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TOWARDS AN INCLUSIVE NARRATIVE MEDICINE: REFLECTIONS ON THE LIMITS AND OPPORTUNITIES OF NARRATIVE MEDICINE IN ENGAGING WITH DIVERSITY

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Abstract: Over the past few decades, Narrative Medicine has emerged as a powerful response to the limitations of biomedicine, offering a more empathetic, individualised, and effective approach to healthcare by centering patients' stories. While acknowledging its considerable benefits, this article critically examines the epistemological constraints and their resulting operational limitations of the narrative paradigm underpinning Narrative Medicine. Drawing on a conceptual analysis of the ambiguities embedded in the notion of "narrative", it offers a previously unexplored framework to categorise and articulate the growing body of critical perspectives in the field.

The paper argues that the lack of critical scrutiny exposes Narrative Medicine to significant risks: implicit universalism, normative understandings of narrative, and forms of epistemic injustice that ultimately affect clinical practice. Within this framework, the article explores the relationship between narrative, power, and diversity, demonstrating how the current paradigm can marginalise minority groups and atypical subjectivities – including neurodivergent individuals and non-native speakers.

In conclusion, the article advocates for a critical and inclusive rethinking of Narrative Medicine. It calls for the integration of decolonial approaches, communicative pluralism, and the cultivation of narrative communities capable of confronting structural inequalities and broadening the communicative and decision-making rights of all actors within the healthcare process.

Keywords: narrative medicine; medical anthropology; epistemic injustice; healthcare inequalities; linguistic inclusion; minority language rights; neurodiversity.

1. Introduction

Over the past thirty years, Narrative Medicine (hereafter NM) has attracted increasing attention as a response to the limitations of Western medicine, positioning itself as a bridge between the standardised, evidence-driven framework of biomedical practice and the subjective, experiential dimensions of human suffering. NM aims to reclaim the centrality of listening to patients' stories, valuing personal illness experiences and the doctor–patient relationship as a means of integrating scientific evidence with personal and social meaning (Greenhalgh 1998; Charon 2006).

While NM has undoubtedly contributed to the humanisation of clinical practice, this article contends that its underlying narrative paradigm remains surprisingly underexplored at the epistemological level. Whereas the concept of "medicine" has been extensively deconstructed by contemporary philosophy and the social sciences, the notion of "narrative" is often uncritically embraced as a self-evident, natural, and universal category – shielded from scrutiny regarding its ambiguities, normative implications, or potential alternatives. Grounded in conceptual and theoretical orientation and informed by critically reflexive insights gained through sustained engagement with narrative medicine, this article seeks to investigate the foundations and limitations of Narrative Medicine, with particular attention to the risks posed by insufficient critical reflection.

Following a brief overview of the origins of NM, its theoretical underpinnings, and the structural differences between Anglophone countries (especially US-based) and Italian models, the paper retraces the main stages in the critique of biomedicine, framing the theoretical context from which Narrative Medicine arose. The third section offers a conceptual exploration of the idea of narrative, highlighting its universalising, naturalising, and normative assumptions, which must be explicitly examined and problematised. Within this framework, the article proposes a previously unexplored typology to systematise emerging critiques of the narrative paradigm, distinguishing between orthodox and heterodox approaches. The subsequent analysis focuses on the practical implications of these critiques for contemporary NM, particularly in relation to distinctions between "good" and "bad" narratives, and between narrative functionality and dysfunction.

The final section outlines a set of proposals aimed at fostering a more inclusive, pluralistic, and critically reflexive NM – one that can challenge implicit universalism and extend communicative and decision-making rights to all participants in the healthcare process.

2. Narrative Medicine: Origins, concepts, and development

2.1. The emergence, growth, and dissemination of Narrative Medicine

NM emerged in the 1990s as a critical response to biomedical reductionism, driven by the urgent need to reintegrate the subjective and relational dimensions of illness into clinical practice. Charon *et al.* (2016: 1) described this moment as a reaction:

> to challenge a reductionist, fragmented medicine that holds little regard for the singular aspects of a patient's life and to protest the social injustice of a global healthcare system that countenances tremendous health disparities and discriminatory policies and practices.

Simultaneously, as Hurwitz *et al.* (2004: 1) observed, many physicians *"sensed the narrowness of the prevailing rationalist framework in medicine and were beginning to take note of the 'narrative turn' in the social sciences and humanities"*.

Although foundational contributions to NM date back to the 1990s (Charon 1994; Greenhalgh 1999; Greenhalgh and Hurwitz 1999), it was only in the early 2000s that the paradigm began to consolidate and establish itself within academic and clinical discourse, leading to more structured practices and a growing body of evidence supporting its benefits. Pivotal works such as *"Narrative Research in Health and Illness"* (Hurwitz *et al.* 2004) and *"Narrative Medicine: Honoring the Stories of Illness*" (Charon 2006) laid the theoretical groundwork for an approach that bridges clinical, anthropological, and humanistic perspectives, fostering a dynamic dialogue between medicine and narrative disciplines.

The team led by Rita Charon at Columbia University remains a major reference point for NM. Charon defines the practice as the capacity to recognise, absorb, interpret, and be moved by patients' stories of illness (*ibid.*). According to the Columbia University Division of Narrative Medicine, NM

> has developed principles and practices that equip clinicians to better comprehend their patients' experiences and perspectives so as to deliver equitable and effective health care. Narrative medicine also engages with writers, artists, scholars, activists, and human services professionals of all kinds to improve health care from the perspectives of patients and providers (Columbia Narrative Medicine Programme).[1]

This definition highlights the patient-centred ethos of the American model, which equips clinicians with refined listening skills that go beyond clinical data to encompass lived experience, perception, and subjective meaning. At Columbia, NM is conceptualised as a professional competence to be acquired through specific training, with an emphasis on narrative development via literature, poetry, and the arts more broadly.

In Italy, NM was met with considerable enthusiasm from the outset, yet its trajectory diverged in some key respects, particularly in terms of its integration into healthcare systems and clinical practices. Notable early initiatives include projects led by the Istituto Superiore di Sanità (ISS),[2] which applied NM to the

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[1] Source: https://www.mhe.cuimc.columbia.edu/division-narrative-medicine (visited 12/11/2025).

[2] Italy's National Health Service (Servizio Sanitario Nazionale, SSN) is a regionally organized public system that guarantees universal healthcare coverage. The Istituto Superiore di Sanità (ISS) functions as the leading national public health research institute, providing scientific

field of rare diseases, creating spaces where patients with complex and uncommon conditions could articulate their suffering[3]. Similarly, the local health authority in Florence (ASL Firenze) launched numerous research and experimental projects from 2006[4] onward (Polvani *et al.* 2011; 2014; Trentanove *et al.* 2011), culminating in innovative tools such as the "Decalogue of the Good Doctor and the Good Patient" (Trentanove *et al.* 2013; Ballo *et al.* 2017). On a national scale, the "Viverla Tutta" initiative – developed in collaboration with the newspaper La Repubblica – collected approximately 4,000 illness narratives.[5]

The growing interest in NM and the proliferation of such initiatives – despite occasional conceptual misunderstandings – prompted the need for a unified framework. This led to the Consensus Conference organised by the ISS (CNMR National Center for Rare Diseases), which produced one of the world's first formal guidelines: *"Linee di Indirizzo per l'utilizzo della Medicina Narrativa in ambito clinico-assistenziale, per le malattie rare e cronico-degenerative"* [6] (CNMR 2015). Here, NM is defined as

> a clinical-care methodology grounded in a specific communicative competence. Narrative is the key tool for acquiring, understanding, and integrating the perspectives of all those involved in illness and care, with the aim of co-constructing a personalised care pathway ('illness story')" (CNMR 2015: 13, author's translation).

These guidelines formally differentiate the Italian model from its American counterpart, reflecting distinct epistemological orientations. Whereas the US approach is firmly patient-centred and rooted in the individual illness narrative, the Italian model embraces a relationship-centred framework, emphasising the collaborative construction of meaning and narrative between patient, physician, and care team.

In recent years, NM has enjoyed considerable success and institutional recognition. A recent scoping review by Palla *et al.* (2024) identifies three major areas of academic production: (1) the definition and conceptual framing of Narrative Medicine (theoretical), (2) the collection of stories, projects, and case reports illustrating its use in healthcare settings (clinical practice), and (3) the implementation of the Narrative Medicine approach in the education and training of medical professionals (education and training) (*ibid.*). Among the studies analysed, it is noteworthy that only three have critically examined the potential pitfalls of the NM approach, noting the risk of its remaining theoretical rather than clinically effective (Kalitzkus and Matthiessen 2009), its frequent

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guidance and coordination. Local Health Authorities (Aziende Sanitarie Locali, ASL) are decentralized regional bodies responsible for delivering healthcare services and implementing national health policies at the local level.

[3] Source: https://www.iss.it/hh-medicina-narrativa (visited 12/11/2025).

[4] Source: http://service.istud.it/up_media/narrazione/polvani.pdf (visited 12/11/2025).

[5] "The campaign gave rise to a graphic novel, a television project in collaboration with Mediaset, a literary initiative developed with the Holden School, an audiobook, and an eBook" (source: https://www.pfizer.it/archivio-iniziative) (visited 12/11/2025).

[6] Recommendations for the Use of Narrative Medicine in Clinical and Healthcare Settings for Rare and Chronic–Degenerative Diseases.

reduction to simple patient storytelling (Zaharias 2018), and the need to clarify its conceptual scope to avoid misunderstandings (Lanphier 2021).

2.2. The critical deconstruction of medicine

Narrative Medicine emerges from a well-established tradition of critical thought which, since the 1960s, has progressively challenged the conception of medicine as a universal and natural body of knowledge. Medical knowledge has increasingly been recognised as historically, socially, and culturally situated – shaped by power relations and interpretative processes (Pizza 2005; Quaranta 2006; Quaranta and Ricca 2012; Pizza and Ravenda 2016). To understand the epistemological foundations of Narrative Medicine, it is essential to retrace the intellectual developments that laid the epistemological groundwork for its emergence.

Among the earliest and most influential contributors, Michael Balint (1957) argued that the doctor–patient relationship is not a peripheral aspect of care, but one of its primary therapeutic instruments – to the extent that the physician may operate comparably to a pharmacological intervention. To disregard the relational and emotional dimensions of care, he maintained, is to diminish its impact, reducing medicine to a fragmented technical intervention. Along similar lines, George Engel (1977; 1980) proposed a biopsychosocial model of medicine, explicitly criticising biological reductionism and calling for the inclusion of psychological and social factors in clinical understanding. For Engel, illness is not merely a biological malfunction but a multidimensional phenomenon involving body, mind, and social context.

This trajectory was systematised by scholars associated with the Harvard School of Medical Anthropology – particularly Arthur Kleinman, along with Eisenberg and Good – who played a key role in formalising the conceptual distinction between disease (as a biological and clinical entity) and illness (as the subjective experience of being unwell) (Kleinman *et al.* 1978). In *“The Illness Narratives”*, Kleinman (1989) deepened this critique of biomedical orthodoxy by showing that human suffering must be understood not only in biological terms but also through the lens of personal experience.[7]

To this established dichotomy, the category of sickness is often added, referring to the socially mediated understanding of illness (Pizza 2005). From this perspective, Taussig (1980) explored how institutional and political dynamics influence the collective construction of the sick role. He argued that sickness is not a mere description of biological or psychological states, but a field of power and social negotiation. In the same period, Young (1982) analysed the role of the patient not as a strictly individual condition but as one that is socially encoded and functions as a regulatory mechanism within the relationship between individuals and healthcare institutions. Illness must therefore be approached not only as subjective perception (illness) or biological dysfunction

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[7] For further information, see Trentanove (2022).

(disease), but also as a socially constructed domain that shapes expectations, roles, and institutional responses to the experience of being unwell.

As Young (1982) compellingly argued, this leads to a fundamental theoretical shift: moving beyond the idea of a self-evident dichotomy that exists independently of cultural and social mediation. He writes:

> Sickness is redefined as the process through which worrisome behavioural and biological signs, particularly ones originating in disease, are given socially recognizable meanings, i.e. they are made into symptoms and socially significant outcomes. Every culture has rules for translating signs into symptoms, for linking symptomatologies to aetiologies and interventions, and for using the evidence provided by interventions to confirm translations and legitimize outcomes […]. The path a person follows from translation to socially significant outcome constitutes his sickness. Sickness is, then, a process for socializing disease and illness (*ibid.*: 270)

These contributions mark a paradigmatic turning point: medicine is no longer seen as a neutral and universal science, but as a historically situated practice shaped by cultural, social, and political forces. Against this backdrop, Narrative Medicine emerges as a mature and self-aware effort to reintegrate into clinical practice what biomedicine has long marginalised – namely, subjective experience, relational depth, and the personal meaning attributed to illness. In doing so, it opens new interpretative and practical possibilities for the future of care.

3. Critique of the narrative paradigm

3.1. The narrative paradigm and conceptual ambiguity

Unlike the term “medicine”, the concept of “narrative” has received relatively limited critical scrutiny.

Classical narratology defines narrative as a chrono-causal sequence composed of events (actions and/or occurrences) and existents (characters and settings), progressing from an initial state of inertia or lack to a final state of reorganisation – either positive or negative (Calabrese and Conti 2022: 330–331, author’s translation). Seymour Chatman expands this perspective, arguing that narrative is not only a means of organising thought, but also a finished product that encompasses both what is told and how it is constructed and communicated. Gérard Genette (2002), in turn, distinguished three key components: récit (narrative discourse), histoire (story content), and narration (the act of narrating). Cognitive narratology has further emphasised the neurocognitive foundations – agency, setting, and purpose – that render narrative organisation of events possible (Calabrese and Conti 2022).

Despite disciplinary differences, these perspectives share a crucial assumption: narrative is considered a universal dimension of human experience, a defining feature of the species, with individual, historical, and cultural variations often reduced to differences in expressive form.

Yet, a closer examination of the concept of narrative reveals a category marked by profound generalisation and semantic ambiguity. As Ahlzén notes,

> It is remarkable that in spite of its ubiquitous use, the concept of narrative and narrativity is seldom defined in a distinct way. If it only means 'any temporal ordering of a sequence of events,' then of course narrative is an outflow of human temporality and hence inevitably present all the time in human experience (Ahlzén 2019: 3).

In other words, if every expression of temporality is deemed narrative, the term risks becoming overly inclusive and thus loses its analytical precision and conceptual rigour.

This ambiguity has facilitated the widespread application of the concept across diverse fields, allowing it to function as a broadly accepted – yet insufficiently defined – interpretive paradigm. As a result, "narrating" is increasingly conflated with speaking, communicating, or merely expressing oneself. In this reductionist move, narrative becomes synonymous with language itself, thereby depriving it of analytical specificity. For instance, Giarelli refers to narrative as "a modality of expressing experienced reality through the attribution of meaning", concluding that "to narrate health means translating bodily perceptions into linguistically meaningful constructs" (Giarelli 2022: 326, author's translation). In such a context, the term narrative drifts into semantic generalisation. Rather than seeking a rigid definition, it may be more fruitful to frame narrative as a "polytetic class" (Wittgenstein 1953) – a category composed of overlapping family resemblances rather than an exclusive identity.

The conceptual vagueness and high adaptability of narrative as an interpretive tool have led many scholars to embrace it as a universal paradigm. The so-called "narrative turn" (Kreiswirth 1992) has entrenched the notion of "widespread" or "total" narrativity (Meneghelli 2013), presenting it as an essential and defining aspect of human experience – a foundational principle for interpreting all facets of "the human". Narration is thus construed as an innate human impulse. Humans are cast as "Storytelling Animals" (Gottschall 2012), and, as A. S. Byatt observes, narrative becomes "part of human nature as breath and the circulation of blood" (Byatt 2000: 166).

In this shift, narrative is no longer viewed as a cultural practice but as an evolutionary trait fundamental to human survival. As Gottschall (2012) explains, "We will explore the benefits of storytelling from an evolutionary perspective, examining how the propensity to invent narratives has helped humans function better both as individuals and as groups" (Gottschall 2012: 49).

Such perspectives lead to a deeply entrenched principle: narrative comes to be identified with life itself. As Byung-Chul Han aptly formulates, "to live is to narrate. The human being, as an *animal narrans*, distinguishes itself from other animals in that by narrating, it realises new forms of life" (Han 2024: 110). This shift – from communication tool to ontological principle – is intellectually compelling, but calls for critical examination. Without such scrutiny, the complexity of lived experience risks being reduced to a single, seemingly universal interpretive model.

3.2. Narrative in medicine, narrative in Narrative Medicine

Conceived in these terms, the narrative paradigm forms the epistemological foundation of NM: the narrative is positioned not merely as an adjunct to clinical practice, but as one of its structuring devices. As early as the 1980s, Mishler (1984) explored the communicative dynamics between doctor and patient, demonstrating how the dominance of technical and diagnostic language – what he termed the "voice of medicine" – tends to marginalise the "voice of the lifeworld", that is, the subjective voice of the patient's lived experience. This tension highlights not only the inherent power asymmetries in clinical communication, but also the risk of reducing the patient to a collection of clinical data, neglecting the experiential and symbolic dimensions of illness.

In the same period, Brody (1987) argued that therapeutic processes are always shaped through stories that give meaning to suffering and guide medical action. For Brody, narrative is not a rhetorical embellishment but a fundamental and constitutive element of medicine itself – one that frames how both clinicians and patients understand and engage with the experience of illness.

Within the framework of Narrative Medicine, Rita Charon identifies five core characteristics of narrative: temporality, causality, singularity, intersubjectivity, and ethicality. According to Charon, narrative offers a corrective to a form of medicine that has lost sight of its core objectives (Charon 2006). As Ahlzén explains, for Charon, narrative competence originates from the analytical skills developed within narratology:

> Doctors as well as other health care professionals should take not only a keen interest in narratives, particularly literary narrative, but also be taught some of the tools of narrative analysis. Narrative competence is not reached only by reading but also by learning to go 'deeper' into texts, how they are constructed and the way they exert their influence on the reader. The physician should be narratively skilled (Ahlzén 2019: 6).

This perspective underscores the idea that narrative competence is not a superficial act of listening, but a methodologically robust component of clinical education. It involves the development of analytical sensibilities and the cultivation of a structured, empathetic engagement with patients' stories – grounded in the principles of the narrative paradigm itself.

3.3. Orthodox and heterodox critiques of the narrative paradigm

As observed in relation to the so-called "affective turn" (Trentanove 2024), the core problem with the "narrative turn" lies in how dominant paradigms often rest upon conceptual assumptions that, in their historical moment, appear so self-evident as to evade thorough critical examination. Under such conditions, these assumptions become progressively naturalised, leading not only to a weakening of analytical inquiry, but also to a context in which raising fundamental questions can be seen as almost illegitimate. Such questions include whether narrative truly constitutes a human universal, and what specific elements – such as those outlined in Charon's model – might substantiate such a claim.

The narrative paradigm has become so deeply embedded and normalised that even the major shortcomings of narratology have failed to undermine its authority. Consider, for instance, the failed efforts of structuralist or classical narratology in the 1960s and 1970s (Calabrese and Conti 2022), which sought to identify the minimal and invariant units of narrative and to formulate a universal grammar capable of revealing the underlying structures common to all narrative texts. As Ahlzén (2019: 1) points out, these attempts ultimately served to demonstrate that "there exists no universally accepted definition of the concept narrative and that several interpretations may be around at the same time depending on field of inquiry".

It is therefore unsurprising that only recently have critical perspectives – more or less systematic – begun to emerge in response to the idea of total narrativity, and that these critiques still remain marginal and under-recognised. Here, I propose to group these critiques into two major categories: orthodox and heterodox (or radical).

3.3.1. Orthodox critiques

Orthodox critiques of narrative have emerged recently and often come from within the very tradition that helped consolidate its prominence. In many cases, these critiques are articulated by scholars who, in earlier phases of their work, played a key role in legitimising narrative as a central and inherently positive component of clinical practice and medical epistemology. Over time, and with the benefit of critical distance, some of these figures have begun to acknowledge the ambivalences, risks, and potential distortions embedded in the narrative paradigm.

Despite the strength of their critiques, these authors do not challenge the epistemological centrality of narrative or the narrative paradigm as a whole. The presumed universality of narrative, along with its foundational link to identity and selfhood, remains largely unquestioned. Rather, these critiques focus on operational limits, grey areas, and distortions, all while remaining within the dominant theoretical framework: they are rooted in an ethical-political orientation arising from a tradition that cautions against the risks of ideological or totalising narratives (Arendt 1951) and othering discourses (Said 1978), which may silence subaltern voices (Spivak 1988) and generate epistemic injustices (Fricker 2007; Medina 2013).

For instance, in his recent work, Byung-Chul Han (2024) highlights the distinction between narrative and information, arguing that contemporary "storytelling" has become a capitalist appropriation of narrative, grounded in consumerism and individualism – what he provocatively calls "informational pornography" – summarised by the slogan "Storytelling is storyselling". Peter Brooks (2022) likewise warns of the seductive power of stories, which can serve not only to create coherence and meaning but also to deceive and manipulate. Similarly, Gottschall (2021) observes that while narratives may act as a social adhesive, they also carry a darker side, functioning as tools for division and even as vehicles for the legitimation of authoritarian power.

3.3.2 Heterodox or radical critiques

In contrast to orthodox perspectives, heterodox or radical critiques do not simply caution against the overuse of narrative or warn of its potential excesses – they challenge the entire epistemological foundation on which the narrative paradigm rests. Such critiques seem rooted, even if not explicitly acknowledged, in ontological and epistemological domains, drawing upon the contributions of modern philosophers such as William James, who conceives experience as a dynamic "stream" rather than a coherent story (James 1912), and Henri Bergson, for whom reality unfolds as continuous duration (durée), irreducible to narrative sequencing or representational closure (Bergson 1911).

One of the most influential voices in this line of thought over the last decades is Galen Strawson, who, as early as 2004, questioned two core assumptions:

1. That all individuals are inherently narrative;
2. That adopting a narrative conception of the self is always beneficial.

On the contrary, Strawson argues: "The narrative tendency to look for story or narrative coherence in one's life is, in general, a gross hindrance to self-understanding: to a just, general, practically real sense, implicit or explicit, of one's nature" (Strawson 2004: 447).

To support his argument, Strawson introduces a distinction between two ideal types of subjectivity in relation to time and the self:

1. The diachronic type, which perceives identity as continuous over time;
2. The episodic type, which experiences no sense of temporal coherence and does not identify with a past or future self.

This distinction creates a critical space: not everyone needs a narrative to make sense of their life. In fact, for some individuals, the attempt to construct such a narrative may be misleading, artificial, or even harmful.

In a later essay, Strawson (2017) further develops this critique, reaffirming his position that the unity of a personal life need not take narrative form. A life, he adds, can be entirely coherent and temporally structured without ever constituting a 'story'. By doing so, he decouples narrative from the assumption that it is the only means through which human beings impose structure and coherence on their lives. He cites examples such as CVs, medical records, diaries, or daily planners as diachronic, structured forms that are not inherently narrative. According to Strawson, self-knowledge can also emerge outside the narrative frame – in fragmented, disordered, non-linear, or even atemporal forms: "There are people who are wonderfully and movingly plodding and factual in their grasp of their pasts" (Strawson 2017: 18). Aesthetic experience, reflective awareness, or spontaneous emotion can serve as equally valid sources of identity – perhaps even more so than the retrospective organisation offered by narrative.

Strawson defends the legitimacy of non-narrative lives: lives marked by weak memory, fluid or plural identities, or a sense of self that is not grounded in narrative coherence. He concludes: “Consideration of the sequence – the ‘narrative’, if you like – may be important for some people in some cases. For most of us, however, I think self-knowledge comes best in bits and pieces” (*ibid.*: 19).

Despite the strength of his critique, Strawson arguably falls into a form of implicit universalism himself: in seeking to dismantle the narrative dogma, he risks replacing it with a rigid dualism – trading one simplification for another. Nevertheless, the pioneering value of his work lies in its fundamental challenge to the assumption that narrative is an anthropological given or existential necessity.

Strawson’s position is echoed by other recent contributions that reject the presumed universality of narrativism. Berg (2023), for instance, questions the idea that a good life must necessarily have a coherent narrative structure, marked by internal cohesion, thematic continuity, and a defined arc: good lives do not have to be “good stories”, and the relationship between existential meaning and narrative form should not be taken as a normative given.

Similarly, Latham and Pinder (2023) critique the claim that viewing one’s life narratively fosters personal flourishing. In their view, this mode of self-understanding often produces the illusion of insight, while actually generating interpretive distortions. Although they acknowledge that narrative can, in some instances, offer valuable self-awareness, they conclude that in most cases it hinders authenticity, interferes with self-formation, and obstructs – rather than promotes – personal well-being.

Taken together, these heterodox critiques urge a fundamental rethinking of the claim that narrative is a human universal. They call for a more pluralistic perspective – one that recognises diverse forms of meaning-making, including non-narrative ones. The distinctions they propose – between diachronic and episodic selves, between good lives and well-narrated lives – offer valuable insight into the role of narrative in constructing the self. Ultimately, resisting overgeneralisation means acknowledging that the meaning of life can arise not only in stories, but also in fragments, in silence, in episodic experience, in gesture, or in simple presence.

3.4 Critiques of narrative in Narrative Medicine

Building on Strawson’s objections to the narrative paradigm, Woods (2011) identifies two implicit assumptions within NM that are rarely questioned:

1. That we are all “narrative selves” – individuals whose identities are primarily constructed through coherent, continuous stories;
2. That the best way to approach illness is necessarily through a narrative form.

According to Woods, these premises risk becoming prescriptive rather than descriptive, imposing a normative interpretive model onto the illness experience.

Hydén (2010) expand this line of critique by situating narrative within a broader anthropological framework. He argues that narrative represents just one among multiple culturally grounded modalities through which we can articulate, communicate, and make sense of illness and suffering. This observation challenges the epistemological dominance attributed to narrative, recognising that individuals draw on a plurality of culturally situated forms to make sense of bodily experience and suffering.

Ahlzén further explores the implications of assuming that all patients are inherently narrative and require life stories to make sense of their conditions. As he writes:

> Therefore, it is the leap from suggesting the value of doctors listening to their patients' stories, which seems next to trivially true by any reasonable definition of 'story', to claiming that all or most patients by necessity are 'narrative' and need to construct 'life-stories' that is deeply problematic. At best, it increases the interest in what ill persons have to say and not much more; at worst, it will tend to press patterns of interpretation on persons who neither want nor should be thought of as Narratives, in Strawson's sense. (Ahlzén 2019: 8).

In other words, transforming narrative from a possibility into an interpretive obligation risks exerting normative pressure on individuals, marginalising those who do not identify with or articulate themselves through narrative logic.

These critiques prompt a deeper reflection on the role of narrative in medicine. It is undoubtedly recognised that NM has long sought to establish an indissoluble connection with an advocacy for social justice (Charon *et al.* 2016), to the extent that leading scholars have issued a increasingly explicit and radical call for deeper political and social engagement within healthcare (Charon *et al.* 2021). This commitment has given rise to several models, including Structural Competency (Metzl and Hansen 2014) – which encourages clinicians to recognise the broader systems (e.g., technological infrastructures and fee-for-service models) that shape medical encounters by reframing 'cultural' issues in structural terms and cultivating structural humility – and Narrative Humility (DasGupta 2008), which rejects cultural mastery in favour of an ethics of openness and reflexivity, challenging the very idea that a patient's story can ever be fully known. Despite the growing inclusion of these perspectives in medical syllabi, workshops, and academic publications, Varman *et al.* (2022) argue that this movement still falls short of translating awareness into structural action, noting that "instead of challenging the white supremacist and racial capitalist conditions of healthcare, Narrative Medicine at its best recognises those conditions and, at its worst, passively enables them" (*ibid.*: 2)

While NM has undoubtedly marked a significant step forward from a purely technical, biomedical model, it must also confront the challenge of recognising diverse forms of self-expression and of suffering. A truly inclusive and pluralistic medical practice should be capable of accommodating not only coherent and articulate stories, but also fragmentation, silence, episodic expression, embodied and symbolic forms that characterise the lived experience of illness.

3.5 Good or bad Stories? Diversity, atypicality, and epistemic justice

As outlined in the preceding sections, classical NM assigns a central role to storytelling in constructing effective, humanised, and personalised care pathways. However, this centrality has a structural consequence that should not be overlooked: the tendency to frame illness and care narratives within normative dichotomies, shaped by culturally embedded value judgements. In clinical practice, this often manifests as a distinction between “good” and “bad” narratives, stories deemed “appropriate” or “inappropriate”, “functional” or “dysfunctional”, according to the goals and criteria established by NM itself.

Arthur Frank (1995), for instance, offers a triadic typology of illness narratives – restitution, chaos, and quest – assigning particular therapeutic value to the quest narrative. Within this framework, the other two narrative forms are seen as problematic and in need of transformation into a more coherent, purposeful form, such as the quest. Similarly, during her lecture “Honoring the Stories of Illness” (Florence, 14 December 2015, as cited in Trenta 2024: 21), Rita Charon emphasised that some narratives are more “functional” than others, reinforcing the idea that health professionals should learn to identify, elicit, and privilege certain types of stories.

In this light, listening within NM is not merely an open-ended act of receptivity to the expressive modality chosen by the patient. Rather, it becomes a professionalised practice in which clinicians are trained to distinguish, categorise, evaluate, and, if necessary, transform patients’ accounts in accordance with specific standards of clinical efficacy and therapeutic relevance. As stated in the official guidelines:

> Narrative Medicine must be understood as a different way of doing what is currently required by ‘good medicine’. [...] Thus, Narrative Medicine is not merely an exhortation for clinicians to adopt a compassionate and philanthropic attitude toward the patient’s desire to tell their story […]; nor can it be reduced to a simplistic call for spending more time listening to narratives. Rather, it requires competence in distinguishing between narratives that are functional and those that are dysfunctional, promoting a medicine that is ‘measured, respectful, and just.’ (ISS 2015: 6; author’s translation).

This orientation carries a significant risk: the implicit alignment of patients’ expressive performance with normative expectations shaped by the healthcare provider’s narrative training. If not critically examined, the use of Narrative Medicine during clinical encounters may become a regulatory device through which the more powerful subject– the physician – is legitimised to determine what constitutes a valid, useful, or intelligible story. This raises a series of critical questions: What happens when the physician encounters atypical forms of narration? When the patient – either by choice or due to limitations – fails to express himself/herselfwithin the dominant narrative conventions? How should clinicians respond to communication that does not conform to the usual standards of linearity, coherence, and narrative sense-making? And who are the individuals or groups whose voices remain unheard as a result?

Deep tensions emerge when NM encounters subjectivities that do not align with dominant communicative models (Erbay 2025) – typically Western, white, male, educated, and linear. The narrative paradigm tends to homogenise, while its normative standards risk reinforcing power imbalances that validate some people and expressive modes simultaneously invalidating others. The consequence is the production of epistemic injustices, silencing those who fail to conform to prevailing narrative expectations: non-native speakers, individuals with varied educational backgrounds, those with disabilities or neurodivergence as well as children and the elderly. In such cases, what fails to be recognised as a narrative becomes silence, and silence becomes exclusion.

For NM to fulfil its potential as an inclusive and effective practice, its proponents must undertake a critical deconstruction of the values and assumptions that underpin dominant notions of both medicine and narrative. Yet this theoretical work alone is not sufficient. It must be accompanied by an active shift of attention to the real individuals who enact – or endure – care practices. The clinician is not a neutral, impersonal, or purely technical agent, but a subject shaped by personal preferences, lived experiences, and professional trajectories. Similarly, the patient cannot be reduced to a generic figure, but must be recognised as a historically and culturally situated subject, bearing specific affiliations.

Otherwise, the therapeutic encounter risks being atomised into a decontextualised dyad, detached from the broader relational, social, and political systems in which it is embedded. When NM overlooks this complexity, it risks perpetuating systemic forms of exclusion and denying certain individuals the right to be recognised as epistemically competent participants in articulating their suffering and making decisions about their care. Only through a critical and pluralistic reimagining can the narrative paradigm evolve into a genuine tool of epistemic justice – capable of broadening the boundaries of what can be recognised and voiced within the space of care.

4. Towards a critical and inclusive Narrative Medicine: Challenges and proposals

To conclude, this final section offers a series of reflections aimed at reimagining NM through a more critical, pluralistic, and inclusive lens. It outlines several strategic directions that, if thoughtfully developed, could help expand the epistemological boundaries of NM – enabling it to better include marginalised subjectivities, communicative modes, and ways of knowing.

4.1 Rethinking narrative

To overcome the naturalised and universalist assumptions that often underpin narrative in NM, it is essential to explore alternative ways of articulating and giving shape to experience. The rhizomatic thinking of Deleuze and Guattari (1987) offers a valuable conceptual tool in this regard. Unlike linear and hierarchical structures, the rhizome unfolds horizontally – without a single centre – through multiple connections, discontinuities, and unpredictable directions. Rhizomatic thought invites us to rethink how experiences, meanings, and life trajectories are connected, not through a predetermined causal order, but via fluid, multiple, and non-linear processes. Causes may not always be explicit or intelligible, and the logic of narration need not conform to sequential, coherent, or teleological models.

Applied to clinical practice, this perspective encourages recognition that patients' narratives do not necessarily follow linear or canonical patterns. Rather, they may unfold in fragmentary, intermittent, non-chronological, and affectively opaque forms.

It is equally important to acknowledge how narrative is frequently associated with writing – and, in particular, with its linear, sequential, and argumentative mode of expression. But what would it mean to expand the boundaries of narrative by including other languages, channels, and expressive forms? This potential is exemplified by graphic medicine. In their manifesto, Czerwiec *et al.* (2020) emphasise that drawing – conceived not merely as illustration but as a fully legitimate cognitive and communicative device – can challenge dominant narrative norms. Graphic representation is not constrained by the linearity of text; it enables a less mediated exploration of meaning, allowing for simultaneity and synchronicity.

Multimodal approaches open expressive spaces that better align with individuals' communicative dispositions, valuing intelligences and styles often marginalised in clinical settings. In this way, graphic medicine expands the boundaries of what is expressible in clinical contexts and enhances the patient's capacity to articulate complex, emotionally layered, and authentically subjective points of view.

4.2 Mistrust as a tool for balancing power

It is impossible to envision a more equitable form of NM without addressing the dimension of power – and the asymmetry that characterises clinical relationships. Pasquini's (2023) ethnographic research on mistrust in care settings offers a crucial contribution in this regard. Departing from traditional views that interpret mistrust as a symptom of relational breakdown or failure, Pasquini shows that mistrust can function as a legitimate and structurally significant relational dynamic – structuring interactions between patients and healthcare professionals as part of an ongoing negotiation of asymmetry.

Within this framework, mistrust becomes a strategic and ambivalent resource for regulating roles, risks, and degrees of authority that each party is willing to claim or delegate. Care relationships are therefore not neutral: they are traversed by tensions and risk management strategies that take shape within forms of "mistrustful dependency", which define the practical and situated limits of clinical interaction. These dynamics must be rendered visible and critically addressed, as their concealment risks reproducing existing inequalities and further marginalising already vulnerable subjects.

4.3 Narrative communities

Another step toward a more inclusive NM involves expanding the very concept of narrative – moving beyond the dyadic and dialogic exchange between doctor and patient. Narrative must be rethought not only as a relational but also as a collective phenomenon: a socially embedded process that takes form and evolves within community dynamics. Illness stories do not unfold solely within the one-to-one context of the clinical encounter; they are continually shaped, sustained, and reconfigured through the social worlds and communities to which patients and physicians belong.

From this perspective, narratives assume multidimensional forms, marked by a plurality of trajectories that enter and exit the clinical dialogue, intertwining with shared memories, layered affective networks, and social structures. To move beyond the atomised vision of the doctor–patient dyad is to imagine and cultivate genuine narrative communities.

As Arthur Frank writes, “To build our stories, we need those of others, which is why suffering must be told. We are all wounded storytellers. Not that suffering magically disappears through storytelling, but the more stories we listen to, the more pain and loneliness diminish” (Frank 1995). In this light, narrative construction is never a solipsistic act, but a communal one.

If, as Frank suggests, narratives emerge through our engagement with the stories of others, the converse also holds true: narratives actively contribute to the creation of communities. As Byung-Chul Han notes, “Narratives make the emergence of a community possible” (Han 2024: 8). The idea of narrative communities thus becomes not only an epistemological proposition but a political one – reclaiming storytelling as a generative, collective practice capable of repairing social fractures and fostering mutual recognition.

In this sense, the struggle against inequality is not external to NM: it is one of its essential and inescapable dimensions.

4.4 Decolonising Narrative Medicine

The final thread of this reflection concerns the need to radically question the primacy of verbal language as the privileged communicative channel in clinical settings and in NM. Through a critical re-examination of their own practice as speech therapists viewed through an anthropological lens, Campajola, Rovai, and Trentanove (2024) reframe therapeutic approaches to autistic individuals. Building on recent calls to promote a more equitable and decolonised global health agenda (Mehjabeen *et al.* 2025), their work reveals how the prioritisation of spoken language can amount to a form of “linguistic imperialism” Phillipson (1992), a colonial vision of communication that imposes verbal codes as the sole legitimate form of expression. This critique aligns with the field of critical applied linguistics (Pennycook 2021), which problematises the hegemony of verbal language as both an epistemic and relational device. In this context, speech functions as a normative filter, marginalising alternative communicative practices and reinforcing dynamics of exclusion and inequality.

Their findings highlight the urgency of making a clear distinction between language and communication. Speaking does not equate to communicating: difficulties in verbal production do not imply a lack of intentionality or communicative competence. In this light, the authors propose a shift from the notion of "linguistic minority" to that of "linguistic–communicative minority", with the aim of extending the protections traditionally reserved for minoritised languages to those groups who, for clinical and/or cultural-historical reasons, use expressive modalities that diverge from normative standards.

In this direction, their work calls for the beginning of a decolonisation of clinical practices – understood as the construction of equitable therapeutic spaces where plural forms of expression may emerge, based on communicative freedom, negotiated meaning, and consensual decision-making. The authors stress that belonging to a linguistic–communicative minority entails a heightened vulnerability to misunderstanding, correction, and marginalisation, precisely because one's communicative style does not conform to dominant codes. This vulnerability manifests systemically across all individuals in such groups. The most serious consequences go beyond difficulties in communication, extending to diminished participation in decision-making and limited access to basic rights, including healthcare and civil rights.

What emerges from this analysis is a call to recognise and legitimise the plurality of communicative styles, ensuring that autistic individuals – and more broadly, all communicative minorities – are welcomed and respected in their expressive specificity. This entails a profound revision of the traditional speech therapy paradigm: from a transformative model aimed at normalising and correcting, to an affirming process that validates the expressive modalities already mastered and preferred by the individual, and that seeks to facilitate mutual understanding. This positioning aligns their work with that of Jacobs *et al.* (2025), who underscore the significance of stories emerging from minoritized communities, and with the more radical proposal advanced by Varman *et al.* (2022), who articulate a model of abolitionist narrative medicine pedagogy designed to dismantle the "exclusionary origins of Narrative Medicine", which, they state, "originated from and lives on within the ivory tower" (*ibid*: 2).

NM must likewise engage with these challenges. If it is to remain faithful to its emancipatory and equity-driven foundations, it must reject the idea that there is only one clinically valid form of narrative. Instead, it must embrace the expressive modes of all linguistic–communicative minorities, recognising them as intrinsically valid and worthy of being heard. Adopting an affirming approach means not only accepting the patient's story in its authentic form, free from the constraints of pre-established narrative templates, but also actively valuing the expressive mode itself – avoiding any transformative intent or at least postponing it until after the patient has consciously granted informed consent. Only through such openness can a genuine co-construction of the care pathway emerge, grounded in equity, reciprocity, and recognition of communicative diversity.

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