

NARRATIVE SENSITIVITY IN MEDICAL STUDENTS: A MIXED-METHOD EXPLORATION

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ABSTRACT

Objective. The paper introduced the concept of narrative sensitivity. The study aimed to identify the facets of narrative sensitivity (NS) in medical students and assess the changes in NS during undergraduate medical education.

Methods. A mixed method study was designed to explore NS. Data was collected from a group of students in their second year (N=50) and then in their fifth year (N=42) of their undergraduate education. The data was analysed using thematic analysis in accordance with consensual qualitative research. A coding system was developed to identify and refine the facets of NS. The theme frequencies were counted for each year separately and Fisher's exact test was conducted to assess the statistical significance of NS change between both years.

Results. Nine themes related to NS were identified in the data. The frequency of themes indicated a trend towards a decline in NS between the second and fifth years of undergraduate edu-

cation. However, the exploratory nature of this study and the small sample size did not allow any definitive conclusions regarding changes over time.

Conclusions. The findings raised doubts about the outcome of undergraduate education based on a narrow biomedical perspective. The study supported the arguments for giving emphasis on training of communication skills including narrative sensitivity during medical education.

key words:

narrative sensitivity,
narrative medicine,
medical education,
thematic analysis

klíčová slova:

narativní citlivost,
narativní medicína,
studium medicíny,
tématická analýza

INTRODUCTION

Following the narrative turn in psychology and social sciences, the metaphor of story and narrative was also adopted in medicine. The narrative medicine emerged to address issues such as the patients' subjective experience and existential themes, which were neglected in the biomedical model for a long time. Kleinman (1988) could be considered one of the first representatives of emerging narrative medicine. He introduced the distinction between disease (the medical definition of pathology based on clinical examination, including objective findings) and illness, which refers to the subjective experience of a patient (experience of symptoms, emotional response, explanatory models, etc.).

It was proposed that the processes of becoming ill, being ill, getting better (or getting worse), and coping (or failing to cope) with illness, can all be viewed as enacted narratives within the context of the wider stories of people's lives (Greenhalgh, 1999; Greenhalgh & Hurwitz, 1999). The concept of narrative was considered as a bridge between principles of evidence-based medicine and subjectivity of the patient (Kalitz-

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kus & Matthiessen, 2009). According to Launer (2018), the mission of narrative medicine has been to restore humanity, compassion, imagination, and moral engagement to the medical world. Charon (2001a, 2004, 2008) defined narrative competence as a set of skills required to recognize, interpret, and be moved by the stories one hears or reads. Regarding the clinical practice, she emphasized the physician's attentive listening during interactions with the patient and representation of both patient's experience and medical knowledge. She deemed those elements of narrative competence necessary for the physician's ability to interpret the patient's story and clinical judgment. Charon (2001a, 2004, 2008) suggested that a physician with narrative competence uses the time of a clinical consultation efficiently and is better able to integrate the medical knowledge with the patient's illness experience. Such a physician is better equipped to achieve the genuine intersubjective contact required for an effective therapeutic alliance (Charon, 2001a).

We propose the term narrative sensitivity as a first level of the Charon's (2001a, 2004, 2008) notion of narrative competence as a set of skills. We assume that narrative sensitivity might be an essential precondition for the more executive/behavioural level of a broader narrative competence. We argue, that before physicians can act in the way, which Charon suggested, they need to be aware of important factors such as the patient's experience (illness narratives) but also of the interplay of bio-psycho-social factors in health and illness. No matter how important and still not granted in clinical practice is the physician's ability to be attentive to the patient's experience, it may not be enough to move beyond the narrow biomedical model of health, illness, and treatment. Not only does this argument correspond with the development of narrative medicine but also with the discussions about which skills are necessary for the application of the bio-psycho-social model in medicine (Launer, 2018; McDaniel et al., 2014). Such discussion is particularly relevant in the Czech Republic, in which a growing community of health care professionals have been trying to foster the application of the bio-psycho-social model in medicine to catch up with some other countries in Europe (Poněšický, 2021; Stackeová, 2020).

The term narrative sensitivity has already been used by a few authors in the past. For instance, Wyatt (1986) and Edelson (1993) used the term within the narrative turn in psychoanalysis. These authors discussed the application of a narrative metaphor in the clinicians' active listening to the client's story within their life context and in the process of meaning-making, in which the clinician plays a significant role. Wyatt (1986) considered the sensitivity to the client's narrative as a way of listening to and organizing of both the client's story content and form. He also emphasised that narrative sensitivity referred not only to what was told, the so-called unconscious material and explicit meaning, but also to the not yet told or revealed, the unconscious material and implicit meanings. In addition, Cramer (1996) argued that narrative sensitivity included an alertness to the repetition of the story lines or patterns, although in multiple variations. She assumed that narrative sensitivity to this repetition was important for both assisting the storyteller to order and integrate his or her experience and also in psychology assessment, because the repetition of particular story lines in various forms and with different content inform about the storyteller's unique way of organizing experience (Cramer, 1996).

Our proposed conceptualisation of narrative sensitivity differs from those authors, who seemed to use the term predominantly in the psychoanalytical framework and/or regarding the psychological assessment. In our conceptualisation, we respond to the long-held discussions about the drawbacks of the narrow biomedical model such as neglecting the patients' (and the physicians') subjective experience, dehumanisation

of the patients, and downplaying the psychological and social factors in health and illness, etc. (Asen et al., 2001; Engel, 1977; Greenhalgh & Hurwitz, 1999; Irvin & Charon, 2017). Thus, we define narrative sensitivity tentatively as the physician's sensitivity to the patient's subjective experience, the physician's awareness of the interplay of bio-psycho-social factors in the patient's disease, including the awareness of the disease's impact on the patient's life. In our view, such sensitivity is necessary for the clinician's ability to perceive the disease not only as a biological phenomenon but also as a narrative disruption. In a similar vein, narrative sensitivity might be necessary for the clinician's ability to see the patient not only as an object of the diagnostics and treatment but also a person experiencing distress, whereby the disease (particularly long term, chronic, or serious one) interferes with his/her life and becomes a dominant plot in his/her life story (Frank, 1995; Chrz et al., 2006). We propose that narrative sensitivity is an important precondition for the physicians' flexible communication with their patients during the treatment, including empathic attunement and reflexivity (Huylter et al., 2013; Charon et al., 2016; Skorunka, 2020).

To conclude, in our conceptualisation of narrative sensitivity we bear in mind not only Charon's (2008) definition of narrative competence, subsequent development of narrative medicine, but also the critical reflection of the narrow biomedical model and the debate about communication skills in psychosomatic medicine based on the bio-psycho-social model. Within the development of narrative medicine, we try to address both the drawbacks of the narrow biomedical model we already mentioned, but also the issue of training the communication skills needed in clinical practice during the medical education (Charon et al., 2017; Launer, 2018; Skorunka, 2021).

There is still little research on training medical students in narrative skills and narrative-based medicine. Several studies explored reflective writing and expressive art to develop narrative competence and related skills among medical students and physicians (Dasgupta & Charon, 2004; Karnieli-Miller et al., 2021; Marchalik, 2017). An exploratory study showed that most of the undergraduate medical students, who attended a 6-week seminar focused on reading the patient's stories and training of reflective writing, reported that their ability to understand patients, empathize with them and take care of them improved due to the training (Shapiro et al., 2009). A comparative study revealed that medical students, who attended a course designed to enhance the ability to reflect on illness experience from the patient's point of view, were more able to feel empathy towards patients and their emotions, expressed their emotions more freely and assessed the clinical situation in a more complex manner (Wald & Reis, 2010). Levine et al. (2008) reported that a training in narrative medicine enhanced the medical students' perceived ability to communicate with the patients, empathic attunement to others, and the ability to reflect on their own work. The prompted narrative writing was found to promote reflective skill and self-awareness among internal medicine residents (Arntfield et al., 2013). Stanley and Hurst (2011) suggested that reflective writing allows professionals in a palliative care to develop a representation of their own emotions and of the patients' suffering. Narrative medicine was considered as an effective educational tool with measurable impact on development of various attitudes, knowledge, and skills. However, its long term impact on physicians' communication skills in clinical practice is still to be determined (Milota et al., 2019).

In this context, we designed an exploratory sequential mixed-method study (Creswell, 2014) to explore the concept of narrative sensitivity (NS). We aimed to 1. Identify and elaborate the facets of NS among undergraduate medical students and 2. Assess the change in NS during undergraduate study.

1. METHODS

1.1. Participants

The sample consisted of $N=50$ Czech medical students (66% males) in the second term of the second year of their undergraduate studies at Faculty of Medicine, Charles University, Czech Republic. We followed the same group of students three years later, in their second term of the fifth year of their undergraduate studies. The number of the participants three years later was lower ($N=42$, 67% males) because of absences or transfers to another university.

1.2. Analysts

D. S. was a psychiatrist and a psychotherapist with an academic background, trained in family therapy. T. K. was an undergraduate student in psychology with no clinical experience. T. R. was a psychologist and a Gestalt therapist.

1.3. Data collection

The participants in both years were exposed to a photograph of a patient with clear signs of a disease on the screen. The photograph was carefully selected from a free, publicly available sample of photographs of several anonymous patients. We deliberately chose a black-and-white photograph made in a plain documentary style without any artistic manipulation with the composition and/or the light to avoid any interference with the participants associations.

The students were instructed in the following way: 'When you see this photo, what comes to your mind? Please put all your ideas and impressions down on the sheet of paper'. The instruction was chosen to be as open as possible so as not to induce any preconceptions. No cues were provided regarding the concept of NS. Furthermore, voluntariness, anonymity, and confidentiality of the participants' responses were emphasized. The students had up to 30 minutes to respond to the instruction. The procedure was repeated with the same group of undergraduate students three years later.

We chose to carry out the study in the second and fifth years because of the aims and feasibility. In the second term of the second year, most students are already adapted to the challenges of medical studies. So far, they had only theoretical courses such as anatomy, histology, physiology, etc. From the fourth year on, the students had clinical courses at different departments at the University hospital. Arguably, such experience starts shaping their ideas about physician-patient communication in various clinical situations. During the final (sixth) year, all students had their rotations at different clinical departments in hospitals, so it would not be possible to reach them for the second phase of the study.

1.4. Data analysis

The data were analysed using thematic analysis according to Braun & Clark (2006) with elements of Hill et al.'s (2005) consensual qualitative research. First, D. S. and T. K. familiarized themselves independently with the data by repeatedly reading texts and generating tentative codes related to the concept of NS. In the subsequent phases, they searched for themes and refined them together. In this process, T. R. served as an auditor who provided independent reflections and suggestions at different phases of the analysis, which were then discussed by all three analysts. First, the data from the second year was analysed. When analysing data from the fifth year, we used the existing codes and themes wherever possible, with the openness to introduce new codes and themes where necessary. Each of the analysts brought a different perspec-

tive based on their distinct professional and personal experience. According to the Hill et al.'s (2005) principles of consensual qualitative research, all disagreements were discussed thoroughly until we found an interpretation we could agree upon. See Figure 1 for the delineation of the analytic process.

Consequently, we counted the theme frequencies (i.e., the number of students in whose response a theme was identified) for each theme in each year separately and assessed the change in frequencies between the second and fifth years (Tab.1). To prevent unwarranted generalizations, we conducted Fisher's exact test to determine the statistical significance of the change using R software version 3.6.3 (2020).

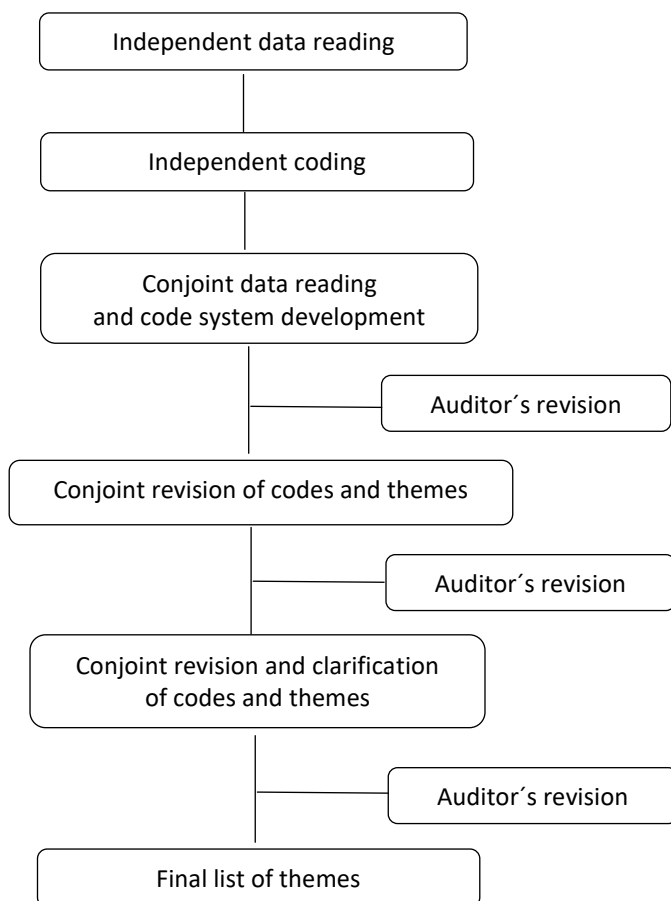


Figure 1 Phases of the analysis

2. RESULTS

2.1 Division of themes

We identified nine themes in the data from the second year that we found relevant regarding NS. No new themes emerged in the data from the fifth year. The list of themes and their frequencies is presented in Table 1. We divided the themes into those that defined NS positively and those that defined NS negatively.

The themes which we considered as defining NS positively met our tentative definition of the concept. Some of the themes derived from the data added other possible facets to our conceptualisation of NS (e.g., Existential reflection; Reflection on the patient's coping). All the themes defining NS positively reflected various aspects of the patient's disease experience including symptoms, illness narratives, interpersonal issues, and unique context of life story, which was disrupted by the chronic and potentially life-threatening health condition. On top of that, those themes also corresponded with a broader application of the narrative framework in medicine: a) the onset of a disease, the process of being ill, the treatment, and the coping strategies in such a potentially stressful situation can be understood as plots in a wider life story of the individual; b) the inclusion of the subjective experience of the individual in the overall picture of the disease and the process of being ill; c) an ethical dimension in recognizing the co-existence of various viewpoints regarding clinical situations, which may pose ethical dilemmas for the patients, their families and the healthcare professionals (Greenhalgh & Hurwitz, 1999; Charon et al., 2016; Skorunka, 2009). The theme *Reflection on the patient's life story* seemed to be the most prominent manifestation of NS, particularly in the text units obtained from the students in the 2nd year, because it included the narrative elements such as temporality, disease as a disruption of life story, disease as a plot in the wider story, etc. These narrative elements related to the disease experience were already discussed and researched by other authors (Frank, 1995; Chrz et al., 2002; Kleinman, 1988). It is also worth noting that the texts, which were analysed as themes defining NS positively, were mostly written in a narrative form, particularly by students in the 2nd year.

The themes, which seemed to be in contrast to both our conceptualisation of NS and a broader narrative framework in medicine, were considered as defining NS negatively.

2.2. Themes defining narrative sensitivity positively

Reflection on the patient's life story

We considered this theme to be the essence of NS. The excerpts showed some typical attributes of a narrative such as the presence of a plot, the imagination of the patient's subjectivity, temporality, and context. The following excerpt also presents disease as a narrative disruption:

'The picture evokes some anxiety and images of hopelessness regarding what happens to human beings when they fall ill. The man on the picture was, for sure, absolutely healthy and energetic and then the disease turned his life upside down. Now he is ill, perhaps he lost his strength to fight, his resigned look seems to tell that. He might even look forward to being dead so that his suffering will be over' (second year).

Expression of one's own emotions

Some students expressed their own emotional reactions. Some were positive, such as interest, care, curiosity, and compassion, others negative, including fear, despair, sadness, and hopelessness, as in *'The picture makes me feel a little bit anxious with a sense of hopelessness, when you imagine what it may look like when you fall ill...'* (second year).

Reflection on the patient's subjective experience

These excerpts captured the patient's subjective experience related to illness, its symptoms, and the treatment. Sometimes the participants used direct speech, assuming with the intention to emphasize the feelings and experience: *'Disappointed, sad,*

accusing look, searching a bit of hope. He is saying: "Should I really give up?" (fifth year). This can be interpreted as empathizing with the patient, 'putting oneself in his shoes'. Occasionally, the excerpts overlapped with *Expression of one's own emotions*, when the students tried to imagine what it was like for the patient, hypothesized about the patient's emotions, and sometimes even imagined how they would feel in such a situation themselves:

'The patient appears spacey, not because of medication, but because he is exhausted. The lips look as if they wanted to say something, maybe wanting to express anger towards the physician or wanting to ask a question if what the physician told him was really true. The hand is lying loosely and almost without any life, any feeling, as if he does not believe it belongs to him.' (second year).

Awareness of other perspectives

In this category, the students' responses showed a degree of uncertainty regarding the disease, the patient's subjective experience, or life circumstances. This was expressed not only by the content of the text units but sometimes even by using qualifiers such as 'perhaps', 'maybe', and 'what if'. We considered the awareness of other perspectives and alternative explanations to be an essential component of NS.

Reflection on the patient's coping

In most text units belonging to this theme, the students hypothesized about the patient's resignation, hopelessness, and lack of strength due to a disease. Sometimes they used the metaphor of a war or battle: *'He looks resigned as if he already stopped fighting and gave up the battle with the disease. His eyes might be saying this: So, could you cut me off, will you?'* (fifth year). Occasionally, they hypothesized about the patient's attitude towards physicians or the treatment.

Existential reflection

The participants shared their thoughts about existential aspects of the human life. Their responses were related to phenomena such as the gravity of a disease, pain, loneliness, suffering, and death: *'(...) death, the end of life. I can see a patient in the terminal stage of a disease, who is reconciled with death'* (fifth year). In our view, this theme can serve as a bridge to the patient's subjective experience.

Reflection on the patient's relational context

In this theme, the participants expressed their thoughts about the patient's family and close ones. Some participants wondered if the patient had the social support he might need: *'He looks lonely, which makes me think whether he has got a family or friends, someone, who could look after him.'* (second year). In our view, the relational context of a patient's life story is an important dimension of NS.

2.3. Themes defining narrative sensitivity negatively

Description of the patient's appearance

These descriptions were often rather simple and focused on physical features. Sometimes, they were expressed with a moral judgement and/or revealed the students' stereotypical thinking about the patient. These descriptions, sometimes combined with a dispassionate clinical assessment, can be interpreted as examples of detachment and dehumanization, which stand in striking contrast to NS.

'There is a patient with scars in the abdominal region. In the thoracic area, there is a plaster covering the wound from the central catheter. The patient seems to be a male

around 50, looking feminine, possibly because of hormonal treatment. I reckon he is treated for prostate cancer in a generalizable state. On the other hand, the “scars” might be signs for targeting the radio-oncological treatment.’ (fifth year).

Downplaying the subject

Only few excerpts were difficult to comprehend, such as the following: ‘*Kojak, pregnant woman, Hawaii, 8bit hand, mafia, what do you want? Just lying here and you disturb...*’ (second year). We hypothesized that in those texts the participants might have either expressed disinterest in the study or even attempted to avoid participating by not being serious. A lack of a sincere concern for the patient is in contradiction with NS.

2.4. Frequencies and change

The most frequent theme in both years was *Reflection on the person’s subjective experience*, a theme closely related to the concept of NS. There was a clear trend towards a decrease in themes positively defining NS and an increase in those negatively defining NS between the second and the fifth year. However, only the decrease in *Awareness of other perspectives* and the increase in *Description of the person’s appearance* reached statistical significance due to the small sample size. Furthermore, we noticed a marked difference in the form of reflective writing as well. In the fifth year, the students used medical jargon more often, the text units were generally shorter and more structured, resembling a formal health record rather than a fluent narrative.

We also identified three themes as irrelevant to the concept of NS. These included clinical reflections about the patient’s health condition, reflection about the health care system, and therapeutic suggestions. Those themes did not seem to correspond either with our tentative conceptualisation of NS or the broader narrative framework in medicine.

Table 1 Themes and their frequencies

Theme	Frequency (%)		Difference <i>p</i>
	second year (<i>N</i> = 50)	fifth year (<i>N</i> = 42)	
Reflection on the person’s subjective experience	36 (72%)	34 (81%)	.339
Reflection on the person’s health condition	28 (56%)	35 (83%)	.007**
Expression of one’s own emotions	23 (46%)	12 (29%)	.131
Awareness of other perspectives	19 (38%)	6 (14%)	.018*
Reflection on the person’s coping	16 (32%)	10 (24%)	.487
Existential reflection	6 (12%)	6 (14%)	.766
Reflection on the person’s relational context	6 (12%)	4 (10%)	.750
Reflection on the health care system	3 (6%)	5 (12%)	.462
Description of the person’s appearance	15 (30%)	21 (50%)	.057(*)
Therapeutic suggestions	8 (16%)	11 (26%)	.303
Downplaying the subject	4 (8%)	4 (10%)	1.00
Reflection on the person’s life story	16 (32%)	13 (31%)	1.00

Note. The frequency represents the number of students in whom a theme was identified. The differences between the second and fifth years were tested using Fisher’s exact test. ** *p* < .01, * *p* < .05, and (*) *p* < .10.

3. DISCUSSION

Because undergraduate medical study in our country is characterized by little emphasis on physician-patient communication skills including narrative sensitivity and neglecting of bio-psycho-social perspective in medicine, we designed a study to explore the concept of NS among undergraduate medical students. We identified nine themes that captured various aspects of NS in students' responses to a photograph of a patient. Both the content and form of participants' text units varied in each year's sample. Whereas some participants showed a marked propensity for an awareness and reflection of one's own and the patient's subjective experience and empathizing with the patient, others were focused more on the so-called objective aspects of being ill. Some participants seemed to be well aware of the interpersonal situation of the patient, existential issues, and context of being treated in a hospital, while others were interested only in biological aspects of a disease and medical treatment. Various terms and concepts from different disciplines might come in mind here, for instance empathy (psychology, psychotherapy), mentalisation (psychoanalysis), and representation (psychology, neuroscience). Charon (2008) used the term representation and considered it as one of the key elements of her notion of narrative competence. However, such a comparative discussion is beyond the scope of as well as limits for this paper.

In terms of the form of writing, the text units from the second year were mostly lengthy, imaginative, and rich in narrative. The text units from the fifth year tended to be rather brief, structured, as if resembling a formal health record rather than a fluent narrative. The participants in the fifth-year sample used medical jargon including diagnosis and technical terms. At the same time, the subjectivity of the patient was often missing, the participants' stance towards the patient on the photograph could be characterized as a professional detachment.

Regarding the frequency of themes essentially related to NS, the participants' text units often included various facets of NS, particularly in the second year. However, the changes in the frequency of themes between the second and fifth years of the undergraduate study was notable. We observed an increased frequency of themes negative or irrelevant to NS and a decreased frequency of themes positive to NS. However, the exploratory nature of this study and the small sample size did not allow us to make any generalizations.

The changes between the second and fifth years of the undergraduate study could be interpreted in the context of the Faculty's medical curriculum. Students have only clinical subjects from the fourth year of their undergraduate study on and, arguably, start to focus more on objective measures of a disease and keep a distance from the patients. We call this a manifestation of emerging clinical mentality, which stems from observing various clinical situations and social learning from their teachers' interactions with patients in university hospital departments.

Our findings correspond with those of Lim et al.'s (2013) who reported a decline in expressed empathy in medical students during undergraduate study and attributed it to a lack of empathic role models during clinical training and a focus on diagnostic skills. For instance, Coulehan (2005) argued, that any effort of passing on the humanistic principles to medical students during their studies is in vain, since later in the clinical setting they implicitly adopt the communication patterns based on emotional distance, and a focus on objective aspects of a disease. Such communication patterns might later affect both the clinical treatment process and outcome (Rakel et al., 2011). On the other hand, an internal process of emotional detachment might play a role as well. The thing is that admitting one's (and the patients') subjectivity does not seem to be an adaptive strategy during the medical study, which primarily favours memorizing

a huge amount of knowledge and objectification over personal development including reflective and narrative modes of learning (Baessler et al., 2019; Skorunka, 2020). Focusing on the subjectivity can be perceived by some teachers and clinicians as a lack of professionalism or even a sign of weakness.

Some recent studies focused on the outcome of the programs designed to foster the development of both narrative and reflective skills during medical study (Caverly et al., 2018; Karnieli-Miller et al., 2021). The results of those studies might suggest that the clinician's ability to reflect on the patient's experience including the illness narratives, emotional response, and the disease as the main plot in the wider life story is one of the key element of narrative skills including narrative sensitivity. The unique life context does matter because falling ill in a particular moment or stage of life, metaphorically speaking during the time between the cradle and the grave, brings about different experience, challenges and illness narratives. Arguably, the essence of narrative sensitivity is the ability to capture the complexity of the life story with the disease as its main plot without reducing the illness narratives only to the symptoms objective data, and nosological category.

On top of that, the ability to perceive the perspective/experience of the other is crucial in the treatment – the process of collaboration between the physician and the patient. Due to the physician's expert position and the asymmetry of power between him or her and the patient, the physician inevitably plays a significant role in the co-construction of a story, which is meaningful for the patient. The narrative is not only a means for sharing the disease experience but also a way of organizing such distressing, identity shattering experience (Chrz et al., 2006; Kleinman, 1988). In our view, the physician 'equipped' with narrative sensitivity may be more able to validate the patients' experience, give voice to their suffering, foster the personal agency, and reconstruction of identity, etc. It also should be noted, that from an ethical viewpoint, illness narratives may have several potential interpretations, but it is the patient who should be the main 'author' of his or her own life story disrupted by the disease, if possible (Elwyn & Gwyn, 1991; Greenhalgh & Hurwitz, 1999; Jones & Hudson, 1999; Launer, 1999, 2018).

In this context, our research findings exposed the drawbacks of undergraduate medical study based solely on the biomedical model. If medical students lose their ability to reflect on their own and the patient's subjective experience during undergraduate years, they may have difficulty in communicating with their patients in the beginning of their career. As a result, they might struggle to develop a trustful, collaborative relationship with their patients and to cope appropriately with emotionally challenging situations in clinical practice. On top of that, McLeod (2007) argued that the increasing use of biotechnology raises the danger of further dehumanization of patients and neglecting their needs. A rapid biotechnological advancement combined with the narrow biomedical model contributes to so called profound divisions between doctors' and patient's position and experience with regard to illness beliefs, subjectivity, context, and mortality (Charon, 2008). In our view, NS encompasses all those issues and could serve as a bridge across those divisions.

Consequently, the main implication of our research is a proposal for a shift in medical education towards a balance between theoretical knowledge and instrumental skills, on the one hand, and communication skills, including NS, on the other. Such a balance is necessary if we expect future physicians to practice medicine based on the bio-psycho-social model, which integrates psychological and psychotherapeutic knowledge into medical care. For instance, the essential psychological and psychotherapeutic principles necessary in medicine and other helping professions are outlined in the concept of embedded counselling (McLeod & McLeod, 2011). In a similar

vein, the contextual model of psychotherapy emphasizes the role of a therapeutic relationship and healing context as crucial factors in treatment (Wampold & Imel, 2015). In our view, narrative skills including NS are an important part of these inspirational sources and should be integrated in the undergraduate medical education. Several authors suggested that such principles and factors are important elements of integrated treatment for patients particularly, but not exclusively, with chronic disorders, mental disorders, and medically unexplained symptoms (Chvála et al., 2012; McDaniel et al., 2014; Skorunka, 2019).

The study has several limitations. First, each analyst brought their own preconceptions and biases. We strived to reflect on these through an open discussion. Second, it could be argued that some participants might have preferred positive ideas regarding the patient on the photograph and deferred the negative ones because of their expectations of socially accepted expressions. However, the frequency of the expressed negative attitudes towards the patient on the photograph indicates that the participants were not afraid to express ideas charged with negative emotions or moral judgement. Third, some text units had ambiguous meaning that made them difficult to categorize. The design of the study did not allow us to ask the participants for clarifications or further elaboration. Fourth, the data in this study were not based on real communication situations, therefore, we might have missed some important aspects of the NS that did not manifest in the written self-reflections. Fifth, a different picture might have generated different responses and, possibly, different themes. Sixth, a small sample size and the explorative design of the study prevented us from rigorously testing the change over time. Seventh, the absence of a control group did not allow us to control for the effect of maturation. Eighth, given the small sample size, the dropout of eight students could have biased the statistical testing. The use of a paired test and the exclusion of these eight students would be preferable. However, the data were collected anonymously and, therefore, could not be paired. Despite the limitations, the study findings could inspire transformation of undergraduate medical training especially in medical faculties, in which the curriculum is still based on biomedical model lacking the emphasis on the future physicians' communication skills and bio-psycho-social complexity. Further research is needed to understand how to best train future physicians in NS as a part of communication skills development.

4. CONCLUSION

In conclusion, various aspects of NS could be clearly identified in medical students' written responses to a photograph of a patient. We also documented a trend for a decline in NS between the second and fifth years of the undergraduate medical training, although our method did not allow us to make rigorous conclusions about these changes. In our view, NS is an essential first level of the set of the Charon's broader narrative competence. It enables the physician to perceive and validate various aspects of the patients experience within the life story, which is disrupted by the disease (symptoms, illness narratives, emotional response, unique context of life story, identity issues, interpersonal context etc.). NS could be understood as a cognitive and affective shift in the clinician's mindset, originally trained in the narrow biomedical model, towards an awareness of the patient's subjective experience including the illness narratives, one's own experience in the clinical encounters, and the interactions during the treatment.

Despite the limitations, the research supports the suggestions for integrating relevant psychological and psychotherapeutic knowledge into medicine in order to embrace the bio-psycho-social complexity of health, illness, and treatment. It goes well along with calls for interactive, communication-oriented teaching methods during

undergraduate medical study and arguments for integrative, bio-psycho-social model in medicine (Baessler et al., 2019; McDaniel et al., 2014; Rolland, 2018; Skorunka, 2021). Thus, the research might serve as an inspiration for changes in medical curriculum towards an emphasis on bio-psycho-social model and communication skills including the training of narrative sensitivity.

REFERENCES

- Arntfield, S. L., Slesar, K., Dickson, J., & Charon, R. (2013). Narrative medicine as a means of training medical students toward residency competencies. *Patient Education Counselling*, 91(3), 280-286. <https://doi.org/10.1016/j.pec.2013.01.014>
- Asen, E., Tomson, D., Young, V., & Tomson, T. (2004). *Ten minutes for the family. Systemic interventions in primary care*. Routledge.
- Baessler, F., Zafar, A., Schweizer, S., Ciprianidis, A., Sander, A., Preussler, S., Honecker, H., Wolf, M., Bartolovic, M., Wagner, F. L., Klein, S. B., Weidlich, J., Ditzen, B., Roeschely, D., Nikendei, Ch., & Schultz, J.-H. (2019). Are we preparing future doctors to deal with emotionally challenging situations? Analysis of a medical curriculum. *Patient Education Counselling*, 103(7), 1304-1313. <https://doi.org/10.1016/j.pec.2019.02.024>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Journal of Qualitative Research in Psychology*, 3(2), 77-101.
- Coulehan, J. (2005). Viewpoint: today's professionalism: engaging the mind but not the heart. *Academic Medicine*, 80(10), 892-898. <https://doi.org/10.1097/00001888-200510000-00004>
- Cramer, P. (1996). *Storytelling, narrative and the thematic apperception test*. Guilford.
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative and mixed methods approaches*. Sage Publications.
- Dasgupta, S., & Charon, R. (2004). Personal illness narratives: Using reflective writing to teach empathy. *Academic Medicine*, 79(4), 351-356. <https://doi.org/10.1097/00001888-200404000-00013>
- Edelson, M. (1993). Telling and enacting stories in psychoanalysis and psychotherapy. implications for teaching psychotherapy. *The Psychoanalytic Study of the Child*, 48(1), 293-325. <https://doi.org/10.1080/00797308.1993.11822389>.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129-136.
- Frank, A. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago University Press.
- Greenhalgh, T. (1999). Narrative based medicine in evidence based medicine world. *British Medical Journal*, 318(7179), 323-325. <https://doi.org/10.1136/bmj.318.7179.323>
- Greenhalgh, T., & Hurwitz, B. (1999). Narrative based medicine; Why study narrative? *British Medical Journal*, 318(7175), 48-50. <https://doi.org/10.1136/bmj.318.7175.48>
- Hill, C. E., Know, S., Thompson, B. J., Nutt Williams, E., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counselling Psychology*, 52(2), 196-205. <https://doi.org/10.1037/0022-0167.52.2.196>
- Huyler, F. (2013). The woman in the mirror. *Academic Medicine*, 88(7), 918-920. <https://doi.org/10.1097/ACM.0b013e3182959e16>
- Charon, R. (2001a). Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA*, 286(15), 1897-1902. <https://doi.org/10.1001/jama.286.15.1897>
- Charon, R. (2004). Narrative and medicine. *New England Journal of Medicine*, 350(9), 862-864. <https://doi.org/10.1056/NEJMp038249>
- Charon, R. (2008). *Narrative Medicine, Honouring the Stories of Illness*. Oxford University Press.
- Charon, R., DasGupta, S., Hermann, N., Irvine, C., Marcus, E. R., Colson, E. R., Spencer, D., & Spiegel, M. (Eds.) (2017). *The principles and practice of narrative medicine*. (Eds.) (2017). *The principles and practice of narrative medicine*. Oxford University Press.
- Charon, R., Hermann, N., & Devlin, M. J. (2016). Close reading and creative writing in clinical education: teaching attention, representation, and affiliation. *Academic Medicine*, 91(3), 345-350. <https://doi.org/10.1097/ACM.0b013e3182959e16>
- Chrz, V., Čermák, I., Plachá, V. (2006). Porozumění zkušenosti nemocných rakovinou: narativní přístup. *Československá psychologie*, 50(6), 507-521.
- Chvála, V., Trapková, L., & Skorunka, D. (2012). Social uterus; Developmental concept in family therapy for psychosomatic disorders. *Contemporary Family Therapy*, 34(2), 293-312. <https://doi.org/10.1007/s10591-012-9197-3>.
- Irvine, C., & Charon, R. (2017). Deliver us from certainty: Training for narrative ethics. In R. Charon, S. DasGupta, N. Hermann et al. (Eds.), *The Principles and practice of narrative medicine* (pp. 110-136). Oxford University Press.
- Kalitzkus, V., & Matthiessen, P. F. (2009). Narrative-based medicine: Potential, pitfalls, and

- practice. *The Permanente Journal*, 13(1), 80-86. <https://doi.org/10.7812/tpp/08-043>
- Karnieli-Miller, O., Michael, K., Gothelf, A. B., Palombo, M., & Meitar, D. (2021). The associations between reflective ability and communication skills among medical students. *Patient Education and Counselling*, 104(1), 92-98. <https://doi.org/10.1016/j.pec.2020.06.028>
- Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic Books.
- Launer, J. (2018). *Narrative-based practice in health and social care: conversations Inviting change* (2nd ed.). Routledge.
- Levine, R. B., Kern, D. E., & Wright, S. M. (2008). The impact of prompted narrative writing during internship on reflective practice: a qualitative study. *Advances in Health Science Education*, 13(5), 723-733. <https://doi.org/10.1007/s10459-007-9079-x>
- Lim, B., T., Moriarty, H., Huthwaite, M., Gray, L., Pullon, S., & Gallagher, P. (2013). How well do medical students rate and communicate clinical empathy? *Medical Teacher*, 35(2), 946-951. <https://doi.org/10.3109/0142159X.2012.715783>
- Marchalik, D. (2017). The return to literature-making doctors matter in the new era of medicine. *Academic Medicine*, 92(12), 1665-1667. <https://doi.org/10.1097/ACM.0000000000001986>
- McDaniel, S., Doherty, W., & Hepworth, J. (2014). *Medical family therapy and integrated care* (2nd ed.), American Psychological Association.
- McLeod, J. (2007). *Counselling Skill*. Open University Press.
- McLeod, J., & McLeod, J. (2011). *Counselling Skills: A Practical Guide for Counsellors and Helping Professionals* (2nd ed.), Open University Press.
- Milota, M. M., van Thiel, G. J. M. W., & van Delden, J. J. M. (2019). Narrative medicine as a medical education tool: A systematic review. *Medical Teacher*, 41(7), 802-810. <https://doi.org/10.1080/0142159X.2019.1584274>
- Poněšický, J. (Ed.) (2021). *Duše a tělo v psychosomatické medicíně*. Triton.
- R Core Team (2020). R: A language and environment for statistical computing. R Foundation for Statistical Computing. <https://www.R-project.org/>.
- Rakel, D., Barrett, B., Zhang, Z., Hoeft, T., Chewing, B., Marchand, L., & Scheder, J. (2011). Perception of empathy in the therapeutic encounter: effects on the common cold. *Patient Education and Counselling*, 85(3), 390-397. <https://doi.org/10.1016/j.pec.2011.01.009>
- Rolland, J. (2018). *Helping couples and families navigate illness and disability; An integrated approach*. Guilford Press.
- Shapiro, J., Coulehan, J., Wear, D., & Montello, M. (2009). Medical humanities and their discontents: definitions, critiques, and implications. *Academic Medicine*, 84(2), 192-198. <https://doi.org/10.1097/ACM.0b013e3181938bca>
- Skorunka, D. (2009). Životní příběhy jako základ psychosomatické medicíny. *Psychosom*, 7(1), 24-44.
- Skorunka, D. (2019). Mental health; Arguments for integrative bio-psycho-social model. *Psychiatria - Psychoterapie - Psychosomatika*, 26(4), 10-18.
- Skorunka, D. (2021). Integrativně a dialogicky; interdisciplinární spolupráce v psychosomatické medicíně. In J. Poněšický (Ed.), *Duše a tělo v psychosomatické medicíně* (pp. 303-340). Portál.
- Skorunka, D. (2020). Lékaři v médiích aneb stojí výroky kolegů za pozornost, souhlas či polemiku? Netradiční úvaha o psychosomatické medicíně. In D. Stackeová (Ed.), *Psychosomatická medicína – nástroje psychosomatické léčby* (pp. 60-91). Palestra.
- Stackeová, D. (Ed.) (2020). *Psychosomatická medicína – nástroje psychosomatické léčby*. Palestra.
- Stanley, P., & Hurst, M. (2011). Narrative palliative care: a method for building empathy. *Journal of Social Work in End-Life and Palliative Care*, 7(1), 39-55. <https://doi.org/10.1080/15524256.2011.548046>
- Wald, H. S., & Reis, S. P. (2010). Beyond the margins: reflective writing and development of reflective capacity in medical education. *Journal of General Internal Medicine*, 25(7), 746-749. <https://doi.org/10.1007/s11606-010-1347-4>
- Wampold, B., & Imel, Z. (2015). *The great psychotherapy debate* (2nd ed.). Routledge.

SOUHRN

Narativní citlivost u studentů medicíny; smíšená explorativní studie
 Cíl. Narativní koncept obohatil kromě psychologie a psychoterapie také medicínu. V zahraničí došlo ke vzniku vzdělávacích programů v narativní medicíně zaměřených na rozvoj narativních dovedností u studentů medicíny a začínajících lékařů. V této souvislosti text představuje pojem narativní citlivosti. Cílem explorativní studie bylo identifikování fází narativní citlivosti u studentů medicíny a posouzení změn v narativní citlivosti u těchto studentů v průběhu pregraduálního studia. *Soubor a metody*. V rámci smíšené explorativní studie byla od dospělých účastníků výzku-

mu získána data v podobě písemných výpovědí v reakci na podnětovou fotografii nejprve ve druhém ročníku pregraduálního studia medicíny (N = 50) a posléze v pátém ročníku (N = 42). Data byla analyzována metodou tematické analýzy s prvky konsenzuálního kvalitativního výzkumu. Byl vytvořen kódovací systém s cílem identifikování fází narativní citlivosti. Četnost témat byla kvantifikována v každém ročníku zvlášť a k posouzení statistické významnosti změny v narativní citlivosti u studentů během tří let studia byl použit Fisherův test.

Výsledky. Během textové analýzy bylo identifikováno devět témat relevantních ke koncep-

tu narativní citlivosti. Četnost témat naznačila pokles narativní citlivosti u studentů medicíny mezi druhým a pátým ročníkem pregraduálního studia. Nicméně explorativní design studie a malý soubor neumožnily učinit definitivní závěr týkající se posouzení změny narativní citlivosti v čase.

Závěr. Navzdory limitům studie výsledky vyvolávají pochybnosti o výsledcích pregraduálního studia medicíny založeném na biomedicínském modelu. Studie podporuje argumenty pro větší důraz na rozvoj komunikačních dovedností včetně narativní citlivosti u budoucích lékařů během studia medicíny.