Medical Students' Knowledge About Narrative Based Medicine: Where we are and Where we Are Going?

Vitória Emanuela Santos Machado [1] https://orcid.org/0000-0001-8347-7645
Iêda Maria Barbosa Aleluia[2] https://orcid.org/0000-0002-7979-1938

ABSTRACT

The medical teaching is basically grounded in a medicine based on evidence, in which the patients are data, submitted to protocols. The narrative based medicine favors the patient's history, their speech and the context in which their history is inserted. With its relatively recent implementation, it is necessary to know the knowledge of medical students on the subject. This is a cross-sectional study, analytical, that uses the qualitative method and content analysis design. Medical students from the third to the sixth semester included, in two stages: first with an online formulary with a question: "do you know what it is Narrative Based Medicine?", with a binary option of "yes" and "no". The second was a focus group with part of these students. There were 134 participants in the 1st stage, where 123 answered "no" and 11 answered "yes". In the focus group, three categories emerged. 1. "Language" as the impossibility of detaching it from the patient's narrative. 2. "Empathy" with the need to establish a bond with the patient that would allow anamnesis in a natural way. 3. "Cake's Recipe / Narrative" is the expression of the stiffness proposed by medical schools in a medical interview and of the students' attempts to remodel it to find greater naturalness in the doctor-patient relationship, fostering the importance of Narrative Medicine. The results of this study show that medical students at this private college have intuitive knowledge about narrative medicine, as it is interwoven with the principles of the institutional teaching program.

KEYWORDS

Medical education. Doctor-patient relationship. Medical profession. Literature.

Corresponding to Authors

[1] Vitória Emanuela Santos Machado
E-mail: vitoriamachado16.2@bahiana.edu.br
Escola Bahiana de Medicina e Saúde Pública
Salvador, BA, Brasil
CV Lattes
http://lattes.cnpq.br/8811041067135858

Iêda Maria Barbosa Aleluia
E-mail: iedaleluia@bahiana.edu.br
Escola Bahiana de Medicina e Saúde Pública
Salvador, BA, Brasil
CV Lattes
http://lattes.cnpq.br/9891638584795073

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O conhecimento do estudante de medicina sobre medicina narrativa: Onde estamos e para onde vamos?

RESUMO

O ensino médico é basicamente fundamentado em uma medicina baseada em evidências, na qual os pacientes são dados, submetidos a protocolos. A medicina narrativa favorece a história dos pacientes, suas falas e o contexto onde estão inseridos. Com sua implantação relativamente recente, impõe-se saber o conhecimento do estudante de medicina sobre o assunto. Assim, tivemos o objetivo de identificar o conhecimento do estudante de medicina sobre medicina narrativa, em uma faculdade privada de Salvador, através de um estudo transversal, analítico, com abordagem qualitativa através da análise de conteúdo. Incluídos estudantes de medicina do terceiro ao sexto semestre, em duas etapas: primeira com um formulário online constando uma pergunta: "você sabe o que é Medicina Narrativa?", com opção binária de "sim" e "não". A segunda, foi um grupo focal com parte desses estudantes. Houve 134 participantes na 1ª etapa, onde 123 responderam "não" e 11 responderam "sim". No grupo focal, surgiram 03 categorias. 1."Linguagem" como a impossibilidade de desvinculá-la da narrativa do paciente. 2. "Empatia" com a necessidade de estabelecer um vínculo com o paciente que possibilitasse a anamnese de uma forma natural. 3. "Receita de Bolo /Narrativa" há a expressão do enrijecimento proposto pelas faculdades de medicina em uma entrevista médica e das tentativas dos estudantes de remodelá-la para encontrar maior naturalidade na relação médico-paciente, fomentando a importância da Medicina Narrativa. Os resultados desse estudo mostram que os estudantes de medicina dessa faculdade privada têm conhecimento intuitivo sobre medicina narrativa, pois está entremeado aos princípios do programa de ensino institucional.

PALAVRAS-CHAVE

Ensino da medicina. Relação médico-paciente. Formação médica. Literatura.

El conocimiento del estudiante de medicina sobre La Medicina Narrativa: ¿dónde estamos y dónde vamos?

RESUMEN

La enseñanza médica se fundamenta en una medicina basada en la evidencia, donde los pacientes son datos, sometidos a protocolos. La medicina narrativa privilegia la historia del paciente, su discurso y el contexto en que se inserta su historia. Con su implementación reciente, es necesario identificar los conocimientos de los estudiantes de medicina sobre el tema. Este es un estudio transversal, analítico, que utiliza el método cualitativo y el diseño de análisis de contenido. Los estudiantes de medicina del tercer al sexto semestre incluyeron dos etapas: la primera, un formulario en línea con una pregunta: "¿sabes qué es Medicina Narrativa?" y una opción binaria de "sí" o "no". La segunda, un grupo focal con parte de estos estudiantes. Hubo 134 participantes en la 1ª etapa, donde 123 respondieron "no" y 11 respondieron "sí". En el grupo focal, surgieron tres categorías. 1. "Lenguaje" con la imposibilidad de desvincularlo de la narrativa del paciente. 2. "Empatía" con la necesidad de establecer vínculo con el paciente que permita la anamnesis de forma natural. 3. "Receta de Torta / Narrativa" es la expresión de la rigidez propuesta por las facultades de medicina en una anamnesis y de los intentos de los estudiantes de remodelarla para encontrar naturalidad en la relación médico-paciente, fomentando la importancia de la Medicina Narrativa. Los resultados de este estudio muestran que los estudiantes de medicina de esta facultad privada tienen un conocimiento intuitivo sobre la medicina narrativa, ya que se entrelaza con los principios del programa de enseñanza institucional.

PALABRAS CLAVE

Profesión médica. Relación médico-paciente. Formación médica. Literatura.

Introduction

Narrative medicine (NM) is a clinical practice sustained by active listening to the patient's story and contextual understanding of the consequences generated by the problems listed by them. Such aspects can be based on methods of linguistic analysis and empathy development (GREENHALGH,1999; ELWYN; GWYN, 1999), besides the study of medical ethics and literature (JONES, 1997; JONES, 1999).

Within this context, globally, current medical education is geared toward evidence-based medicine (EBM), with parameters guided by data analysis and randomized clinical trials (GREENHALGH,1999; CHARON; WYER, 2008), while the way in which patients tell their story is through elaborate narratives and not by citing signs and symptoms listed in textbooks (GREENHALGH; HURWITZ, 1999).

Recently, MN has been finding space in some medical universities in the United States of America (USA), either to form more empathic physicians, or, in a more current context, to improve the doctor-patient relationship and medical ethics (JONES, 1997; JONES, 1999). But it is still a focal and little worked knowledge in the medical course, which remains structured in anamnesis formulations and the medical optics of a consultation, easily forgetting the patient's optics (THISLETHWAITE, 2014).

The medical student's knowledge about MN is scarce, either because of the lack of discussions about narratives during their student period, or because of the lack of importance that is given to the subject. We can extend this statement to the importance given to this subject in the formation of a physician's professional life: insignificant.

Thus, there is a clear need to bring up this issue to medical students so that they can reflect on the quality of the professional they want to be in the future, and what kind of relationship they want to build with their patients even now, while they are training and starting to relate to them. This need justifies this study, which seeks to understand the students' vision, as well as to open a space for reflection on the subject.

Methodology

This is a cross-sectional, analytical study, qualitative in nature, which was done in two stages.

The first stage was done by issuing a form answered by medical students at a private college, in Salvador/Ba, from the third to the sixth semester (range of the course in which there is the curricular component of Medical Semiology), in which the name, e-mail, telephone

number and semester were required, and the question "do you know what narrative medicine is?", being provided only the objective answer options "yes" and "no".

In the second stage, the invitation to the participants was made in person, by e-mail, or by phone. Those who accepted the invitation were drawn by lot, and if one could not, another one was drawn until a maximum of twelve members - minimum of six - were reached, according to the focus group technique, and divided between those who answered "yes" and those who answered "no" in the first stage. These groups met with the researcher in a previously reserved room at EBMSP, thus establishing privacy for the participants. Then, there was a non-directive data collection through the interactions that took place there when the researcher pointed out the subject to be discussed, thus having a resource for the understanding of group perceptions and attitudes with a facilitator - the researcher - mediating the discussion. All the meetings between the focus groups were recorded and later transcribed for the qualitative analysis of the material.

The analysis of the data obtained was done in two ways. The quantitative data were analyzed by simple descriptive statistics, thus determining the frequency of students and their distribution between "yes" and "no", and their semesters through Excel. Qualitative data were analyzed by Bardin's (BARDIN, 2011) and Minayo's (MINAYO, 2010) content analysis, subdividing them into categories and subcategories by semantic correlation of each participant's ideologies, for further discussion of each one.

The choice for Bardin's Content Analysis (BARDIN, 2011) considered the analysis path itself, demonstrated in three aspects: pre-analysis, with the organization of the data, after a floating reading of the material; the exploration of the material, which will codify the data; the treatment of the results, and their interpretation. And Minayo (MINAYO, 2010) brought light in these categories and subcategories, creating a cohesive narrative, not just an analytical description of the data.

Results

Analysis of sociodemographic characteristics

There were 134 pre-project participants who answered the form, 40 belonging to the third semester, 24 to the fourth semester, 42 to the fifth semester, and 28 to the sixth semester. Regarding gender, 93 considered themselves female and 41 male. Finally, most of the pre-project participants (123 students) answered "no" to the key question, while only 11 answered "yes".

Of the six participants who took part in the focus group, five answered "no" and one answered "yes"; five considered themselves female and one male, and all were from the fifth

semester, which may represent the greater availability of students from this semester for the scheduled date and time of the focus group.

Focus Group Analysis

Post form, previously thought-out invitations were emailed to six drawn pre-project participants who answered "yes" and six drawn pre-project participants who answered "no" aimed at forming two small focus groups for a discussion on MN. Several rounds of invitations were issued, as many of these individuals declined. In the end, due to these refusals and the limited number of people available for the "yes" focus group, a small focus group was formed with six pre-project participants, of whom five answered "no" and only one answered "yes".

This focus group met in a previously reserved room on the college campus together with the mediator not directly involved in this work who was trained to mediate a focus group. The group discussion lasted 71 minutes. All participants previously signed two copies of the ICF, one for them and the other for the researcher, and were informed about the audio recording of the discussion for future transcription, maintaining their anonymity.

The focus group discussion was divided into three main blocks, corresponding to the main questions in the script, and so, block by block, the participants discussed the aspects they considered important to them on that topic, sometimes agreeing on their opinion and other times not. It is important to point out that the participants had no knowledge about the closed response of the other to the key question of the form ("yes" or "no").

The transcription of this discussion was made while keeping the identity of the participants anonymous, thus being identified as F1, F2, F3, F4, F5, and M.

Discussion

Analysis of the emerging categories throughout the focus group

The focus group analysis showed the emergence of three main categories: Language, Empathy and "Cake Recipe"/Narrative.

Language

Because of the great characterizing value of language for NM, this category was listed as one of the main ones evoked during the focus group. We realize that it is not possible to talk about a patient's narrative without talking about how it is told, what forms of language are used

to tell this story (ELWYN; GWYN, 1999) and, in the context of this work, how, or if, medical students notice them.

The way you look at the patient, and the way they look at you, are a type of nonverbal language expression that you both understand, the words you choose and the context in which they are put into a verbal language say a lot about you and the other, and both are inseparable from a doctor-patient relationship (BIRCK; KESKE, 2008; RAMOS; BORTAGARAI, 2012). During the discussion, the theme of language came up several times in the speech of all participants with the belief of being a fundamental component for the doctor-patient relationship, such as:

> **F1:** "What I think is more important in the relationship is listening, but an active listening, which shows that you are there interested in him as a person, as a subject, and not only in... in what I want to learn, to find out what he has (...)"
> **F3**: "(...) this issue of non-verbal communication as well, it is... it makes a lot of difference that you pay attention to the posture and... the gestures, the mimicry of the patients. (...) Sometimes we would be talking to the patient, and he would start to present himself a little more withdrawn, then... he would stop making eye contact with us, or else he would start talking lower, turn the other way, and then... yes, it was noticeably clear that he did not want to continue the interview (...)"
> **M**: "(...) seeing him narrating that story you will be able to extract data that... it would be unnecessary for you to ask again, like he is already giving you ready information, in the most reliable way that he felt, and that you need to keep asking in medical ligatures... (...)"

In view of these statements, and many others that have emerged, it is necessary to segment this main category into two subcategories to discuss language in more depth.

Verbal Language

When it comes to this subcategory, it is noted that there was a correlation between the study of a patient's verbal language and his socioeconomic and cultural context (RAMOS; BORTAGARAI, 2012), which says a lot about "reading what is between the lines", sometimes it is up to the health professional to read what is truly said with a patient's sentence. In this study, this point is brought out as well, as shown in the speech of one of the participants, below:

> **F1**: "(...) the language shows a socioeconomic profile that is important, especially important, this 'I spent the whole morning in pain and even, so I went to work', this reminds me a lot of a person that his health is not the priority and that maybe he went to work because he had no option. (...)"

Moreover, we also have the knowledge of techniques to collect information from the patient in an open manner that allows greater use and validation of their verbal language, with the future use of information that emerged with fluidity, instead of having been questioned in closed questions and without semantic connection for that patient. Which demonstrates certain technique in communication and path building as a good facilitator of a consultation, in line with the literature (ELWYN; GWYN, 1999):

> **F5**: "(...) when we ask broad questions to the patient, he always ends up narrating more or less what happened and when he narrates we take out several implicits... (...) if we asked directly we would also get some information, but it wouldn't be as reliable as him narrating... (...) So I think that for us to have this narrative from him, we need to have an open question and I think that this open question is essential for us to understand the little story that happened to the patient.

Non-Verbal Language

This was the subcategory most emphasized throughout the focus group discussion in its various aspects. As, for example, in the initial reading of a patient to propose him better comfort either by knowing his limits through his mannerisms or his tone of voice, in close connection with the studies done in this area (ELWYN; GWYN, 1999; BIRCK; KESKE, 2008). The excerpt from a student's speech below exemplifies this positive association with literature:

> **F5**: "(...) as soon as I arrive, I try to do a nonverbal reading of the patient (...) I stay at Hospital X, so sometimes there are patients who are there for a long time and are usually a little weak. (...) this non-verbal communication for me is also essential, because even if they are sick, I have never seen them saying 'hurry up, I have to go', never. But I can tell by their expression that they want me to go ahead. (...)"
> **F2**: "(...) sometimes even us asking the normal anamnesis things that we are used to asking everyone, for example, if the patient has already had an abortion, many patients say 'no' but there are others that you feel that the voice is low... (...) so you also have to give this comfort... (...) you perceive by the non-verbal communication if you ended up entering in a delicate subject for her."

In the aspect of non-verbal language expression, the study participants themselves, as health figures in that doctor-patient relationship, brought the perception that they had regarding their awareness of their postures and mannerisms (BIRCK; KESKE, 2008; GROSSMAN; CARDOSO, 2014) and the negative consequences of that for their patients, remembering that communication is a two-way street, where the doctor and the patient are connected on different levels:

> **F2**: "(...) we see some quite different things and sometimes I can't hold my expression... (...) I realize that I frown, because the patient has something that no one else has. And then I get, 'Gee, imagine how he must be feeling'. (...)"
> **F3**: "(...) I've noticed that I have more of an attitude of finding it interesting, but like a little excitement for finding something that we had only seen in a book or... you know, it's never talked about? And then... after it happens, I think 'my God! There's a person who has that problem over there!'(?)"

Or in its aspect of use for better diagnostic formulation through theatricality faithful to the reality of the context in which their health-disease process occurred, attesting to its importance for the medical clinical reasoning (BIRCK; KESKE, 2008). Communication is essential throughout the process of the clinical encounter, and the students involved in the study brought this understanding, and the speech below shows this connection:

> **M**: "I think he might have used... since he is narrating the story that he felt the pain, he might have noticed that place of pain and that will make you think of the specific location, the organs that might be affected... When he said that his eyesight darkened,

> he may have mimicked what that was like, his fall, for example, the loss of consciousness... (...)"

Empathy

This main category transpired in the participants' need to find a way to connect with the patient to have open communication and 'understanding of their limits, since the existing rigid system of information collection, the anamnesis, did not allow them a soft presentation in a context of vulnerability, such as getting sick.

The asymmetry between the sociocultural contexts of the health professional and the patient can stiffen, even make the formation of bonds in the doctor-patient relationship unfeasible, which makes the doctor responsible for facilitating this communication, opening channels for such (THISLETHWAITE, 2014; FAVORETO; CAMARGO JÚNIOR, 2011). We can notice this, when F5 says:

> **F5**: "(...) understanding this empathy with the patient makes him able to talk more and open up more and explain his problem more. This facilitates all our conduct, all our understanding of the disease that he has and how we are going to treat it. (...)"

Empathy is not only in a process of putting yourself in the place of the patient, but also of seeking identification, a common place between your world and that of your patient to provide a better line of care and better relationship (FAVORETO; CAMARGO JÚNIOR, 2011). The material collected and analyzed in this work relates positively with the literature data on the importance and role of empathy in the doctor-patient relationship.

Throughout the focus group discussion, much of this Empathy category, was creating linkage with the next category, "Cake Recipe"/Narrative, as a method of escaping the postulated investigative norms of anamnesis in medical schools. This may demonstrate the positive influence of the use of the narrative technique in providing an empathic movement, and consequently strengthening the relationship between the doctor/student and the patient; besides making the collection of the clinical history more flexible, bringing lightness and uniqueness to the clinical encounter. This becomes clear in these reflections that emerged in the FG:

> **F1**: "(...) And then I go to the identification, which is what we do in the anamnesis, (...) I try to do the identification after creating some contact with him, regardless of... if the TV is on, he says something, 'this soap opera is good, right?', but I try to start the communication this way."
> **F3**: "(...) I prefer to seek to link more within the identification, so when I ask about marital status there ask something about marriage, some are in a state of widowhood, ask about schooling, occupation... Then, in this identification, I take the opportunity to get a little into the HPS to get to know the person a little more and break this ice, instead of asking introductory questions (...) well what we learned in the fourth semester, the step-by-step."
> **F5**: (...) I try to do more or less like F1, I try to create this bond with the patient, even if it's with silly things, even if it's with...for example, he's wearing the shirt of Bahia, 'ah, Bahia won yesterday, lost yesterday', I kind of look for something like that so that

> the patient feels comfortable with... with me, because it will be something kind of boring that he will have to keep talking, talking, talking...".

"Cake Recipe" / Narrative

This category was named "Cake Recipe" because of participants' repeated citations to the stiffened step-by-step anamnesis, criticized by NM for pruning medical students' creativity and diagnostic senses (GREENHALGH; HURWITZ, 1999). The categories in this paper talk a lot to each other, making a connection to the others. Participants used much of their resources such as nonverbal language, attachment, and empathy to evade, circumvent, or modify the systematic order of the model of a medical consultation (BIRCK; KESKE, 2008; FAVORETO; CAMARGO JÚNIOR, 2011). What brings this study closer to the literature on MN, is that it brings exactly the recovery of creativity and uniqueness in the encounter between the patient (and his story) and the doctor (and his life experiences). We can observe this in the last-mentioned statements.

One can also observe their perception that the patient tells the only possible story: his own! And it is up to us, health professionals, to use our knowledge to better conduct the consultation, adapt the "cake recipe" and interpret the information that we are given (FAVORETO; CAMARGO JÚNIOR, 2011). The speech of F2 is an example:

> **F2**: "(...) we are studying precisely so that we... have the skeleton of what we want and... know how to lead the story, but... we can't complain about the way the patient tells the story because it is his limitation, he will not tell it with medical words, he will not tell it exactly the way you want, you have to know the necessary information to be able to lead the story. So... from a case like this, you... if you have studied, have... finally, learning this kind of thing, this kind of technique, you can get a lot of information out of it, as the boys have already said, you don't need to keep saying 'ah, but how was this pain? So, you do not need to ask questions, you can even check the data, but you don't need to do a repetitive thing."

The idea that following a model to the letter may not be the best method for collecting information and formulating better care. It is clear that students need to circumvent this model and adapt it to something more tangible and natural. The belief that using narrative leads to something elongated, in which the patient talks a lot, but does not say anything "important", is erroneous (GREENHALGH, 1999). And the data from this study shows this understanding on the part of the students. The same objectives and diagnostic suspicions are as achieved and raised as those of a "cake recipe" anamnesis. It can be said that even with greater accuracy, due to the broader knowledge of the fact or problem, and the scenario where it is inserted in the patient's life. There was a speech by a participant, F3, which shows the extreme relevance of the subject and portrays exactly that:

> **F3**: "(...) when you mentioned this topic ((indicates the moderator)), I thought, 'but, hey? Yeah... the collection always starts with the narrative, one way or another', but then I thought about my most recent experiences. (...) When you let the patient speak, it comes naturally and... all the aspects that he believes are associated, he creates a chronology, a sequence of facts, establishes causal relations between things... then he

> already presents you with a story and I thought this was very nice, I liked to review the story with the patient afterwards, 'ah, this happened, and this and this. And do you think it happened because of...', I found this very enriching. (...) The doctor who was there with us, she never stopped us, but she said that we were letting the patient fool us ((she and everyone laughs)), and he was missing the point. But then, when I took this story (...), I realized that everything that... my colleagues or the tutor imagined that we could have asked had emerged in the story, that no gap had been left in what we had set out to discuss at that moment, while in other moments that I tried to direct a little more, so as not to let the patient fool me, so to speak, to go to the focus of what would be the main problem, some things that could have emerged if I had let the patient speak freely, tell the story, ended up being left out, because my perception... is not... the same as his. You end up closing yourself off, so everything that you believe is relevant and... you don't let the patient tell you what they think is relevant sometimes."

It is understandable to think that using the narrative may lengthen your consultation time, especially in a socioeconomic environment that demands haste. But the participants of this study, as students, can establish in which contexts it can and should be used, and ways to conduct a consultation to avoid prolixity, even using the resource of nonverbal language (FARIA; NOGUEIRA, 2014; GROSSMAN; CARDOSO, 2006). The following lines show this thought of the students:

> **M**: "I think that there is a... this certain limit of not letting the patient be so prolix and... go directing a little. Because he won't know the causes of syncope, fainting, that he had and which problems could have caused it, so you listen and direct him. (...) And as he continues to narrate, you go on... adding more medical information, necessary for his care.
> **F1**: "I'm very wary about this narrative thing, of leaving an interview too open, because there are people who talk a lot and sometimes, they talk... things that in my point of view are not so important. (...) I think that the secret is in the non-verbal language. You know when the person needs to talk about something, because they need to get it off their chest or because they just like to talk ((everybody laughs)). (...)"
> **F3**: "(...) this that you said ((indicates again F1)) reminds me of something also interesting that is what is the position that the doctor occupies at that moment? Because we saw, last semester, family health, and the position that the doctor occupies as a family and community doctor is different from... in an emergency room, for example, or... in the wards of the hospitals we are visiting. Maybe this approach I was talking about is much more interesting for the doctor who follows the patient... longitudinally, to have a broader notion of the patient's health in general, than... at that moment when you have a... a focal problem that you need to deal with and guide your care in the sense of taking care of it. So... this is going to vary a lot, depending on the position that we... occupy at any given moment. (...)"

It is machinery to think that students, as future physicians, will attend the same way, following the same steps, following the same model (GROSSMAN; CARDOSO, 2006), considering that as individuals we are singular, as students we are odd and as future professionals ... we will also be unique! Even more, that right after our uniqueness comes the uniqueness of the patient: also, a unique, singular, and odd individual. The examples below show these reflections, which bring the results of this study closer to what is recommended in the literature on the use of narrative in medicine.

> **F3**: "there are going to be several different contexts and different patients, and there won't be a formula, there won't be a model that is more adequate than the other. So,

> we will have to create a baggage of... what was that really like? Light technologies ((she and everyone laughs)) of communication and how to behave... (...)"
> **M**: "(...) come in willing and open to new things, not just following a script, following a standardization of what was technically passed to you, but... knowing how to lead from here in a good-humored way, knowing how to deal with the difficulties and sadness of patients and knowing how to lead in adverse situations... (...)"

The medical students who participated in the survey and answered "no" to the direct question in the first step already practiced MN. They just didn't name it; they didn't know the name of the method.

> **F2**: "I didn't know what narrative medicine was, so..., but now, after the discussion, I realized that we... I didn't just have a name for it, but I understand the concept. (...)"
> **F5**: "I think I, like F2, just hadn't given a name to something that I...I, F3 and I think you guys always do too. And... I can't imagine a... good practice of medicine without narrative medicine. I don't think it makes sense, because right when you think about the history of the actual illness, the patient is going to tell you a story. So, I don't think there is any medicine without narrative medicine. That's my conclusion."

The participant who answered "yes" to the direct question felt that knowing what MN was did not change her practice. The analysis of the results obtained, leads one to believe that, like all other participants, their experience in narrative flowed naturally, even without naming it, because they are medical students from a school that has a pedagogical political project grounded in a humanistic medicine (EBSMP, 2017).

> **F3**: "I had heard about what narrative medicine was ((she laughs)). I was in a... in a congress and... presented some things about it, but at that moment I didn't... stop to observe so much, I didn't think much about it. So, I knew what it was, and it didn't... alter my practice in any way, I think that what... has an impact is that we do something like we are doing here, we are thinking about the subject, we are reflecting on narrative medicine. Then, based on this reflection, several issues in our practice, in our way of thinking can... can be changed, but not... the isolated fact of us knowing that this exists... and it happens".

The concept that the doctor-patient relationship is formed by two human beings, and not only by a doctor in a position of hierarchy, came very strong in some statements. Both are building an anamnesis, with interactions, narratives, and additions of equal importance, thus validating MN for the sake of this relationship (FAVORETO; CAMARGO JÚNIOR, 2011):

> F1: "(...) I think that... narrative medicine gives the patient the power and importance that he has, because care is not unilateral. A... a care, a consultation, is not only done by the doctor, and the doctor, under no circumstances, is more important. (...) It is 50% and 50%, I think. And if you take that 50% and turn it into 10, it's not... it's not medicine. (...)"
> F3: "(...) narrative medicine, it takes the relationship a little more... of the doctor and the patient to the pole of two people relating... in relation to... a machine analyzing variables ((she laughs)). Of course, the analytical function is important, but with narrative medicine we get closer to a... a contact that is true to our nature...(?)"

The data is in line with the studies on MN, and appreciation of empathy in the doctor-patient relationship, and the examples below portray this stance of the participants of this work:

> **F4**: "(...) you know how to communicate, establish a communication with a person, create a bond, create a level of trust... I think it will be especially important, not only for us as professionals, but also as people. (...)"
> **F1**: "(...) He knows what he is feeling. There is a phrase that a teacher of ours says: "in a consultation there are two specialists, the doctor and the patient", and this is absolutely true. So... the measure of the narrative is the... is the space, is the path that... allows him to occupy the space that is his. (...)"
> **F5**: "(...) I think that to have a good practice it is necessary to have this narrative medicine and..., for me, good practice of medicine involves empathy. So, for me it is all "linked" there... it all makes sense. (...) I came here not knowing what narrative medicine was, I came here and discovered that I already knew ((she laughs)). So, it is kind of... it is already in my experience. I think that this... narrative medicine does make me a... a... more empathetic health student, and that I will practice... better this consultation, that I will listen better to the patient. (...)"

In the end, not only did the students think that MN would make them better professionals by using knowledge and valuing different forms of language (BIRCK; KESKE, 2008), building empathy and better care focused on the patient and not the disease, but also make them better on a personal level (JONES, 1999; FAVORETO; CAMARGO JÚNIOR, 2011).

Conclusion

It is concluded in this paper that, the medical students of this college have knowledge about narrative medicine. It is interwoven into the principles of the teaching program of the institution (EBSMP, 2017), although they do not initially name it that way.

They realize the importance of narrative medicine, both in a professional context, in building their doctor-patient relationships, and in a personal context, with their human growth.

Therefore, it is evident, due to its magnitude, the need to work and research more explicitly on a subject that is anchored in the cultural imaginary of the institution and its members: teachers and students.

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APÊNDICE A – ROTEIRO DE DISCUSSÃO DO GRUPO FOCAL

1. Na nossa prática, como estudantes de medicina, estamos expostos à diversas situações nas quais nossas relações médico-paciente, ainda que em desenvolvimento, são testadas. Assim, respondam:

a) O que você enxerga como importante para essa relação?

b) Como, normalmente, aborda seu paciente?

c) Qual o tipo de comunicação usada entre vocês?

d) Faz uso da compreensão da linguagem corporal, das pausas entre discursos, entre outras formas de linguagem?

2. A medicina narrativa reconhece a importância da história narrada por um paciente, no dia-a-dia, ao chegar aos seus consultórios, seus pacientes te contarão em que contexto eles começaram a sentir algo de errado e como se sentem estando doentes, eles não citarão sinais e sintomas que estudamos em um livro. Por exemplo, estamos nos seus consultórios e "seu João" narra para vocês: passei a manhã inteira com uma dor nas costas, mas fui trabalhar mesmo assim. Quando estava andando para lá, senti uma pontada forte no meio do peito e, de repente, tudo escureceu, foi como se tivessem apagado o sol.

a) Você percebe o caráter narrativo da história de "seu João"?

b) Quais outras formas de linguagem pensa que ele possa ter usado?

c) Acredita que a medicina narrativa agrega a sua formulação de diagnóstico?

d) E na sua relação médico-paciente com "seu João"?

3. Discutido esses aspectos, agora me respondam:

a) De tudo o que foi discutido entre nós, o que lhe parece ser mais importante?

b) Qual a importância que medicina narrativa tem para você?

c) Acredita que conhecê-la te tornará um profissional mais empático e capaz?

APÊNDICE B – TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO

Prezado (a) Senhor (a),

Você está sendo convidado a participar da pesquisa "O CONHECIMENTO DO ESTUDANTE DE MEDICINA SOBRE MEDICINA NARRATIVA" que está sendo desenvolvida por Vitória Emanuela Santos Machado, do curso de Medicina da Escola Bahiana de Medicina e Saúde Pública (EBMSP), sob a orientação da Profª Drª Ieda Maria Barbosa Aleluia.

O objetivo do estudo é identificar o conhecimento do estudante de medicina sobre medicina narrativa, em uma faculdade privada de Salvador. Sua finalidade é promover a discussão sobre medicina narrativa em âmbito acadêmico, incrementar a formação profissional desses estudantes e colocar em evidência o impacto da narrativa na relação médico-paciente.

Solicitamos a sua colaboração para a participação no preenchimento desse formulário e na integração posterior em um grupo focal - formado por seis à doze pessoas, com um roteiro abrangendo aspectos das formas de utilização da medicina narrativa e a formação da relação médico-paciente e com duração de uma hora - que será realizado em uma sala da EBMSP previamente reservada, como também sua autorização para a destinação desse estudo em uma defesa de monografia na EBMSP e em publicações científicas**.** Por ocasião da publicação dos resultados, informamos que nessa pesquisa pode haver a exposição de seus dados, entretanto, para prevenir e/ou minimizar tal risco, seu nome será mantido em sigilo absoluto. Informamos ainda que essa pesquisa pode te trazer constrangimento, porém tal desconforto será acolhido e esclarecido pela pesquisadora e, caso haja necessidade, você poderá ser encaminhado ao Núcleo de Atenção Psicopedagógica (NAPP) da faculdade.

Esclarecemos que sua participação no estudo é voluntária e, portanto, o(a) senhor(a) não é obrigado(a) a fornecer as informações e/ou colaborar com as atividades solicitadas pela Pesquisadora. Caso seja comprovado dano real e significativo, poderá ter ressarcimento financeiro. Caso decida não participar do estudo, ou resolver a qualquer momento desistir do mesmo, não sofrerá nenhum dano. Uma via desse documento lhe será entregue devidamente assinada pela pesquisadora desse estudo. A pesquisadora estará a sua disposição para qualquer esclarecimento que considere necessário em qualquer etapa da pesquisa.

_____

Assinatura da pesquisadora responsável

Considerando, que fui informado(a) dos objetivos e da relevância do estudo proposto, de como será minha participação, dos procedimentos e riscos decorrentes deste estudo, declaro o meu consentimento em participar da pesquisa, como também concordo que os dados obtidos na investigação sejam utilizados para fins científicos (defesa de monografia e divulgação em eventos e publicações). Estou ciente que receberei uma via desse documento.

Salvador-Ba, ____de _____de _____.

Impressão dactiloscópica

_____

Assinatura do participante ou responsável legal

Contato com a Pesquisadora Responsável:

Caso necessite de maiores informações sobre o presente estudo, favor contatar a pesquisadora Vitória Emanuela Santos Machado, pelo telefone: (71) 9 9152-8519 ou pelo e-mail: vitoriamachado16.2@bahiana.edu.br, ou a pesquisadora Iêda Maria Barbosa Aleluia pelo e-mail: iedaleluia@bahiana.edu.br ou celular (71) 9 8805-4525, ou contatar o Comitê de Ética em Pesquisa da EBMSP no endereço Avenida D. João VI, 274, Brotas, CEP 40285-001, Salvador–Bahia, ou pelo telefone (71) 2101-1921 ou pelo e-mail cep@bahiana.edu.br.