Narrative Medicine: An unexplored perspective in the medical curriculum to enhance patient-centredness and empathy in medical students

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Abstract : A medical narrative is a physician-patient dialogue, where the physician listens carefully to fragments of the patient's story, while interpreting their hidden messages and word sequences, as well as observing their gestures and body language. This aspect of the therapeutic relationship contributes to deciphering symptoms which are not apparent in the conventional interview and contributes to a much broader perspective of illness and health.

The arts and the humanities have always been inseparable from each other in medical education. In this biomedical revolution, the humanities are needed now more than ever before to bridge the divides that separate the physician from the patient, from self, from colleagues, and society.

Narrative Medicine (NM) which aims to treat the whole person, and not just the illness, is an emerging patient-centred discipline in medical schools that can humanise medical care and promote empathy.

NM helps medical students cope with the suffering of their patients as well as their own emotions by reducing the anxiety and threat that come with illness, thereby providing a psychologically-sound foundation for the development of self-reflection and empathy. NM facilitates medical students' adoption of patients' perspectives with the hope of ultimately leading to more humane, ethical and empathetic healthcare for their patients. The discipline of NM is critically examined in this review paper from the perspective of external and internal stakeholders.

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Key words: Narrative medicine, curriculum, patient-centredness, empathy, medical students

Introduction

Narrative Medicine (NM), which deals with how patients build and tell their stories to their physicians is an important emerging discipline in medicine. Its incorporation in medical schools would aim at treating the whole person and not just their illness[1]. A medical narrative is a physician-patient dialogue; the narrator who is the patient, expresses his or her views of illness in his or her own words leaving the listener, the physician or health carer, listening carefully to fragments of this story, interpreting hidden messages and word sequences as well as observing gestures and body language, and being moved by these stories of illness[2]. This aspect of the therapeutic relationship contributes to deciphering symptoms which are not apparent in the conventional interview and contributes to a much broader perspective of illness and health, and, is a reminder that medicine is an innately human practice.

With rapid changes in technology and the impact of extensive invasive and non-invasive investigations, medicine, which was a profession of traditional personalised care has changed to the systematic involvement of processes involving many stakeholders in the care of the patient. The healthcare needs of today cannot be seen in isolation. Medical schools have to look beyond their campuses for supportive evidence so that the quality of their graduating doctors would be responsive to the demands of various stakeholders[3].

This review seeks to explore if the inclusion of NM in undergraduate medical curriculum would help to enhance empathy[4] in medical students and contribute to the improvement of medical education and healthcare.

Method

A search of the medical literature published in the English language that included PubMed, Cochrane Library, EBSCO Host, Google Scholar and bibliographies of retrieved articles using the search terms "narrative medicine", "curriculum", "patient-centredness", "empathy", and "medical students", was carried out for scientific papers that discussed the subject of NM, ensuring that the views of medical educationists, medical students, patients and physicians

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were included. Literature relating to NM between 1927 and 2016 was then reviewed, and the impact of NM on internal and external stakeholders in the healthcare system namely, medical educationists, medical students, physicians, patients and healthcare administrators, examined critically for supportive evidence, as seen below.

Results

i. Influence of Medical Educationists on Narrative Medicine

The Flexner's Report of 1910 by the Carnegie Foundation for the Advancement of Teaching, attempted to redefine medical educational practices arguing that the proper goal of medicine was simply "to attempt to fight the battle against disease". Critics soon opposed Flexner's Report alleging that medical schools were training physicians to treat medical problems purely on symptoms alone, without taking into consideration psychosocial issues and the personal history of the patient.

In 1927, Francis Peabody[5] emphasised the need to listen to patients and to care about what happens to them, quoting "the treatment of a disease may be entirely impersonal; the care of a patient must be completely personal".

Much later in 1977 George Engel[6] shared the same sentiment, and expressed concern that the Western culture had dichotomised the science and art of medicine. He propounded the biopsychosocial model of medicine which he said was merely applying medical knowledge to the needs of the patient to give them a sense of being understood. He said clinicians must attend not only to the biological, but also simultaneously to the psychological and social dimensions of a patient's illness.

Rita Charon of Columbia University Medical Centre has, in recent times, been one of the pioneer physicians to focus on NM recognising it as being integral to empathetic medicine[7]. Since then, other teaching institutes of medicine have also included NM in their curriculum.

There is increasing attention from medical educators and healthcare administrators to focus on interpersonal and communications skills for effective information exchange with patients and their families, and also other healthcare professionals. This has generated an increased interest in physician-patient communication research to help teach and measure this specific clinical skill. Clearly, the era of paternalistic medicine has been replaced with consumerism and shared decision-making where patients' cultural traditions, their personal preferences and values, their family situations and their lifestyles, must also be considered. Physician-patient discussions play a central role in how successfully this transition is accomplished[8].

Stewart M[9] an epidemiologist and researcher in Family Medicine, in her reflections on the physician-patient relationship and the training of future doctors asked, "What can we do in education to counter the imbalance and to model the middle way?" Her recommendations were, "First, we will resist teaching the science of medicine separate from the art of medicine and the disease as separate from the person. We will stress that each patient is surrounded by a web of caring (or uncaring) relationships that matter to a patient's health, healing and wholeness", and recommended that "the use of art, poetry and prose can serve such an integrative function."

ii. Desired Impact of Narrative Medicine on Medical Students

NM supports the skill of 'observation' and 'listening' in the makings of a good doctor following the dictum "Listen to the patient: he is telling you the diagnosis"! NM enhances reflective and analytical skills in medical students' clinical engagement with the patient, allowing them to respond better to the patient's plights and their stories. Most importantly, NM helps to bring the

patient as a subject back into medicine, honing students' ability to show expressed feelings and empathy with more patient-centredness. NM inculcates a quest to understand the cultures and beliefs of patients better, enlarging understanding of the human experience, as well as enhancing self-reflection and professional development in medical students in training. Teaching NM through a mentor-mentee system in the curriculum would also allow several attributes of the student to be assessed.

The physical, emotional, and social impact of patients' problems on both themselves and their families is better understood and elicited through Narrative Medicine. In a diagnostic encounter, narratives, which are the phenomenal form[10] in which patients experience ill-health, allow for construction of meaning and supply useful analytical clues. In research, narratives serve as a tool in qualitative research. In the management of patients, narratives are intrinsically therapeutic and palliative.

Strengthening medical students' 'narrative competence' helps them in their development of intangible goals like humanism and professionalism by providing them with graduated skills in better adopting patients' points of view, visualising what patients endure, and comprehending what they need. NM also helps medical students reflect on what physicians themselves undergo in caring for patients.

A third-year medical student once said "… it is a good reminder that as physicians, we may not always be able to fix patient problems but we can certainly be caring and supportive. It reminded me that good medicine takes into account the whole person including body, mind, and spirit and not just the sum of its parts"[11].

While disease is the clinical perspective of patients' problems, 'illness' relates to the innate human experience of patients' symptoms and suffering. Medical education should go beyond just taking a comprehensive history, performing a physical examination, a diagnostic work-up or discussion about a plan for action. The desired therapeutic relationship requires the student to establish deeper connections through which he can delve more meaningfully into the human experience, the hidden aspects of which are best understood and vocalised by the sick person.

iii. Enhanced Physician Engagement with Patient

NM allows physicians to imaginatively enter into other peoples' worlds through their patients' stories, shift their viewpoints, change their perspectives about their patients and become more humane in their response to patients' experiences[12]. NM may be the remedy to Western medicine which arises from modernistic philosophy, and which has long been associated with paternalistic 'doctor-centred' care[13]. Competency in narrative interpretation helps physicians become more effective carers as it contributes to the development of empathy and acknowledgment of the plight of the patient. Over the last decade or so, communication skills were incorporated into the curriculum of medical schools because doctors of today are expected to deal with psychosocial issues concerning their patients and adopt a more negotiating and partnership style with them. Exploring the social and emotional impact of patients' problems helps to further strengthen the physician- patient relationship. Fear of increase in consultation time and fear of transference of emotive factors, as well as the purported increase in patients' distress, have all been given as reasons for some doctors' reluctance. This 'blocking behaviour' by attending physicians, dismissing distress associated with illness as normal, and quickly moving on to establishing a diagnosis as core to the physician-patient relationship, contributes to non-disclosure of vital aspects of illness by patients and to the detriment of the therapeutic relationship between physicians and patients.

NM helps to pave a deeper relationship in which physicians can reach and join their patients in illness, as well as recognise their own personal journeys through medicine[14]. Listening to patients and documenting their stories confers on medical practice a new understanding

of patients[15, 16]. Clearly, the inclusion of NM in the therapeutic relationship improves the physician's own well-being and contributes to greater mutual satisfaction of both patients and their attending physicians.

Viktor von Weizsäcker, a German physician and physiologist opines that the physician-patient relationship should be an example of 'inclusive therapy' where the doctor allows himself to be changed by the patient, and allows the feelings of the patient to affect him to bring the "I and the Thou" more effectively together, aligning with NM[17].

Joseph Levenstein[18] conducted an audit on his practice in South Africa by listening to 1000 audiotaped physician-patient interviews to determine which elements of his consultations went well. He opined that patients' feelings, especially fear and expectations, needed to be attended to and that patient-centredness was central to the discipline of family medicine. He also proposed that the clinician should follow the patient's cues and interests, uncovering important psychosocial issues relevant to their care, and that interruption and the use of open-ended and non-directive questions should be avoided. He opined that the most common reason for an unsuccessful consultation was the doctor's failure to find out why the patient came!

Planning the clinical consultation improves physician engagement by being inclusive and patient-centred. In many consults involving uro-gynaecology and infertility treatment, planned approaches are often in place where counselling and the collection of relevant information precedes specific treatment and often involves a healthcare team consisting of incontinence nurse, professional counsellors, physiotherapist and ultrasonographers. This model allows for the establishment of a therapeutic relationship with several members of the healthcare team stretched over several consultations.

iii. Patients' perspectives

A patient-centred inclusive 'therapeutic alliance'[19] is often associated with better physician-patient relationship, where further anxiety is markedly reduced, adherence to therapy is enhanced and fewer investigations done, with ultimate benefit to all parties as patient complaints and litigation are also seen to be reduced[20]. However, some patients prefer skilled techniques to a good bedside manner. The preference for technical skills and the 'fix-it model' of a no-nonsense physician is frequently seen in consultations that involve purposive diagnosis and treatment approaches, such as in both invasive and non-invasive cardiology and intrusive procedures like ambulatory endoscopy. Current practice trends in medical care require serial investigations pushing the 'art of medicine to the fringes of medical care.

Serial investigations have also become a norm with less reliance on the art of medicine. Such approaches are not necessarily considered inappropriate in busy set-ups, if patients have been primed on the purpose of such procedures.

Beckman and Frankel[21] studied 74 office visits in which in only 17 (23%) visits were patients allowed to complete their opening statements of concern. In 51 (69%) visits the physician interrupted the patient's statement and directed questions toward a specific concern; in only one of these 51 visits was the patient allowed to complete the opening statement. In six (8%) return visits, no solicitation whatsoever was made. The study also revealed that physicians listen to patients' concerns for an average of 18 seconds before interrupting. Physicians play an active role in regulating the quantity of information elicited at the beginning of the clinical encounter. However today, many physicians unfortunately use closed-ended questions with premature interruption of the patient disclosure resulting in potential loss of relevant information.

Patients desire a personal relationship from their physicians, with communication and empathy. In one of the largest observational studies to date by Little *et al*[22] to assess patients' preferences and specifically preferences

for patient-centredness, 865 patients in waiting rooms of three General Practice consults in the United Kingdom were given a pre-consultation questionnaire. Results showed that from the patients' perspectives there are three distinct domains of patient-centredness, viz. communication, partnership and health promotion, and that patient-centredness was best measured in primary care by an assessment made by patients themselves. The Commonwealth Fund, 2003 National Survey of Physicians and Quality of Care[23] has also put forth a set of attributes of patient-centred care for all primary care physicians to improve their responsiveness to patients' preferences.

In a study on the effect of physician solicitation approaches on the ability to identify patient concerns by Dyche *et al*[24], solicitation was seen to carry more weight than interruption in the exchange necessary for effective bilateral communication between physician and patient. However, the study leaves unanswered the question of how interruption might affect patient satisfaction. Both Dyche *et al*[24] and Marvel *et al*[25] also found that a considerable number of patient visits contained no physician inquiry about current patient concerns in either physician-initiated or patient-initiated encounters. It was also noted that prior studies have shown that when physicians understand patient concerns, there is improvement in patient satisfaction and patient adherence, and that failure to solicit patients' agendas result in significant reduction of physician database.

iv. Humanising Healthcare

Patient-centered care has renewed prominence in the work of healthcare administrators. In 2001, the Institute of Medicine reported a distinct difference between the kind of care that patients receive and the kind of care they should get[26], calling for a change in the American Healthcare System which has grown more complex and fragmented. As providers feel more pressured to see more patients in less time, care has become centred not on the needs of patients, but around the needs of the system itself. Therefore, a redesign of the system with the six "Aims for Improvement" viz. safety, effectiveness, patient-centredness, timeliness, efficiency and equity, were recommended. Donald M. Berwick, former President and CEO of the Institute for Healthcare Improvement in the United States so rightly reminded healthcare professionals in 2001 that they are "guests in their patients' lives instead of hosts in health care organisations[27]."

The Affordable Care Act of the United States, in its emphasis that collaborative, patient-centered healthcare improves outcomes while reducing costs, has since 2007 established '***patient-centered medical homes (PCMH)***' in an effort to improve the quality of primary care. Such general practice which is supported by a practice team, is chosen by a person to be responsible for the ongoing, comprehensive, whole-person medical care, for himself/herself and family. It is well known that hospitalist care of patients is notorious for missing the patient's emotional input due to the rushed and ritualistic care afforded in routine business ward rounds, bureaucratic rules governing ward work, and the so called 'passivity of the health care system where third party involvement through healthcare insurance and commodification prevail[28].

Analysis and Discussion

Narrative ethics[29] is not unlike 'virtue ethics' where the patient's story and events engages the physician /carer and forms the basis for reflective practice. It paves the way for physicians to adopt new means of understanding that leads to meaningful and patient-centred care. Narrative ethics forms the basis for NM where patients' bio-psychosocial factors are considered; care is patient-centred with the patient playing a dominant role. The power imbalance in the patient-physician relationship is blurred in NM, and the authority to conclude the consultation is renounced by the physician.

The promotion of trust between patient and physician, and the establishment of a more meaningful bondage

and patient-centredness that contributes to care beyond what is generally perceived as the biomedical care of disease, should be inculcated early in medical schools.

Clinical empathy is an essential skill that can be taught and improved, producing changes in physician behaviour and patient outcomes. Empathy and physician's expertise lead to value added narrative competence. Empathic responsiveness, which conveys the understanding of another person's perspective through the integration of knowledge, skills and attitudes, can be improved and successfully taught during medical school especially if it is embedded in students' actual experiences with patients[30]. This is closely aligned with NM.

In most medical schools the teaching of clinical empathy is only briefly covered in communication skills, and not in depth. Teaching of clinical empathy needs to be incorporated into clinical practice at all levels, and may need to be assessed as early as the selection interview of candidates for medical school.

Guided formative assessment of such responses through a mentor-mentee system is a good way of making empathetic responsiveness an integral part of becoming a competent physician. Clinical sessions comprising brief didactic presentations and followed by supervised role-play using standardised patients, and, DVDs or movies to help integrate the skills into clinical practice will also be useful.

Physicians' work load and often technology override adequate clinical enquiry because a diagnosis is commonly established by 'processing' the patient through a variety of medical investigations, leaving little time for narration and listening to the patient. Today, unfortunately paternalistic approaches still exist in many a therapeutic relationship and is readily accepted by patients if the focus is on diagnosis and appropriate treatment.

In order to listen to the patient, medical students need to be culturally competent without being judgmental, as well as, competent in communication skills. A patient-centered approach which is altruistic in nature is also essential. 'Telling of illness stories' impacts on medical students and carers to develop skills required of holistic medicine, lending to the dignity the patient deserves. Students' awareness of patients' sufferings should be factored into the patient care pathway. This aspect of the healing process will consider virtue ethics and the trustworthiness that the patient desires, focusing on the character of the moral agent rather than the rightness of an action, while taking into account the importance of the emotional element of the human experience[31]. Empathy can be one such virtue that encourages patient autonomy.

NM is a good example of how to engage clinical-phase students to act on others' suffering. The broader perspectives of NM would include observation, skills in active listening and analytical skills with reflection, together with the ability to tell patients' stories. Skills go beyond listening as the actions that are to be taken need to be aligned to personal convictions and ethical practice. Undeniably, for better experience of the processes that are induced through NM, the listener should also be wary of patients' cultural and social perspectives. Herein lies the link between NM and professional ethics.

Professional ethics is a complex domain for students, teachers and practitioners alike. Today, as part of ethics education in medical schools there is a need to enhance moral sensitivity and reduce the objectification of patients. Additionally, the principles of 'ethical analysis'[32] should also be taught in medical school, so that students' and physicians' ethical capacities in dealing with ethically-troubling situations throughout their clinical careers are enhanced.

It is generally agreed that being a competent physician and making the right diagnosis or sorting out appropriate management does not completely treat the illness in value based healthcare. The reality of each patient as a person is actually created and recreated

through dialogue. A physician should come to a shared understanding of the patient's narrative with the patient, where illness and health should be interpreted from an inter-subjective perspective by giving the patient space to articulate his or her concerns and by finding out about patients' expectations. Physicians have a duty to extend the help patients need beyond scientifically-based treatment, so that patients find meaning in illness.

Can patient-centredness and empathy be taught?

There is now abundant evidence that empathic communication is an essential medical skill that can be taught[33]. Even though physicians differ in their innate capacities, as with any other skills in medicine, clinical empathy can be taught and acquired. Improvements have to be seen at every level of training and practice.

The focus in learning NM is to enable students to experience their ideations and feelings, and in the process empathise. As most physicians become involved in the stories of their patients' lives they often become players in these stories too. This process involves a conscious effort to transform the primary biomedical focus on disease to the broader model of incorporating the elements of reflective learning. This is well illustrated in analysis of narratives written by medical residents where internal personal conflicts and struggles at each stage of the engagement or their personal development, surfaces[34].

Empathetic responsiveness may not always be determined by the formal curriculum but by the subtle hidden curriculum[35] encompassing the organisational culture and role-modelling of teachers, and has to become a seamless part of the training process.

In a study to determine whether vicarious empathy (versus role-playing empathy) decreases during the course of medical school, and whether students choosing specialties with greater patient contact maintain vicarious empathy better than students choosing specialties with less patient contact, Newton B W *et al*[36] opined that undergraduate medical education greatly affects the vicarious empathy of students on the basis of gender and/or specialty choice, more men choosing non-core specialties.

Behaviour of practising physicians has been shown to improve after video-recorded encounters and feedback[37], and students' behaviour is commonly assessed using objective structured clinical examination (OSCE) stations[38]. Recently, valid and reliable measures to assess clinical empathy, such as the Consultation and Relational Empathy (CARE)[39] measures have been developed to facilitate the teaching and evaluation of these skills.

Between September 2013 and June 2014 an online questionnaire survey was administered to 15 UK, and two international medical schools[40]. Participating schools provided both five to six- year standard courses and 4-year accelerated graduate entry courses. The survey incorporated the Jefferson Scale of Empathy-Student Version (JSE-S) and Davis's Interpersonal Reactivity Index (IRI), which are widely used to measure medical student empathy. Participation was voluntary. Interestingly, no differences in scores of empathy were recorded between students in the first/second and final year, amongst either graduate or standard-entry course students. However, graduate-entry course students recorded significantly higher scores for all measures of empathy as compared to standard-entry course students. Since they start medical education having completed a first degree, graduate-entry course students tend to be older and many have more relevant life experiences than standard-course students. Participant male and female medical students approaching the end of their undergraduate education, whether on standard or graduate- entry courses, did not record lower levels of empathy, compared to those at the beginning of their course. This finding of no reduction in empathy during medical studies before qualification is encouraging. Nevertheless, concerns remain as the trajectory of empathy after qualification appears to be preset when starting out in medical school.

In NM, doctors take their lead from what patients want to tell them, and the way in which they want to tell it[41]. Consideration of narratives in the medical consult has shown new directions paving the way for the conception of the 'Database of Individual Patient Experience' (DIPEX)[42].

There is a general feeling that medical care has become technically oriented and purpose- built, adopting paternalism as a convenient approach. Human aspects should be factored in through narratives so as to narrow the gap between the physician's remedy and the patient's expectations[43]. Fragmentation of medical care with rapid resort to technology, medical informatics and earnestness to diagnose, has eroded the autonomy of patient- physician relationships[44]. Patient load in busy clinics and sub-specialisation have contributed to a platonic relationship with the physician with less time for direct consultations and the need to evaluate psychological and cultural perspectives of the illness. The nuances of managed care and litigation contributes to over-investigation and medicalisation of healthcare, leaving doctors to take a technical approach to treatment of illness. "Every person is a story and every patient is a story" says Klass, a pediatrician novelist[45]. Johna S went on to say that patients are not just 'bodies, organs and tissues'[43]. Narratives assist physicians to learn more from patients so that decision-making is more holistic. 'We understand our own lives in terms of narratives…' says MacIntyre, a philosopher[46].

NM contributes to another perspective of conventional medical teaching as it provides a platform for doctors to listen to their patients, relate it to their own lives, and understand the inner feelings of patients. Narratives extend to management of the patient beyond illness as one would have access to hidden messages in the story the patient shares with the physician.

Table 1: Educational tools for developing skills of Narrative Medicine

1	Clinical encounters and simulated patients[47]
2	Literature, poetry, drama[48]
3	Non-fictional and fictional feature films[49]
4	UNESCO Core curriculum in Bioethics
5	Portfolios, reflective writing[50, 51]
6	Books on humanism[52]
7	Creative writing[53, 54, 55]

Conclusion

The arts and the humanities have always been inseparable from each other in medical education. In this current biomedical revolution and technology enhanced medical care, the humanities are needed now more than ever before to bridge the divides that separate the physician from the patient, from self, from colleagues and society. The use of medical humanities in medical education softens total reliance on technology and treatment of the acute disease, enhancing the need to work on the art of medical practice and incorporate humanism so that the physician-patient relationship becomes more patient-centreed and empathetic.

Many physicians are beginning to believe that NM can provide the 'basic science' to honour patients who endure illness, and nourish physicians who care for them.

NM has been introduced into the curricula of only some medical schools in developed countries to strengthen reflection and self-awareness, and also to facilitate medical students' adoption of patients' perspectives with the hope of ultimately leading to more humane, ethical and empathetic healthcare[56]. Modern medicine and the

field of medical robotics could contribute to an increased decline of empathy in medical students in future, and therefore, it is important that more awareness about this meaningful and emerging discipline in medicine needs to be raised amongst medical academics.

Patients find words very helpful to contain the chaos of illness and enable them to endure it better[57]. Physicians, on the other hand, find writing about patients and themselves confers on medical practice a new understanding that is otherwise unobtainable[58]. NM humanises medical care and promotes empathy, and may indeed prove to be the remedy for low levels of empathy among doctors. NM enhances medical students' ability to empathise with the suffering of their patients as well as their own emotions by reducing the anxiety and threat that accompanies illness; thereby providing a psychologically-sound foundation for the development of self-reflection, inquiry and empathy[59].

NM promises to hold the answer to the current crisis in the physician-patient relationship. Its impact extends beyond empathy and compassion to patients; it also extends into physicians' own wellness. Medical educators should consider incorporating narrative writings not only in medical school but also in internship and post-graduate education, so that doctors learn to write about their patients in non-technical language. This would not only help them uncover knowledge about their patients, but also understand their own implicit feelings towards them and relieve stress and burn-out.

The teaching of NM in medical schools may indeed bridge the gap in empathy.

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