The value of narratives in the practice of internal medicine

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Los médicos no pueden penetrar en los dominios de lo incomunicable
(o de lo que es extremadamente difícil de comunicar)
a menos que se conviertan en un compañero de viaje de sus pacientes,
los acompañen en sus exploraciones, se muevan constantemente en su compañía
y descubran con ellos una experiencia viva, exacta y lenguaje figurativo
que les permite comunicar lo que parecía incomunicable.
OLIVER SACKS (1933-2015)

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Abstract

Physicians' work requires narrative skills, as they must be able to recognize, absorb, interpret and act in response to the stories shared by their patients, from a biopsychosocial perspective that can elucidate the very environment in which the disease develops. The idea is to preserve a solemn setting in which authentic empathy for the other person through listening becomes a strong bridge between modern biomedicine and the lived experience of the person seeking assistance. This essay attempts to elucidate, through a concise historical perspective, the need to implement narrative medicine skills within internists' training, which will also promote reflection and self-awareness to complement evidence-based medical practice. **(Acta Med Colomb 2024; 49. DOI: https://doi.org/10.36104/amc.2024.3135).**

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Historically, internal medicine had its origins in the narrative surrounding the development of the scientific method. Bacteriology, chemistry and physics progressed notably in the second half of the 19th century. Their discoveries began to be related to clinical medicine and the rise of experimental medicine guided by Claude Bernard, who adopted the biological sciences method (1). This cultural process had effects in Germany, generating favorable action aimed at incorporating the scientific developments for researching the inner nature of diseases, adopting new technological resources to aid or hone the semiological diagnosis, testing new treatments and objectively evaluating the advantages and disadvantages of the old and new treatments, within clinical medicine. As part of these changes, physiology, anatomy, histology and other biological sciences gave rise to pathophysiology. The terms "internal medicine" and "internist" were born around 1880, in the German medical setting, representing the sum of several experimental disciplines encountering the health-disease process (1,2).

Sir William Osler, the famous Canadian physician, gave the definitive boost to internal medicine on the American continent, by founding his own school of clinical medicine at Johns Hopkins University Hospital in Baltimore (3). From there, through a firm belief in transmitting the knowledge of that era to future generations of physicians, he was able to break away from fallacies that called into question things like antiseptic measures to prevent bacterial infections.

Thus, his persistent transdisciplinary work in the practice of clinical medicine, echoed by his own fellow students, gave rise to the book *"The Principles and Practice of Medicine: Designed for the Use of Practitioners and Students of Medicine," published in 1892, in which, with quiet skill, he examined, explored and reflected on the nooks and crannies of professional practice, under the precept of understanding medicine as "a science of uncertainty and an art of probability." It could be stated, then, that with devoted narrative talent, Osler was able to construct the western school of internal medicine, as we know it today. Without a doubt, this historical fact was consolidated in the book "Aequanimitas," which was first launched in 1904, defining the practice of this branch of medicine as "the calmness, serenity, equanimity and transparency" that the*

physician should have in the face of any adversity related to the medical act (3, 4).

Thus, we address an initial historical encounter, an anecdotal pact to help us understand the narrative not as a trivial story, but rather as the collection of verbal and nonverbal structures erected around a shared story between the narrator (sick person/patient) and the interpreter (physician/clinician). Modernity brought with it a series of scientific advances which, in the field of medicine, have not only improved the diagnosis and treatment of diseases, but also patients' quality of life. This is an undeniable achievement; however, the development of new diagnostic techniques and technologies and the brief time allocated for healthcare appointments have led to the clinical encounter and patient-clinician interaction being increasingly tenuous (5). Therefore, the ability to understand the complexity of the clinical encounter, in which the subjectivity of the patient and clinician, the scientific-technical knowledge and the experience provided by each author have a part, is less appreciated (Figure 1).

Narratives have been used as research instruments in other social science fields. Authors like Edward Bruner (6) state that anthropologists do not construct stories from the data, but rather discover data through accounts that shape their perspective of the field. The same author underscores that "the narrative structures constructed by scholars are not secondary narratives built on the data, but rather primary narratives that determine what is considered to be data." This is interesting, considering that the medical act has an implied scope that covers not only the subjective aspect but also the entire social and cultural framework that emerges from the suffering human being who, through this same suffering, questions, interprets and challenges his/her own reality. All of this is included in the elusive meaning of the medical history, which, for the sake of time, is taken in an unconscious and (generally) inflexible manner, sacrificing the diagnostic threshold for a comprehensive therapeutic goal, which inevitably begins with an invisible connection: the seal of trust, the harbinger of confidentiality that can cut across an apparent power relationship.

We can consider the clinical encounter as a dynamic interpretation space that is based, on the one hand, on dialogue and understanding and, on the other, on relief and cure or mitigation of suffering. It, in turn, consists of three acts: 1) taking an adequate medical history; 2) performing a complete physical exam; and 3) a rational use of laboratory tests and diagnostic imaging. These acts lead to the integration of data with scientific knowledge, which will result in assigning a diagnosis and respective treatment plan (7). However, each clinical encounter has its idiosyncrasies, as it depends, among other things, on the type of clinician and the needs of each person seeking care. And this is where medicine goes beyond a merely mechanistic side to coalesce in artistic virtues: a good clinician is also a taster of silences immersed in the ambivalent nature of human beings.

Unquestionably, understanding others begins with a dialogue that is sufficiently purged to allow the physician to simultaneously extract determinant aspects for a specific intervention, aspects akin to careful listening and a guided, methodical and neat interview. In his book, Truth and Method I (8), Hans-Georg Gadamer stated that genuine conversation is an essential way of "being with others," coded in three levels of conversation in the relationship between two people: openness to the other's position (starting from oneself), the essence of the question (from a hermeneutic perspective, assuming the unknown and indeterminate in the other person), and the idea of possibilities, that is, that based on a personal experience in a given situation, consensual decisions between the physician and patient can be made.

This calls to mind one of the most famous phrases attributed to Claude Bernard, a French physiologist and remarkable figure in the history of medicine: "…sometimes to cure, often relieve, always console" (9). Thus, narrative competence in medicine emerges as an interpretive act that requires the acknowledgement of an unknown and unique phenomenon that we will only be able to understand through close and true communication with the patients in which they can reveal their vulnerability through a story consistent with their symptoms, and the clinician can identify this personal experience to interpret it in its subjectivity, using accessible language with few technical terms foreign to the empathetic relationship that should be intentionally sought beginning with this first human contact.

During the final decades of the twentieth century, and almost simultaneously, movements arose in Europe and the United States in response to the tedium linked to the practice of mass medicine, which was technified, devoid of dialogue and at risk of dehumanization. These movements were led by British researchers Trisha Greengalhd and

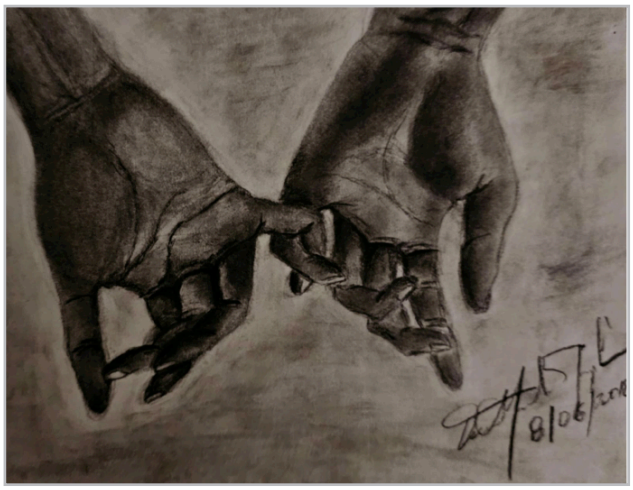

Figure 1. *As expressed by Siri Hustvedt in her book of essays "Living, Thinking, Looking" (2013), no one can escape their subjectivity. There is always a "me" or an "us" hidden somewhere in the text, even if the pronoun itself does not appear. Charcoal drawing titled "From the hands as revealing symbols." Courtesy of Dr. Óscar Reyna-Carrasco (original author).*

Brian Hurwitz, as well as Rita Charon, a North American internist who coined the term "narrative medicine" in 2001 (10) to establish it as a model for humane and effective medical practice, as this requires narrative skill (namely, the ability to recognize, absorb, interpret and act in others' stories and conditions). That is, to return to basics, under a parable similar to Nietzsche's philosophical concept of the "eternal return."

Exploring these language channels (that is, narratives in the clinical context), either from a research perspective or as part of the office visit, broadens the horizon of professional knowledge and practice. Therefore, including them in an educational plan will help achieve a balance between the different contents implemented through the pedagogical guidelines and didactic strategies of any internal medicine training program.

In line with the mission and vision of the specific university project at Universidad de Antioquia (11) which, under a "full exercise of its autonomy commits to the comprehensive training of human talent, with the criteria of excellence, knowledge creation and dissemination in the various fields of knowledge, and the preservation and revitalization of the cultural heritage," [translated] we propose that implementing a microcurriculum on medical narratives meshes perfectly with the university mission axes of teaching, research and expansion stipulated by the Department of Internal Medicine, based on a theoretical foundation of basic concepts from some literary genres.

Implementing the so-called "cognitive paradigm," in which the one who teaches and the one who learns are transformed into a dialogical relationship in which "educating is no longer leading, carrying, but rather forming, developing. Teaching is no longer showing, delivering, informing, but rather stimulating, promoting, tempting, seducing. Learning is no longer acquiring information but rather constructing objects of knowledge with tools from one's own thought" (11), implies mastery of some fundamental communication tools which cannot be passed over in an internal medicine training program without first promoting them through the medical act. Thus, as Albert Einstein said in an interview in 1926, "imagination is more important than knowledge. Knowledge is limited while imagination embraces the entire world" (12), which delves into the importance of absorbing, intuiting and interpreting beyond the doctrine that addresses the patient as a group of facts that lead to a specific diagnosis.

Establishing a conscious relationship with the environment is not a simple task. It involves, as noted in the internal medicine curriculum at Universidad de Antioquia (13), helping students develop skills to enable them to actively process knowledge, to "learn to learn". This confronts the students with the growing complexity of knowledge, providing elements that help them process knowledge, retain, analyze and understand information, develop synthesis processes and, finally, apply what has been processed and grasped to transform the milieu and intervene in the world of life and death, health and disease (14).

The different definitions in the literature indicate that the internist is the axis around which the entire healthcare team moves, representing the role of advisor, consultant and integrator of other specialists, while avoiding fragmentation of the patient's care, through comprehensive care of adolescents, adults and older adults, based on scientific and humanistic training (15). Although internists' professional practice has been linked to the constant endeavor for high diagnostic and therapeutic precision, it is clear that the dizzying pace at which professional practice is advancing will preclude them from staying up to date with the vast knowledge in all the internal medicine fields. Therefore, they must act with prudence and scientific rigor, from a transdisciplinary perspective that rests on their communication skills and, above all, their humanity.

On the other hand, the physician's underlying ethical actor should be prioritized over the teaching role required of him/her in the care setting. Drawing from its traditional philosophical definition, ethics is related to a reflection on ethos; that is, the character, disposition or habit whose subject of study (or part of its subject) is morality, studied through social interaction (16). This is relevant to the degree that internist training is linked to the oral tradition in medicine and the teaching of good medical practice, often disregarding the individual's integrity in values and the impact this can have even within the dynamics of a given healthcare ecosystem.

Thus, the goal of performing effectively within the current legal and ethical guidelines should be emphasized, to help solve not only the medical problems, but also the patients' social constraints in the context of their diseases, based on a constantly reflexive attitude. Naturally, including training in complementary narrative skills within the technical-scientific training, as asserted by Rita Charon (17), will help examine and illuminate four of medicine's core situations: the physician and patient, the physician with him/herself, the physician and colleagues, and physicians and the society, through methods like reading literature and writing reflectively.

With this narrative ability, physicians can reach and join their patients in disease, identify their own journey in medicine, recognize their closeness to and responsibility toward other healthcare professionals and begin a coherent discussion with the general public on health care (18). Physicians learn from patients' situations in many ways, including written or unwritten stories, and registering moods through nonverbal language. In this way, they absorb knowledge about others and even themselves with no need for words. Considering the advent of artificial intelligence and all the ethical dilemmas around its implementation in the healthcare setting, this is the time to redouble efforts to retain these deontological principles which help cultivate our being by virtue of our doing.

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