MEDICAL STUDENTS' PERCEPTION OF NARRATIVE MEDICINE: A CASE REPORT

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Abstract: This study explores the perception of Narrative Medicine (MN) among medical students at the University of Siena, Italy, where this discipline is mandatory. Literature shows a low number of studies on the role of this subject in medical education (Palla *et al.* 2024), despite the increasing importance of narrative research both in seeking meaning coherence in illness experiences and in treatments and coping strategies to face clinical uncertainty (Charon 2001; Greenhalgh 2016). As part of a broader research program (Tuscany Health Ecosystem – THE – project), an online questionnaire on the perception of NM was designed and administered to students in Medicine and Surgery attending the mandatory course on Narrative Medicine at the University of Siena. The answers were examined applying descriptive statistics and Thematic Analysis (Braun and Clarke 2006; 2022). Moreover, the students' anonymized comments on topics discussed during the NM course were collected into a text corpus, processed by Sketch Engine software for the identification of lexical patterns and analyzed through thematic analysis. Adopting qualitative and quantitative methods and drawing on multiple data sources, triangulation yielded three main themes representing the participants' perception of NM. While better diagnoses and a human approach to care emerge as tenets of NM on which students agree, awareness of the patients' priorities and of NM benefits for the physicians' emotional balance could be increased (potential). At the same time, students are willing to attend more NM courses and experience this approach at a more practical level, also because they recognize that the NM model is hardly compatible with the current standards of healthcare management. This study involved a small population of medical students, but it may be extended to a larger number of respondents from other universities offering NM courses, providing healthcare managers with new insights for the future design of medical education plans.

Keywords: narrative medicine; corpus analysis; thematic analysis; medical education; narrative competence.

1. The role of narratives in medicine and medical education

1.1. Narratives and uncertainty in medicine

The word "narrate" derives from "*gnārus", which conveys the meaning of knowing, and from "agere", meaning "to do", so the verb defines the action of letting know, making something known (Nocentini 2008). The etymological reference to knowledge introduces a relevant but reluctantly accepted topic in medicine: the potential and limits of knowledge, the condition of uncertainty and the need for interpretation.[1]

Living and working with uncertainty is a condition experienced by both clinicians and patients for different reasons: the outcome of treatments, the evolution of disease and the possible feeling of human limitedness, failure and helplessness, even despite advances in medical technology.

As argued by Greenhalgh (2013), Evidence-based Medicine (EBM) tries to reduce uncertainty through evidence and statistics: patients can be classified and treated based on diagnostic and therapeutic criteria, probabilities and best research evidence. Narrative Medicine (NM) approaches uncertainty by seeking meaning coherence both in the disease trajectory from a medical viewpoint and in the illness experience from the single patient's point of view. It is crucial to recognize that in NM stories are not regarded as a "substitution for" but as a fundamental "integration with" evidence. Yet information in NM does not stem from statistical data, but from events, experiences, explicit or underlying messages and emotions that the single patient is willing to share.

As pointed out by Greenhalgh and Hurwitz (1999), narratives are indeed powerful tools in medicine: at a diagnostic level they have a phenomenal function consisting of showing verbally how patients experience illness and providing useful information to generate new diagnostic hypotheses. At a therapeutic level, narratives help doctors to choose the right treatment by identifying the individual patient's priorities, beliefs and values, including them in critical decisions: a patient may prefer better quality of life to facing the side effects of specific therapies, for instance, and in this case the only source of information, before deciding on treatment, is what the patient says about his personal life.

At the same time, what the patient says requires appropriate reception by professionals so that they can grasp the story's meaning and co-decide on the therapeutic process in the care relationship. This specific requirement is defined through the "narrative competence" […] meant as the ability to "absorb, interpret and respond to stories" (Charon 2001: 1897). Narrative competence is strictly connected to the centrality of stories: stories are not the key to uncertainty if not adequately related to aware, participative, receptive listeners or readers. In Charon's view, represented in this study, Narrative Medicine does

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[1] Lippi and Donell (2023) suggested an etymological connection between the verb "narrate" and the noun "knee", the latter defining the largest joint in the body, symbolically associated with sacredness, life and power.

not owe its name to its relation to narratives alone, but to the narrative competence itself, that is, to what to do with narratives and how to co-construe their sense in order to cope with clinical and human uncertainty.

Dr. Rita Charon, physician with a degree in literary studies, introduced and developed NM in mandatory courses of the medical curriculum at the Columbia University (USA) as a "method of fortifying the capacity of the physician to reach, understand, and ally with the patient in care" (Charon 2013: 3). This method leverages the potential of writing as a disclosing and transformative act: writing about stories told by patients gives doctors access to insights and information otherwise ignored or neglected, as it sharpens intuition, increases attention to details and enlarges the evidence on which clinical judgment and decision can be based.

According to this approach, NM practice unfolds through different phases (Charon 2006): *attention*, consisting of attentive listening to patients' stories, foregrounding the patient's needs and vulnerability; *representation*, which refers to how the patient's experience is represented from the physician's perspective in a non-clinical document (*parallel chart*); *affiliation*, i.e. the process of engaging with the patient in the light of this new representation and sharing the reshaped care experience with colleagues or other listeners (caregivers, patients' associations, etc.).

Another view of NM is represented by John Launer, oriented towards oral communication and the unpredictability of conversations in medical encounters, where participants are "intrinsically uncertain and open to multiple interpretations and outcomes" (Launer 2013: 148). The core idea of Launer's approach is that the basic narrative skills used in an effective patient encounter can also be used when talking with colleagues about that encounter. Launer's method stands out for its focus on the discussion of complex medical cases among peers and trainees.

In the Italian context, specific guidelines define NM as a methodology designed for clinical interventions and based on specific communication skills: integrating the perspectives of people involved in the illness and care experience (patients, health professionals, and caregivers) is made possible through the interpretation of patients' narratives and results in a tailor-made, personalized and co-participated clinical intervention and decision-making (ISS 2015).

1.2. Teaching and studying Narrative Medicine: An under-researched area

In a recent scoping review by Palla *et al.* (2024), 838 peer-reviewed papers on NM published in Italian or English from 1998 to 2022 were screened and classified into three categories: theory of NM, NM application in clinical practice, and education/training in NM. Only 19 of the eligible papers focus on NM education, that is on how NM is or should be taught and how its reception among students is; 10 of them are from the USA, two from Europe, four from Taiwan and three from Canada, Israel, Iran respectively. Furthermore, according to Remein *et al.* (2020), methods assessing the effectiveness of NM courses are still limited and unsystematic.

The studies seem to reveal that education and training in NM is an under-researched area and the Italian context aligns with this result: according to Palla *et al.* (2024) no study has been performed on NM teaching in Italian medical schools, although Italy boasts 28 studies on NM implementation in clinical practice. The first Italian NM project (NaMe) started in 2006 (Polvani *et al.* 2024) in Florence, followed, almost 10 years later, by the issue of official guidelines on NM approved by the National Institute of Health (ISS). So, historically and interestingly, in Italy, the implementation of NM preceded its official integration in academic studies[2] and its formal definition by healthcare institutions.

Italy has several associations concerned with NM, both at the national (SIMEN – Italian Society for Narrative Medicine) and at the European level (EUNAMES – European Society for Narrative Medicine) and has also successfully explored NM in digital environments (DNM – Society for Digital Narrative Medicine). Yet, according to a recent survey conducted by Miodottore Connect (2024), 97% of patients and 57% of physicians in Italy do not know what NM is.

This data call for reflections on whether, what and why something is missing in NM awareness in Italy and whether this missing piece should be sought in medical education. To the best of our knowledge, Narrative Medicine courses are not always *mandatory* in the academic programs of Italian medical schools.

In addition to academic settings, in Italy NM can be studied in courses accessible also to people with non-medical backgrounds, for example caregivers, members of patient associations, communication professionals and so on.[3] The reference to these non-academic courses is not intended to assess or compare their quality.[4] The distinction highlighted here is the relation between NM and the medical profession and education, that is whether NM is included in syllabi designed specifically for future healthcare professionals and, as such, it is taught in mandatory courses as is the case with Surgery and Anatomy, or is simply considered as an essentially additional, optional discipline that does not affect the quality of medical practice.

In this framework, the present study aims at exploring the perception of NM among medical students in one of the Italian universities with mandatory NM courses. Specifically, the research questions addressed are: how much and why do medical students think NM is known among and applied by healthcare professionals? How much and why do they find NM helpful both for health professionals and patients? What features of NM do they hold as most important? In the students' view, should NM be more developed in medical education and what may promote and limit the application of NM to clinical practice?

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[2] Università Politecnica delle Marche started just a postgraduate specialization course in NM in 2017.

[3] As the author of this article, with a background in Language Studies, I add that I attended one of these courses, often labelled in Italian as "master" at ISTUD, in the framework of privately funded education programs.

[4] The definition "non-academic" refers here to courses other than those held in universities.

2. Research design and methodology

2.1. Qualitative and quantitative analysis

To answer these research questions, the University of Siena (UNISI) was identified as an eligible research partner because its medical school program features Narrative Medicine as a mandatory course and because it complies with the requirements of THE, the broader program to which this study is related, addressing the Tuscany Health Ecosystem.

Respondents involved are UNISI second-year students of Medicine and Surgery. They attended a mandatory course in Integrated Medical and Scientific Methodology, Human Sciences and Health Promotion, consisting of five modules, respectively on: 1) Medical Deontology and Ethics, 2) Surgery and Gender Medicine, 3) Internal Medicine and Gender Health, *4) Narrative Medicine and Communication Skills,* 5) General Psychology, Global Health and Sustainability. The NM course is designed as one out of five modules of a more comprehensive course and is intertwined with the development of communication skills.

The main learning materials provided in the course module are articles, essays, talks and documentary films (see references). Charon's (2001) reading "Narrative Medicine" focuses on the narrative competence; Peabody's (1927) "The Care of the Patient" anticipates the NM inviting to a holistic approach to the patient; Verghese's (2011) talk "A doctor's touch" highlights the ritual value of human and physical touch during medical consultation. The documentary film "Quel qualcosa in più" (Smith 2019) explores the way physicians are trained, and how communication is determining but underdeveloped in modern medicine. In the video "Nemesi Medica" (Barnard and Minoli 2005) doctors diagnosed with serious diseases tell how their experiences influenced their perspective on illness and healthcare, shifting from the role of doctors to that of patients. Sackett's *et al.*'s (1996) "Evidence based medicine: what it is and what it isn't" defines the success and limits of EBM; McIntyre and Popper's (1983) "The critical attitude" concerns medical errors and how to positively turn them into learning experiences; Trotter's (1932) "Art and Science in Medicine" highlights the aspects of uncertainty and intuition as peculiar of medicine, which for this reason is a practical rather than an applied science. "Sorry works" (Wojcieszak 2015) showcases experiences of adverse medical events and suggests to health professionals how to deal with them at an emotional and practical level. Groves' (1978) article "Taking care of the hateful patient" discusses possible doctors' reactions to patients' behaviors that may be overwhelming or overstep professional boundaries.

Data for this study were collected in 2023 and 2024 at the end of the mandatory course described, both through a questionnaire related to the NM module and through a corpus consisting of the students' anonymized comments on the course contents.

The questionnaire, completed by 476 respondents, was accessible online through the Moodle platform. The questions aimed at capturing students' views of the following issues: knowledge of NM before the course, NM awareness in

healthcare and its application to clinical practice, NM usefulness for professionals and patients, potential need for more NM training courses, factors that may promote or limit NM application, and finally a definition that may best represent NM.

The 2023 and 2024 questionnaires differ slightly from each other in terms of wording, but the significant difference concerns the last question on the definition of NM: in 2023, it was closed-ended and included the option "other" as an alternative to those suggested, whereas in 2024, respondents were given more room for critical thinking and unfiltered self-expression, to capture how the course had impacted their understanding of NM, "based on" but "not limited to" predefined patterns.

Yes/no questions aimed at obtaining more quantitative information (e.g. see question 1, or 3 or 4 etc.) and were analyzed through descriptive statistics. Open-ended questions, more targeted at exploring subjective aspects (e.g. when respondents are asked to motivate their yes/no answers) were examined through Reflexive Thematic Analysis (RTA), following the six-phase process proposed by Braun and Clarke (Braun and Clarke 2006; 2022). After reading data repeatedly (familiarization), relevant pieces of information were coded on a reiterative basis through representative labels (coding); the subsequent codes, were combined into candidate themes meant as patterns of shared meanings (theming): these, in turn, were refined and reviewed for consistency and informativeness (review) and named (naming). The analysis results were discussed in a report (writing up) of which I provide here the most peculiar points. In line with the Reflexive Thematic Analysis adopted in this study (Braun and Clarke 2022), themes are not predefined in order to "find" codes in data nor do they "emerge" as they were static and pre-given in data, but researchers "develop" themes through a recursive analytical process, so their subjective reflexivity on the material analyzed plays an important role.

The students' writings on the NM course topics were also read, collected and organized into an electronic corpus consisting of 471 commentary texts and 452,054 words. These were processed through Sketch Engine (SE) software and discussed through RTA, mixing the quantitative approach of corpus-based research with the qualitative approach of thematic analysis.

The SE feature "Wordlist" was used to generate a list of the most frequent words; in this case the top 100 content words were considered, mostly nouns and, to a lower extent, adjectives and verbs, but again, a reflexive approach was adopted: the list items analyzed in this study were selected based on their relevance to the research questions and not only on their statistical ranking (Braun and Clarke 2012). For example, the noun "volta" (time, used 382 times) is more frequent than the noun "ascolto" (listening, 287 times), but since the pattern of the former mostly accounts for temporal reference as in the documented formulaic expression "a volte", while the latter is more informative with regard to features of narrative competence held important by participants, only "ascolto" was actually included in the RTA.

For the same reasons, in the report section, relevant words and the themes they allowed to generate were discussed not following their statistical order but based on their meaningfulness to the students' perception of NM.

Through the SE feature "Keyword in Context" (KWIC) all instances of a target word were listed and displayed in lines showing their context (concordance). The "Word Sketch" function showed the most frequently co-occurring items for a specific word, grouped by grammatical categories, e.g. adverbs or adjectives (labelled as "modifiers" in SE).

Table 1.1 Examples for the coding and theming process (questionnaire and corpus – Reflexive thematic analysis)

REFLEXIVE THEMATIC ANALYSIS OF THE ANSWERS TO THE QUESTIONNAIRE			
Question No.	**Answer**	**Code**	**Theme**
7–8	[La MN è utile ai curanti] per formulare diagnosi più corrette ([NM is useful to caregivers] in making more accurate diagnoses.)	Diagnostic function	Successful clinical judgement
9–10	Instaurare un rapporto di fiducia con il paziente è utile anche dal punto di vista terapeutico (Establishing a relationship of trust with the patient is also useful from a therapeutic point of view.)	Trust	Quality of care relationship

Following the aforementioned steps of RTA, concordance lines resulting from the KWIC research were progressively analyzed and coded. The codes were aggregated in potential themes based on meaningful and common concepts conveyed, which in turn were refined and named. The process that led to the provisional themes (finalized later in figure 6) is shortly exemplified in Table 1.1 and Table 1.2.

After collecting and comparing the analysis results of both the questionnaires and the comments, developed themes were recursively refined and arranged in a finalized thematic map to provide a coherent and comprehensive view of the students' perception of NM (Figure 6).

Table 1.2 Examples for the coding and theming process (questionnaire and corpus - Corpus-based thematic analysis)

CORPUS-BASED THEMATIC ANALYSIS			
Selected words from the frequency list	**KWIC line (concordance)**	**Code**	**Theme**
Paziente (patient) Malato (the sick) Persona (person)	Il medico […] deve essere capace di vedere il paziente come una persona unica, al di là della sua malattia. (The doctor [...] must be able to see the patient as a unique person, beyond their illness.)	Patient vs person	Humanization of care

Caso (case)	Non si può estrapolare una persona dal contesto che la circonda […] o il rischio è quello di […] creare una mancanza di fiducia nel dialogo tra medico e paziente, ridotto, quest'ultimo, a uno sterile caso clinico, una cartella da chiudere sbrigativamente. (One cannot extrapolate a person from their surrounding context […] or the risk is that […] a lack of trust will be created in the dialogue between doctor and patient, the latter being reduced to a sterile clinical case, a file to be closed hastily.)	Person vs medical case	
Emozione Emotivo (emotion, emotional)	L'empatia, la comunicazione e il supporto emotivo forniti dal medico possono fare la differenza nel percorso di guarigione del paziente (Empathy, communication and emotional support provided by the doctor can make all the difference to the patient's recovery.)	Patients' emotions	Lightening emotional burdens in healthcare
	La MN […] contribuisce ad affrontare […] la crescente disconnessione emotiva e la sindrome del burnout nel medico. (NM [...] helps to address [...] the growing emotional disconnection and burnout syndrome in doctors.)	Doctors' emotions	

3. Results and discussion

3.1. Questionnaire results and discussion

The answers to the close-ended questions are summarized in Table 2.

In both years considered, only 18% of the respondents had heard about Narrative Medicine before attending the course. More significantly, less than 11% of them had learnt about it from other clinicians, and less than 2% had experienced it as patients or heard of it through other patients (less than 1% in

2023–2024). These low percentages are striking, considering that, although the targeted students are in their 2nd year of study and have limited hospital experience, their exposure to medical topics and trends is greater than that of laypeople. Nevertheless, 50% of them think that health professionals know what NM is (question 3) but 55% think NM is rarely applied to clinical practice. These figures contrast with the high percentage of students who find NM useful/very useful for both doctors and patients as beneficiaries of this approach (questions 7, 9).

Table 2. Main questionnaire results

Question	Answer 2023/2024	Answer 2024/2025
1. Had you ever read or heard of Narrative Medicine before this course?	Yes: 17% No: 83%	Yes: 18% No: 82%
2. If you answered Yes, how did you learn about Narrative Medicine before this course?	From professionals: < 11% Out of personal or professional interest: 5% As or from patients: < 1%	From professionals: < 11% Out of personal or professional interest: 5% As or from patients: 2%
3. Do you think healthcare professionals are familiar with Narrative Medicine?	Yes: 50% No: 50%	Yes: 50% No: 50%
5. Based on your experiences and studies, you believe that Narrative Medicine is applied to clinical practice:	Always: 3% Often: 33% Rarely: 63% Never: 1%	Always: 3% Often: 40% Rarely: 55% Never: 2%
7. For medical and healthcare professionals, the Narrative Medicine approach is:	Necessary: 70% Useful: 30% Useless: 0%	Very useful: 66% Useful: 33% Not very useful: < 1% Useless: < 1%
9. For patients, the Narrative Medicine approach is:	Necessary: 55% Useful: 42% Useless: 3%	Very useful: 60% Useful: 38% Not very useful: 2% Useless: 0%
11. Do you think more hours or more courses should be devoted to the study of Narrative Medicine?	Yes: 75% No: 25%	Yes: 74% No: 26%

The most recurrent themes identified in the answers to question 4 show that, in the students' view, the common reason for poor knowledge of NM is insufficient coverage of this subject in syllabi, a tendency to neglect human relationships in healthcare, a dominant biomedical approach to diseases, and poor communication skills among professionals. Interestingly, lack of empathy and time are identified as minor reasons:

> La MN non viene trattata abbastanza durante i corsi di medicina.
> Ci si concentra praticamente solo sul trattare la patologia.
> Ritengo che spesso in ambito medico manchi una buona capacità comunicativa.[5]

Themes related to the reasons for scarce application of NM (question 6) are logically connected with the ones mentioned for question 4: as NM is not studied enough, it is also insufficiently applied. Yet, beyond this objective relationship, the theme I named "clinician's personal attitude" offers insights into the subjective personality features that students ascribe to healthcare professionals, seemingly regardless of their (lack of) specific education on NM: doctors are defined through connotative vocabulary as "rude, cold, detached, unfriendly" and "feeling superior to" their patients, while some answers specifically depict senior doctors as less inspired by their job. Besides, as conveyed through the theme "variability", the application of NM may depend on the clinicians, the healthcare department and the pathology:

> I professionisti sanitari sono distaccati; […] pensano di essere superiori.
> [La MN] è applicata maggiormente da medici giovani, più affascinati dal loro lavoro che da medici già 'stanchi'.
> Credo dipenda dalla patologia, […dalla] materia e dal carattere degli operatori sanitari.[6]

These evaluations suggest a relationship with the theme "personal experience", one of the most reported arguments on which students based their answers. The theme "lack of time" already mentioned for question 4 is here supported by a larger amount of data and renamed "lack of resources" referring to inadequate ratio between workload, available time, and staff. It concerns the effects of the clinicians' rush and work overload on the patient's experience, revealing a generally more empirical approach to this question:

> [La MN è applicata raramente] per mancanza di tempo da parte dei medici che sono sempre oberati di lavoro.

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[5] Back-translations provided in this article were optimized through Deepl.com.
Back translation (BT): NM is not covered sufficiently during medical school courses. The focus is almost exclusively on treating the condition. I believe that good communication skills are often lacking in the medical field.
[6] BT: Healthcare professionals are detached; […] they think they are superior; [MN] is used more by young doctors, who are more fascinated by their work than doctors who are already "tired"; I believe it depends on the pathology, […] on the subject and on the character of the healthcare professionals.

> Spesso durante alcune visite sono stata trattata in modo frettoloso e poco esaustivo.[7]

Interestingly, also among the students stating that NM is "often" applied to clinical practice, their claim is based on their personal experiences and on the idea that NM is a fundamental, basic feature in healthcare that clinicians end up by using even unconsciously:

> Anche se in modo inconscio, la MN viene spesso messa in pratica dai medici.[8]

Such statements arouse a twofold reflection on whether a systematic theoretical framework for NM is missing or overlooked in medical education (as argued in answers to question 4), and/or whether it is merely the label "narrative" that sounds unfamiliar, but in fact, the NM tenets are known and hence applied.

As for the usefulness of NM to health professionals (question 7-8), the following two themes were developed: "quality of doctor-patient relationship" – which includes more trust, empathy, and better communication as subthemes – and "performativeness", implying more effective anamnesis, diagnosis and prognosis, which results, in turn, in better clinical judgement and patient treatment:

> [La MN] permette una migliore relazione, soprattutto fiducia.
> [La MN è utile] per dare una diagnosi e terapia corretta.[9]

If these concepts align with the literature mentioned in Section 1.1, other data in these answers inform new themes on the "complementary/fundamental role" of NM, conveying different and opposed students' insights into NM: on the one hand NM seems to play just an integrative role in clinical practice, on the other hand it is depicted as a constitutive and unavoidable element of any medical profession, a difference recognizable in the following excerpts:

> [La MN] va a completare il ruolo del medico.
> [La MN] è un ausilio alle cure concrete.
> Senza la medicina narrativa non esiste medicina utile al paziente.[10]

Beyond the statistical weight of these answers as reported in Table 3, it is meaningful that medical students, as future health professionals, are aware of this controversial issue already during their education, a dilemma theme recurring also in the free definitions of NM provided, which will be presently illustrated and where few respondents defined NM just as medicine with distinctive features, rather than a method/approach. Another theme concerned

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[7] BT: MN is rarely applied due to a lack of time on the part of doctors, who are always overworked. During some visits, I was often treated in a hurried and incomplete manner.
[8] BT: Even if unconsciously, narrative medicine is often practiced by doctors.
[9] BT: [NM] enables a better relationship, especially trust. [NM] is useful for providing a correct diagnosis and treatment.
[10] BT: Narrative Medicine complements the physician's role/is an aid to concrete care. Without Narrative Medicine, there is no medicine that is useful to the patient.

the concept of "humanity", meant as the condition of being human, as a reason for the necessity of NM in healthcare:

> [La MN è utile] perché si ha a che fare con soggetti umani, non inanimati. La clinica è una disciplina umana, applicata su esseri umani da altri esseri umani.[11]

Less frequently, students included in the positive effects of NM on medical staff also "improvement in the work environment", and – just in 6 answers – explicit reference to the "doctor's wellbeing":

> [La MN è utile] per avere una migliore esperienza sia lavorativa che personale. Per il medico è importante anche per imparare a gestire le sue emozioni.[12]

A comparison between these findings and the declared NM benefits for patients offers interesting insights into the differences and commonalities between clinicians' and patients' view of care. The themes of a better doctor–patient relationship and more effective treatment are confirmed, especially in terms of trust, but they are expanded by more nuanced observations: the theme "communication" articulates into subthemes of "listening", and "understanding" not only meant as activities but also as feelings and experiences with an impact on the patient's vulnerability. The answers show a causal relation between the patient's feeling of understanding/being understood/listened to and that of safety and reassurance over anxiety:

> Il paziente deve sentirsi ascoltato e capito anche solo perché in questo modo è più fiducioso e più disposto ad ascoltare i consigli e seguire le cure. [La MN] riduce l'ansia.[13]

This special focus on the NM effects on patients' fears and uncertainty informs the theme that I named "change in patient's attitude to illness", as represented in the following answers:

> La MN aiuta [il paziente] ad affrontare il caos portato nella sua vita dalla malattia […] ad accettare possibili fallimenti/complicanze.[14]

Another related theme revealed by the analysis is "awareness and participation", which concerns the patients' cooperative role in the care process as well as their expectations about the healthcare delivery, as expressed here:

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[11] BT: We are dealing with human beings, not inanimate objects. Medicine is a human discipline, applied to human beings by other human beings.
[12] BT: [NM is useful] for a better professional and personal experience; it is also important for doctors to learn how to manage their emotions.
[13] BT: The patient must feel listened to and understood, if only because this makes them more confident and more willing to listen to advice and follow treatment; [NM] reduces anxiety.
[14] BT: NM helps [the patient] cope with the chaos brought into their life by the disease; […] to accept possible failures/complications.

> [grazie alla MN i pazienti] riusciranno a comprendere e a seguire meglio le indicazioni del medico, [la MN] li rende più coinvolti nel loro processo di cura. Lo reputo utile in quanto così il paziente sa come dovrebbe essere trattato dal personale sanitario.[15]

The main theme related to the factors that may contribute to NM application is "education", including subthemes "awareness-raising activities", and the small represented but interesting subtheme of "emotional education". The theme "healthcare management" runs through students' considerations both at a microlevel, with answers suggesting the design of specific communication spaces in the hospitals, and at a macro-institutional level, highlighting the need for a more rational workload per doctor and reasonable time to spend in meaningful communication with patients.

> [Possono favorire la MN:] Un'educazione al sentimento.
> Sicuramente la formazione dei professionisti sanitari [...]. È importante anche la sensibilizzazione sulla medicina narrativa e la creazione di tempi e spazi dedicati.[16]

Data related to the potential factors limiting NM application are specular to those just illustrated, but for students more responsibility (50%) lies with the healthcare institutions and the decision makers, recognizing work overload as the main causes of short time for nurturing relations and communication with patients.

> [...] il tempo ridotto [dedicato a] ciascun paziente [...] potrebbe portare a concentrarsi maggiormente sull'aspetto clinico, trascurando quello umano. Altro fattore è l'elevato carico di lavoro che provoca stress e stanchezza, così come anche la carenza di personale.[17]

Compared with the answers to the previous question, education still plays an important but lesser role: it may be hypothesized that students view implementing more courses in the academic curricula as a more likely scenario than changing the healthcare system, so they are more skeptical about the applicability of NM if considered under an institutional–political perspective.

> La mancanza di tempo sia in ambito accademico che lavorativo [e] la scarsa propensione del ministero ad orientare la pratica clinica sul malato piuttosto che sulla malattia [limitano l'applicazione della MN].[18]

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[15] BT: [Thanks to NM, patients] will be able to better understand and follow their doctor's instructions; [NM] makes them more involved in their treatment process. I find it useful because it means that patients know how they should be treated by healthcare professionals.
[16] BT: [The following can promote NM:] Education in empathy.
Certainly, the training of healthcare professionals [...]. It is also important to raise public awareness of narrative medicine and devote specific time and space to it.
[17] BT: [...] short time for each patient [...] could lead to focus on the clinical aspect and neglect the human one. Another factor is the high workload, which causes stress and fatigue, as well as staff shortages.
[18] BT: The lack of time in both academic and professional settings [and] the Ministry's [of Health] reluctance to focus clinical practice on the patient rather than on the disease [limit NM].

Within the widely discussed theme of education, most of the students declared that NM requires more classes for reasons recalling the benefits of NM (question 4), but it is worth mentioning the theme "importance of training in NM" and the idea of attending NM courses throughout the academic path, as a distinctive new insight into the students' expectations and priorities, as argued in this excerpt:

> [...] credo che ci debbano essere più ore e più attività, soprattutto al quinto/sesto anno, quindi quando ci si inizia a interfacciare direttamente con i pazienti.[19]

As for the free definitions of NM that students provided, this is mainly seen as an *approach* to care, a set of acquired *competences* focusing on communication, among which the narrative competence stands out. Interestingly, in a few students' view, the act of listening identifies with NM itself, a theme further developed in their comments to the course learning resources (section 3.2). Other answers classify NM overtly as "medicine" or a medical branch, and anyway as the hallmark of the doctor–patient relationship:

> La MN è un approccio clinico volto a migliorare la relazione medico– paziente.
> È la metodologia di narrazione del dialogo con un paziente.
> La MN è una parte fondamentale della medicina, che riguarda il rapporto umano tra medico e paziente. Può fare la differenza sul tipo di medico che sei.
> La medicina narrativa è una medicina in cui torna ad essere importante il significato di comunicazione, ascolto e rapporto medico–paziente.[20]

The thematic analysis of the questionnaire answers shows an emerging gap between the idea of NM, the acknowledgement of its benefits, its awareness and practical application.

Considering that the first Italian NM project was implemented in 2006 and the ISS officialization of NM dates back to 2014, a possible issue raised by the results is the actual institutionalization of NM over the last decades, how NM is construed and integrated in the ideas of health and sickness rooted in the current healthcare system, in the academic establishment and, broadly speaking, in society, since the biomedical scientific model has become also the cultural folk dominating model, as Engel noticed already in 1977.

Another important result concerns the theme of successful care: students seem to consider it as the main advantage that NM offers to doctors (9,7%) rather

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[19] BT: [...] I believe there should be more hours and more activities, especially in the fifth/sixth year, when you start interacting directly with patients.
[20] BT: Narrative Medicine is a clinical approach aimed at improving the doctor-patient relationship.
It is a methodology for narrating while having a dialogue with a patient.
Narrative Medicine is a fundamental part of medicine, concerning the human relationship between doctor and patient. It can make a difference to the type of doctor you are.
Narrative Medicine is a form of medicine in which the importance of communication, listening and the doctor-patient relationship is restored.
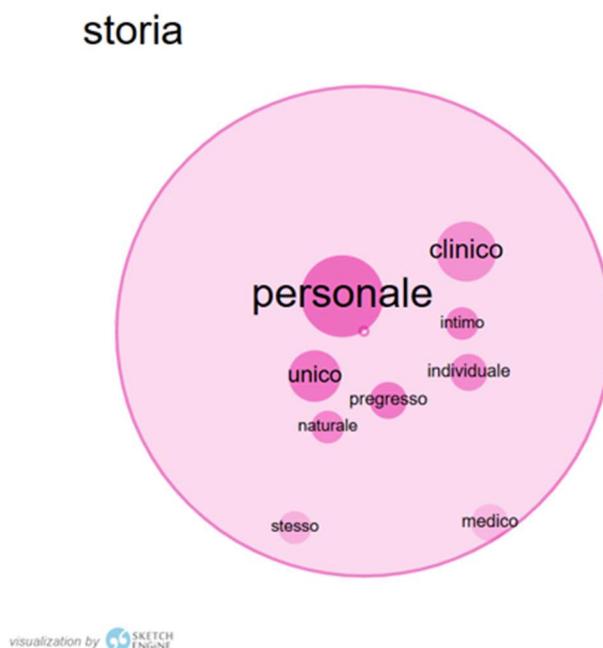
than to patients (5,3%). In contrast, among the NM advantages that students identify for patients, emotional effects of communication, attitude to illness and active and aware involvement in the care process are the main themes. This difference reveals the priorities for doctors and patients in illness experiences: of course, patients wish for effective treatment and want to heal, but it seems that for them "how" to heal matters more than expected.

Curiously and not casually, this theme is reflected in the video about doctors diagnosed with severe disease, watched in the MN classes: doctors who are/have been also patients better grasp the key role of communication in healthcare. In this respect, gaining insight into the patient's priorities can prove a source of enrichment and not of minimization of medical sciences.

3.2. Corpus analysis results and discussion

The frequency list generated through the corpus analysis (Figure 1) features among the first 100 most recurrent words the word "storia" (story), detected 415 times in the texts. The prepositional phrase "del paziente" (patient's) and the attributes "personale" and "unica" (personal and unique) are the most frequently co-occurring words in the students' comments. Figure 2 shows the adjectives most used by students for "storia", and their frequency (the larger the circle, the more frequent the matching word).

#	Noun	Frequency	#	Noun	Frequency	#	Noun	Frequency	#	Noun	Frequency
1	paziente	6,510	14	importanza	807	27	relazione	509	40	momento	388
2	medico	5,728	15	evidenza	757	28	malato	484	41	fatto	386
3	medicina	3,705	16	dottore	732	29	tocco	471	42	trattamento	385
4	cura	1,749	17	conoscenza	675	30	discorso	447	43	volta	382
5	malattia	1,320	18	approccio	635	31	situazione	445	44	competenza	377
6	rapporto	1,252	19	caso	620	32	punto	440	45	studente	377
7	persona	1,183	20	vita	615	33	capacità	437	46	salute	362
8	errore	1,101	21	tempo	562	34	riflessione	425	47	lavoro	357
9	pratica	966	22	aspetto	550	35	storia	415	48	atteggiamento	355
10	esperienza	932	23	fiducia	544	36	visita	405	49	problema	349
11	scienza	926	24	attenzione	522	37	studio	391	50	professionista	348
12	arte	877	25	comunicazione	522	38	bisogno	391			
13	diagnosi	872	26	empatia	514	39	confronto	391			

#	Noun	Frequency	#	Noun	Frequency	#	Noun	Frequency	#	Noun	Frequency
51	esame	347	64	emozione	294	77	patologia	263	90	sintomo	229
52	professione	345	65	terapia	293	78	rituale	263	91	dialogo	224
53	anno	335	66	base	289	79	ricerca	259	92	comportamento	223
54	vista	334	67	ascolto	287	80	tipo	257	93	dato	218
55	corpo	333	68	ruolo	286	81	figura	256	94	giorno	216
56	percorso	333	69	tema	286	82	atto	253	95	conseguenza	216
57	concetto	329	70	medicine	285	83	comprensione	252	96	mente	214
58	contatto	324	71	cosa	278	84	paura	249	97	informazione	206
59	evidence	309	72	esempio	278	85	tecnologia	245	98	umanità	201
60	frase	308	73	necessità	277	86	visione	245	99	formazione	200
61	ospedale	307	74	parola	273	87	qualità	235	100	realtà	199
62	strumento	303	75	senso	270	88	ambito	235			
63	grado	302	76	fine	265	89	condizione	233			

Figure 1. Frequency list for the top 100 nouns in the corpus.

storia

Figure 2. Collocates for "storia" (story) in the corpus.

These collocations allow us to infer that, after the course, students have internalized the idea of the patient as an individual and unrepeatable being, as a living carrier of their own story, and not just as an anonymous professional task to complete, identified through and with a disease or number. This is supported by 62 occurrences of the noun phrase "caso clinico" (clinical case), repeatedly used in combination with attributes such as "mero, semplice, sterile" (mere, simple, arid), verbs such as "ridurre, trattare, considerare" (reduce, treat, consider) and adverbs such as "non, non solo, solo" (not, not only/only/just). These data allow for the definition of the theme "personalization of care" and reveal that students recognized the proclivity to treat and reduce the patient to a clinical case as opposed to the equivalence patient = person = story assumed in the NM-based approach. The following quote from one of the students' comments is representative of the language used to establish this correlation:

> Considerare il paziente come una persona con una storia, non solo come uno sterile caso clinico, arricchisce il valore della cura.[21]

Also, the word "paziente" (patient, 6510 instances, with its synonym "malato" (the sick 464 instances) is the most frequent noun in the text corpus, and "persona" (person, 1182 instances) often co-occurs as predicate of "paziente", specifically 26 times in the phrase "il paziente come persona" (the patient as a person):

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[21] BT: Considering the patient as a person with a story, not just as a sterile clinical case, enriches the value of care.

> Un paziente ancor prima di essere un malato è una persona che prima di ricevere una diagnosi aveva una vita come noi; […] non ci rivolgiamo al paziente come persona ma ci rivolgiamo alla sua patologia ed è totalmente sbagliato.[22]

Further analysis of word patterns for "paziente" also suggests that the student's view aligns with Charon's (2001) definitions of NM as patient-centred and that it is the patient that is regarded as the main beneficiary of the NM-based approach, as exemplified in this sentence:

> […] questa intesa […] che si instaura tra il narratore e il lettore o ascoltatore, […] porta all'esecuzione di diagnosi più accurate e a uno stato d'animo migliore del paziente. Il medico non può trascurare la profondità emotiva del paziente. Il dialogo e l'empatia possono sicuramente portare dei benefici al paziente.[23]

Yet, as argued in Charon's text provided to the students as a reflective prompt and as outlined in section 1.1, NM is also a powerful self-reflection tool for physicians, who, through story-sharing, can better experience "their" daily challenge of facing uncertainty. Including and recognizing the doctor's perspective alongside the patient's and caregiver's in medical encounters is crucial to a full understanding of NM, which cannot be reduced to a mere collection of patients' illness stories. Comparing the questionnaire results with the corpus writings better reveals the students' stance on this point: in the questionnaire answers 66% of the students stated that NM can benefit physicians more in terms of effective, successful professional performances than of their emotional balance. As for the corpus of students' comments, the idea that patients' stories help optimize diagnosis and choose the best treatments through a wider array of information is argued more often than the physicians' need to absorb and re-construe those same stories to make more sense out of their profession and reduce the emotional burden of suffering and uncertainty they face every day. The analysis of the concordance for the words "diagnosi" (869 occurrences) and "diagnostico" (diagnosis, diagnostic) supports this insight: often qualified by adjectives like "corretto/accurato/veloce/sbagliato/errato" (correct/accurate/quick/wrong/incorrect), as in Figure 3, the noun "diagnosi" is accompanied by words related to the domain of communication, such as "ascoltare/ascolto/comprendere/comprensione/dialogo" (listen to/listening/understand, comprehension, dialogue). Some of the most concise and pregnant formulations of the role of patients' stories in the diagnostic process are the following:

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[22] BT: Even before being a patient, a person is someone who, before receiving a diagnosis, had a life just like us; […] we do not address the patient as a person but rather address their condition, and this is completely wrong.

[23] BT: […] this understanding […] that is established between the narrator and the reader or listener […] leads to more accurate diagnoses and a better state of mind for the patient. The doctor cannot ignore the emotional depth of the patient. Dialogue and empathy can certainly benefit the patient.

Si può giungere a una diagnosi più accurata e precoce tramite l'ascolto e la comprensione del disagio del paziente […].
Credo che, sebbene siano importanti le nuove tecnologie e sicuramente molto utili, non ci sia fonte migliore del paziente per riuscire a fare una diagnosi: il dialogo, l'ascolto, la comunicazione sono le parole chiave per riuscire a comprenderla.[24]
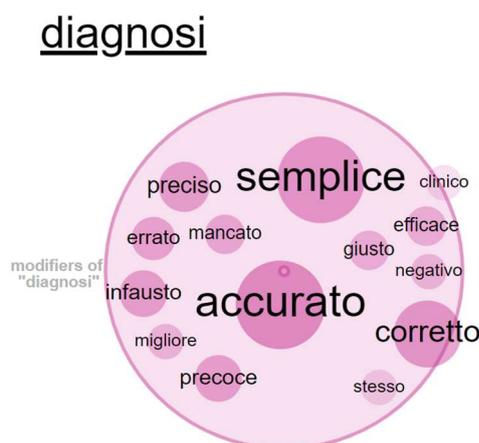

Figure 3. Adjectives co-occurring with the word "diagnosi" (diagnosis) in the corpus.

If correct diagnoses are an objective advantage for doctors and patients, the emotional self-support of NM for health professionals looks more complex. A concordance (i.e. context) analysis of the adjective "emotivo" (emotional) shows that 188 out of 366 instances refer to the emotional impact of illness on the patient; 84 to the same impact on the doctor and 90 are neutrally used. The theme of the patient's vulnerability caused by pain and life-threatening risks proves more recursive than that of the doctor's emotional reactions to the same challenges. The latter are not ignored, but comments tend to focus on them specifically when doctors deal with "hateful" patients, whose behavior can undermine their balance and professionalism. The students also connect the doctors' reactions to these particular behaviors with "containing" strategies, self-control, and detachment from overwhelming cases:

cercare di contenere il proprio coinvolgimento emotivo […] è una delle strategie possibili […]
[…] il rapporto medico–paziente implica un grado di intimità […] che […] pone necessariamente il medico in una posizione di ascolto e talvolta nel ruolo di 'confessore' […] Questo ruolo rappresenta uno degli aspetti maggiormente impattanti a livello emotivo. […] In molti casi la scelta più semplice è quella del distacco.

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[24] BT: A more accurate and early diagnosis can be reached by listening to and understanding the patient's discomfort […]. I believe that, although new technologies are important and certainly very useful, there is no better source than the patient for making a diagnosis: dialogue, listening and communication are the key words for understanding it.

> […] Ciò fa riflettere su come il medico debba mantenere un certo autocontrollo anche nei momenti di tensione.[25]

Besides, in students' comments, doctors' self-reflection is considered helpful especially when serious errors, adverse treatment outcomes and litigation issues arise:

> Riconoscere i propri sentimenti verso un paziente difficile è fondamentale per mantenere la professionalità, negare infatti queste emozioni può portare a errori clinici.[26]

According to Charon (2001), however, NM is helpful but not only limited to the management of extreme situations that doctors can go through or the prevention of errors they can make: it aims to a better connection to one's self, colleagues and patients and it is rather a routine task and an attitude – not an emergency solution – to cope with uncertainty.

Also, the theme of "empathy" illuminates the students' perception of the effect of doctors' emotions on their profession. Although it is mentioned 514 times, the word "empatia" (empathy) is defined just five times and its meaning proves controversial.

Figure 4 represents how students depict empathy on a lexical level, describing it as a "tratto" (trait), "dono" (gift), "risorsa" (resource) or "caratteristica" (distinctive feature).

Figure 4. Definitions for "empatia" (empathy) in the corpus.

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[25]BT: Trying to contain one's emotional involvement [...] is one possible strategy [...]
[...] the doctor-patient relationship involves a degree of intimacy [...] which [...] necessarily places the doctor in a listening position and sometimes in the role of "confessor" [...] This role is one of the most emotionally impactful aspects. [...] In many cases, the simplest choice is detachment.
[…] This makes us reflect on how doctors must maintain a certain self-control even in moments of tension.
[26] BT: Recognising your feelings towards a difficult patient is essential for maintaining professionalism; denying these emotions can lead to clinical errors.

Although empathy is frequently associated with the idea of NM and a more human approach to patients, comments diverge on whether it is a learnable skill that can be trained, or an intrinsically human quality that does not require any specific education.

> la medicina narrativa […] non deve essere fraintesa come una nuova forma di specializzazione, quanto, invece, un metodo che non va insegnato, che non si trova in nessun manuale, che prescinde dalle lezioni universitarie, ma che venga acquisito con l'esperienza e che abbia come matrice qualcosa intrinseco all'uomo: l'empatia.
> Charon [...] sostiene che questa competenza [empatia] può essere allenata leggendo opere letterarie, o scrivendo. La parola che più mi è saltata all'occhio è "allenare". Perché effettivamente, si può allenare l'empatia? Ho sempre pensato che alcune persone fossero più empatiche di altre e che fosse così per indole, ma […] ho capito che è solo una questione, per l'appunto, di allenamento.[27]

More often, comments highlighted doubts on the limits and risks of empathy, seen as a feeling that could emotionally overload doctors, already coping daily with illness, pain, and death.

> È difficile essere un medico empatico e non essere risucchiato da ogni singolo paziente che si vede, dalla sua condizione, dalla tristezza della sua malattia e dalla sua vita. […] da una parte l'empatia è indispensabile, dall'altra per continuare a esercitare la professione in modo efficiente, deve essere allontanata, quasi lasciata allo stretto necessario.[28]

The ambivalence of empathy in healthcare lies also in the understanding of the word (Jeffrey 2016), which in the corpus frequently collocates with the adjective "umano" (human) and linked with moral speculations, as emerged in this student's definition of empathy:

> la capacità di interpretare e 'farsi carico' dei sentimenti altrui.[29]

Ardis (2025) draws attention to the distinction between compassion on one hand, i.e. a natural emotional reaction experienced when one feels the others' pain and the urge to help them, and empathy on the other hand. The latter is not a virtue, but a cognitive condition which allows us to recognize others' feelings

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[27] Narrative medicine […] should not be misunderstood as a new form of specialization, but rather as a method that cannot be taught, that cannot be found in any manual, that is independent of university lectures, but that is acquired through experience and has its roots in something intrinsic to human beings: empathy.
Charon [...] argues that this skill [empathy] can be trained by reading literary works or by writing. The word that caught my eye is "train". Because, can empathy actually be trained? I always thought that some people were more empathetic than others and that it was a matter of temperament, but [...] I realized that it is just a matter of training.

[28] It is difficult to be an empathetic doctor and not be sucked in by every single patient you see, by their condition, by the sadness of their illness and their life. […] On the one hand, empathy is indispensable, but on the other, in order to continue practising the profession efficiently, it must be set aside, almost reduced to the bare minimum.

[29] The ability to interpret and take on the feelings of others.

and thoughts, but at the same time to set boundaries between each other in order to help them.

In this respect, says Ardis (*ibid.*), empathy has self-protective effects for doctors, it is not correlated with burnout (unlike expressed in the quoted comment and contended by other scholars), and is a refined communicative competence to train.

Another reason for which students seem to overlook the "doctor-oriented" side of NM and rather highlight the "patient-centered" one may be the still relatively scarce deployment of parallel charts in clinical practice – as described in the Columbia's approach – or of systematic supervision to guide and support clinical judgment, as suggested by Launer (2013).

In the students' comments just one reference to doctors writing about their perception of patients' stories was found, but also Charon's (2001) specific reading prompted in the course mentions this aspect swiftly, although it is constitutive of NM. In the parallel chart, medical students and health professionals write – in nontechnical language – how uncertainty and caring for the sick affect them, not necessarily filtered through a medical lens. In parallel charts, the prompts offered by patients' narratives arouse associations, memories, and interpretations that directly involve the physician's self: "Indeed, it may be that the physician's most potent therapeutic instrument is the self" (Charon 2001: 1899). Parallel charts help doctors to express and verbalize what they feel, to become aware of their emotions, instead of controlling or containing them.

As for Launer's approach instead, its hallmark lies in the teaching and deployment of supervision: intensive discussion sessions between professionals about their work, especially in cases where uncertainty rules over data, when the answer is not only one and easy, e.g. when a colleague is stuck in the decision-making process, or ethical issues are involved (e.g. continuing, changing or stopping the treatment, lack of concordance with therapies etc.).

Although supervision was not among the topics covered systematically in the course, usefulness of conversations on critical medical cases between peer professionals and advisors during medical training was interestingly highlighted in comments like this:

> […] a mio avviso potrebbero essere estremamente utili delle vere e proprie simulazioni dove lo studente comunica una diagnosi a un collega, ovviamente supervisionate da un docente/[da] i nuovi medici.[30]

The comparison between the benefits of NM for patients and physicians in clinical practice leads to the definition of the theme "managing vulnerability in the care relationship", which refers to both doctors and patients. It also raises questions about the NM perception among (future) health professionals: would doctors develop more NM skills if they knew how it helps them in managing emotions and stress? This question proves particularly meaningful in light of the latest pandemic and of a recent survey on the perception of healthcare quality

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[30] In my opinion, real-life simulations in which students communicate a diagnosis to a colleague, under the supervision of a teacher, of course, could be extremely useful.

in Tuscany, according to which the management of doctors' and nurses' fear and anxiety, alongside the engagement of patients, families and caregivers in medical interviews, are critical areas for improvement in the regional medical system (ARS Toscana 2022). This theme is represented also in the students' thoughts:

> dobbiamo anche riflettere sul fatto che i medici stessi sono persone con emozioni e storie degne di essere prese in considerazione.
> […] la cura, […] implica la consapevolezza che ognuno di noi è vulnerabile (anche i medici) in modi che spesso ignoriamo.[31]

43 out of 270 occurrences of the word "significato, senso" (meaning) in the text corpus shed light on two core ideas and related subthemes of NM and how relevant students found them in the course. The first one concerns the role of story-sharing in seeking meaning to pain and suffering, as a way to make sense out of unexpected and disruptive events like illness and trauma in NM, in line with Charon (2001), and summarized in the students' excerpts:

> La storia del paziente […] consente di attribuire un significato e un'organizzazione al caos dell'esperienza di malattia; […] trovare un senso nel percorso di cura e sentirsi partecipi del processo.[32]

The second idea is the co-creation of this very meaning, that is, the negotiation resulting from the act of both telling and listening to a story. Narrative itself is a very relational act (Bakhtin 1984): as in any communication act, it involves at least two participants, entails telling, listening, decoding the story from the listener's different perspective, retelling it and reshaping its meaning(s), checking the consistency with the intended message or renegotiating it. This point has been scarcely commented on but effectively expressed in 9 students' writings, such as:

> Quando un medico ascolta attentamente la storia del paziente, si impegna in un processo di lettura del racconto, […] diventa, in un certo senso, un 'lettore competente' che, attraverso l'atto di ascoltare, partecipa alla costruzione del significato di quella storia.
> Nel documentario […] un medico dice una frase di particolare impatto: 'Io non ho avuto pazienti, ho scritto storie con altri esseri umani'.
> […] Il medico diventa un co-autore: ogni diagnosi, ogni cura, ogni parola scambiata col paziente diventa un capitolo di questa storia condivisa.[33]

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[31] We must also reflect on the fact that doctors themselves are people with emotions and stories that deserve to be taken into consideration.
[…] care […] implies an awareness that each of us is vulnerable (even doctors) in ways that we often ignore.
[32] The patients' stories allow them to attribute meaning and structure to the chaos of the experience of illness; […] to find meaning in their treatment journey and feel involved in the process.
[33] When a doctor listens carefully to a patient's story, they engage in a process of reading the narrative, […] becoming, in a sense, a 'competent reader' who, through the act of listening, participates in constructing the meaning of that story.
In the documentary, a doctor says something particularly striking: 'I didn't have patients, I wrote stories with other human beings'.

The idea of co-construing the meaning of stories as a functional element of the therapeutic process is also confirmed through a query on the adjectives of the word "ascolto" (listening, 287 instances), mostly qualified as "attivo", "attento", "empatico" and "diagnostico" (active, accurate, empathetic, diagnostic, Figure 5), as commented in this sentence:

> […] l'ascolto attivo e l'empatia diventano strumenti altrettanto importanti quanto i farmaci o le terapie […].
> l'ascolto diagnostico attivo sembra essere la chiave che un medico […] deve sempre avere in tasca al pari del fonendoscopio.[34]
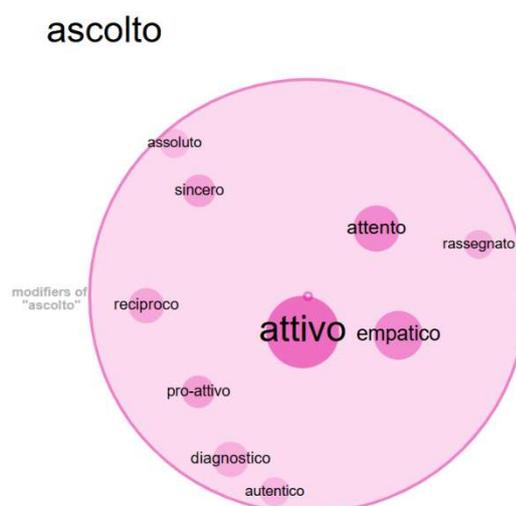
Figure 5. Adjectives collocating with the word "ascolto" (listening) in the corpus.

In this light, narrating is not a subjective, but a performative act resulting in a new product, a new story (Charon and Montello 2002), which also determines a specific course of action, a specific therapy and path of care, co-decided, co-participated. In this respect, NM recalls the performative role of particular utterances (Austin 1962) that not only state or describe but also determine and cause actions, a concept echoed in Charon: "the narrating of the patient's story is a therapeutically central act" (Charon 2001: 1889). Indeed, the noun "atto" (act) collocates with the phrase "di cura" and the adjective "terapeutico" (therapeutic) 18 times in the text corpus, as can be seen in this example:

> La capacità di ascolto del medico e la narrazione della propria storia da parte del paziente è un atto terapeutico centrale.[35]

[…] The doctor becomes a co-author: every diagnosis, every treatment, every word exchanged with the patient becomes a chapter in this shared story.

[34] Active listening and empathy become tools that are just as important as drugs or therapies. Active diagnostic listening seems to be the key that a doctor […] should always have in their pocket, just like a stethoscope.

[35] BT: The doctor's ability to listen and the patient's narration of their own story is a central therapeutic act.

While active listening is one of the narrative skills that most impressed the students, some writings assessed the feasibility of this practice against the lack of time and the increasing use of technology (data entry instead of eye-contact conversation during medical interviews). On this note, hedging strategies expressed through a more frequent use of epistemic modality – especially in the conditional form, as opposed to the indicative mode used in the comments on the therapeutic role of communication illustrated above – were noticed, as these examples show:

> […] la narrazione […] che ciascun medico dovrebbe imparare ad attuare, può andare, dunque, a migliorare la fiducia del paziente nei confronti del dottore.
> Formare i medici all'ascolto attivo e coinvolto potrebbe migliorare l'efficacia terapeutica.
> Il tempo dedicato alla comunicazione e alla relazione con il paziente non dovrebbe essere visto come un lusso, ma come una componente essenziale della cura.[36]

A gap between the narrative competence theorized in NM and the actual trend in healthcare seems to inform the students' comments in the examples provided, as if they doubted the real chances of applying NM to the hospital's daily routine.

This doubt is clarified by the following argument, which is representative of the students' expectations about the education they wish to receive. NM and doctor–patient interaction are not simply "skills" that can be learnt; they can only be developed through practice:

> La comunicazione con il paziente non è solo una chiacchierata di contorno; è un atto terapeutico centrale dentro al quale si trovano indizi sull'essenza di una persona e possibilmente anche della patologia ad essa associata. Per padroneggiare questa capacità, a mio parere però, non è sufficiente l'apprendimento di concetti e "skills": è un insegnamento che non sta scritto sui libri, si forgia lentamente praticando la professione […]. Gli anni di studi universitari forniscono una miriade di informazione sugli aspetti più teorici dell'arte medica ma non possono provvedere a trasmettere l'essenza di lavorare e confrontarsi con altre persone.[37]

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[36] BT: […] narrative processes […], which every doctor should learn to implement, can therefore improve the patient's trust in the doctor.
Training doctors in active and engaged listening could improve therapeutic effectiveness.
The time spent communicating and building a relationship with the patient should not be seen as a luxury but as an essential part of care.
[37] BT: Communication with the patient is not just small talk; it is a central therapeutic act in which clues about the essence of a person and possibly also about the pathology associated with them can be found. In my opinion, however, learning concepts and skills is not enough to master this ability: it is a lesson that is not written in books, but is slowly forged through practicing the profession […]. Years of university study provide a wealth of information on the more theoretical aspects of the medical profession, but they cannot convey the essence of working and interacting with other people.

4. Conclusions

In this study multiple data sources and mixed methods were employed to gain different insights into the idea of NM that medical students developed after the related course.

Figure 6 shows that after triangulation, three overarching themes were identified and named as "Tenets", "Limits" and "Potential" of NM perceived by medical students involved in this study.
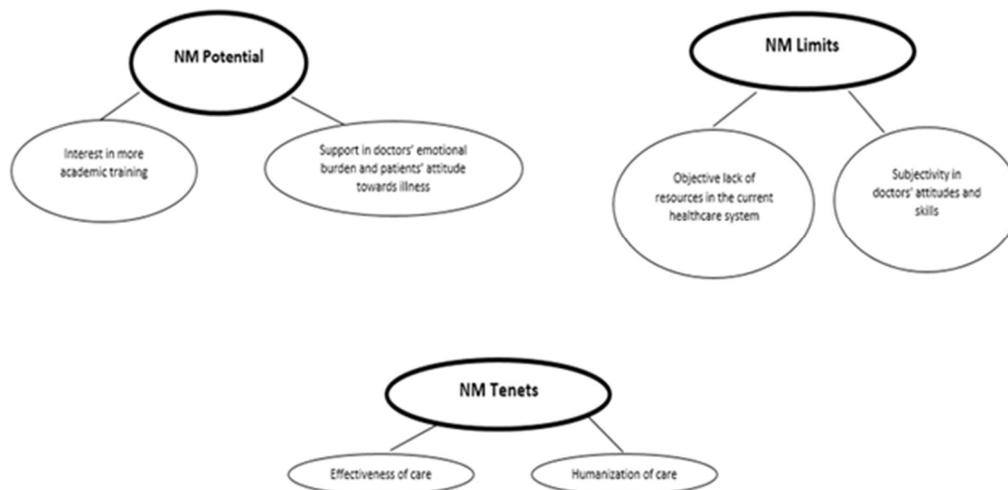

Figure 6. Finalized thematic map

NM is considered as a relatively familiar but insufficiently covered subject in educational settings and as underapplied to clinical practice. Students agree on the point that narratives allow doctors to personalize care thanks to their uniqueness, and to make it more effective thanks to their diagnostic function (tenets).

Most students perceive the principles of NM as indispensable and not only incidental in medicine, but they also think that current standards in healthcare delivery as well as personality features of medical staff can undermine their application (limits). As for the "Potential" theme, students acknowledged the cooperative role of doctors in seeking meaning in illness, but there is still relatively low awareness of the emotional support that NM can provide to doctors themselves, and not only to patients. Study and practice on different approaches to self-reflection such as parallel charts and supervision among peers may prove helpful to compensate for this gap. The analysis also revealed that although healing is a shared goal, the way patients heal – their journey towards healing – matters at least as much as the healing itself, so the communicative attitude is the most important concept with which they associate NM.

The interest in the topic of empathy may suggest that more coverage of the subject would be helpful and welcome by students. In this respect, the

importance of practicing NM in hospital real-life, highlighted by participants and represented as a subtheme of "Potential" in the map, is another result that may open up a debate on the opportunity to rethink the distribution of NM courses in the academic syllabi.

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