bathe me in stages, covering me with towels throughout, beginning with my head and ending with my inflamed feet. And he did so thoughtfully and tenderly. His method became the standard. I will never forget it. In circumstances of extreme vulnerability, the small gesture of explaining and caring becomes an act of immense significance."

I invite you to listen attentively, to reflect inwardly, and to let your imagination soar. With heartfelt thanks.

Competing interests

No financial, legal, or political conflicts involving third parties (government, private companies and foundations, etc.) have been declared for any aspect of the submitted work (including but not limited to grants and funding, advisory board membership, study design, manuscript preparation, statistical analysis, etc.).

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