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## **NARRATIVE AS A TOOL IN MEDICAL EDUCATION: THE USE OF THE MCGILL ILLNESS NARRATIVE INTERVIEW.**

This presentation is based in a research about the experience of using a narrative eliciting tool—the MINI-McGill Illness Narrative Interview (Groleau, Young and Kirmayer, 2006)—in training medical students and the evaluation of possible effects that the use of this narrative eliciting tool brought to the training process of every student.

### **1. Why study Narrative Medicine?**

The criticism over the biomedical model and the conceptual reduction of medical practice to its biological dimension, which were intensified on the second half of the XX century, brought consequences to the models of medical development and the medical practice itself. This criticism happened not just in the debating field of the public health system, which is part of social security policies, but also in the field of private health services—stronger in the United States of America—when medical issues concerning the doctor-to-patient relationship involved, likewise, legal and ethical matters that, at certain times, grew doctors and patients apart.

This doctor-to-patient relationship is built through bureaucratic procedures, sometimes even juridical ones, in which the doctor is known as the only responsible of every decision that is made in both the diagnosis and the therapeutic processes. He is enclosed in a series of evidence (exams that apparently show what is wrong, flowcharts/guidelines of behavior), that can be claimed as the truth or the proof that the doctor did the best he could in the therapeutic process with his patient.

In Moira Stewart's conception, as well as the research group of Patient-Centered Medicine's (2003), the patient notices and resents the fact that the biotechnological knowledge becomes more important in his doctor's appointment than his own personal history, unique as it is. For that matter, the biomedical model was marked by the lack of attention to the person behind the patient, with specific characteristics and concerns, and it all tended to inadequate collections of clinical data, which brings little endorsement and bad results (Platt, Gaspar, Coulehan et al., 2001).

It's wise to recall that the medical dichotomy between the attention brought to the patient and the same brought to the illness is not new, because it was mentioned by Greek medicine, through the different approaches of the School of Cos—attentive to the patients and their particularities—and the School of Cnidus—mainly worried about the classification of diseases and its patterns (Ribeiro and Amaral, 2008).

Due to such crisis centered in the doctor-to-patient relationship, other problematic models arose and were also established in the health field, especially in the last two decades of the XX century, introducing convergences in their quality improvement proposals for the communication/interaction between doctors and patients, besides proposing to offer full attention to patients (Moura, 2012). The Narrative Medicine is one among these models, which uses communication skills as base to a medical practice of full care.

The **McGill Illness Narrative Interview (MINI)** is a tool of qualitative interview to recollect personal narratives of the disease that might improve the development of communication skills of medical students and that can work along with the model of Narrative Medicine.

## **2. Narrative Medicine**

The attempt to subvert the strict biomedical logic of classic narratives used only in medical school, being the anamnesis and its structure the classic example, it can be quite difficult, but with some experiences obtained in built cases and narratives of patients becoming objects of study, overall in the context that will induce curricular changes in medical school.

According to the author and researcher Rita Charon (Brasil, 2012), the narrative knowledge plays an elementary part and also irreplaceable to Medicine and many other subjects, such as Anthropology, History, Psychology, Social Science, Law and even Mathematics. The narrative knowledge and the practice of Narrative Medicine allows closer approaches between: doctors and patients, teachers and students, doctors and doctors, as well as doctors and other professionals.

These approaches occur due to the development of empathy in the medical formation, which already uses methodological narrative tools. The Narrative Medicine is, at the same time, a clinical practice and a teaching methodology in the academic medical formation and in health, for the most part. Just as Person-centered Medicine is, it's not about a medical specialty, but about change in medical practice, particularly in the context of criticism against the biomedical model, to bring back the proper attention to the patient and not only the disease.

The author's methodological proposal, initiated in the decade of 1980 with the "Literature in Medicine" movement and developed at the *College of Physicians and Surgeons from Columbia University* in United States of America, included literature and the writing of narratives, besides staying in touch with the patient, aiming not just the development of interpretative skills and the logic behind the patient's narratives, but the ability of interacting, absorbing what is told, besides making medical students keep in touch with their own narratives possible.

In the book that introduces the methodology, Rita Charon (2006) made sure to tell personal stories, from her family and her clinical practice, to exemplify what her patients expected from her: an attentive and experienced listening of their narratives, told through words and quietness, through body language (corporal changes, gestures, physical signs in general), exam results and even stories from relatives or other healthcare providers that were already familiar with the situation, searching for some sort of meaning, a commonly diagnosis and a therapeutic conduct. Their reports don't follow the logic of the disease stated in the patient's

records or in the academic point of view, but are told in the literary way, narrating the people's stories and their own relation with them, their reactions, fears and interactions.

According to Charon (2006), the development of narrative proficiency pursues to graduate doctors capable of sustaining a relationship with a patient from beyond the moment of providing a diagnosis and the establishment of a proper treatment, but also during the process of that treatment, including a long-term monitoring of patients with chronic diseases, just as offering support to patients with terminal diseases. It would be the graduation of a doctor capable of witnessing a patient's story and not just telling the story of a disease.

Researches in the medical education area, from different countries and cultures such as Taiwan (Tsai and Ho, 2012), the United States (Garrison et al., 2011) and France (Goupy et al., 2013) have been demonstrating that the use of Narrative Medicine methodologies during the academic formation improves the performance of students when it comes to abilities in communication, including the skill of listening and building a connection with a patient.

The training of Narrative Medicine allows medical students to develop the ability of communication through two phases: at first, listening and comprehending the patient, his life's experiences and how the disease is part of it; secondly, speaking, explaining the diagnosis to the patient, as well as the treatment and its monitoring. Therefore, it's possible to build a straightforward connection with the patient, allowing an exchange of knowledge between the latter and the student, a future doctor (Coaccioli, 2011).

### **3. The McGill Illness Narrative Interview (MINI)**

The McGill Illness Narrative Interview is a protocol of qualitative interview, semi-structured, that enables the personal recollections of diseases (Groleau, Young and Kirmayer, 2006).

It was developed by professors Danielle Groleau, Allan Young and Lawrence Kirmayer, all from McGill University, in Canada. It's about a methodological tool developed initially to take part in researches in the ethnographic field, and in the health field as well, about experiences of illnesses and the way people dealt with them, and what it meant to those people according to their environment, their social context and their previous experiences, used in various sociocultural contexts (Craig, Chase and Lama, 2010; Pelaéz and Caballero, 2011; Barradas et al., 2012).

The script of the MINI interview was translated into Portuguese and trusts the authorization and monitoring of its authors. What was first developed for research, has now become a tool studied further and further, and utilized as an educational tool in programs and projects that searches for the development of narrative skills and communication among medical students.

The authors propose that the accounts of experience from the disease can be classified in three models of acknowledging how a patient becomes sick (the signs and medical symptoms) and how the illness developed inside that person, the way the disease meant and was understood by them within the quality of their own singular existence:

1. *Explanatory Models* based on casual awareness that involves conventional models of explaining the development of an illness, and can be based on scientific knowledge and wide propagation of health matters, such as: "I have a cold, you know, a virus" or "I had a heart attack because I was under a lot of stress".

2. *Prototypes* of experience that analyze important episodes of the individual's life or of someone close to them that allows an elaboration of meaning to the disease through analogy (with a certain episode). In one of the

examples given by the authors, a person explains that they quit smoking after their uncle and aunt passed away due to lung cancer, an episode that left him “very afraid”.

3. *Chain-complexes* in which there are metonymic and temporal connections between past experiences and symptoms where the individual shows at the present moment—the doctor’s appointment—no possibility of establishing, through that first encounter, a casual connection or prototypic between the events and the symptoms related. The example the authors give is quite narrative: “When I was getting a divorce, I started having a pain in my chest. Then, I got a cold that never went away.”

The script of the MINI interview is divided in five sections that explore the following themes in the experience of getting ill:

Initial Narrative – it’s a non-structured section that aims the narrative of events related to the illness in an organized way, considering time and space.

Prototypes – the most structured part of the interview, which targets to elicit accounts of the prototypes of experience of getting ill, lived by the person interviewed or told by someone close to them, according to the connections made by the person who is the object of the interview.

Explanatory Models – this section’s purpose is to elicit narratives that allows the acknowledgement of the explanatory models that the person interviewed built to understand the cause(s) of their illness.

Help Seeking and Service Utilization – it’s a section considered optional by the authors, the need of being utilized can be considered only if it’s relevant to the context. It aims to explore the narrative of the experience built in the treatment held in health services.

Impact of Illness – its goal is to explore the impact of the disease in the person’s life.

The script is composed of forty-six open questions. Some questions are repeated, encouraging the person interviewed to tell the story again in a way that comes out more naturally, in a most accurate perspective of the experience and not just what they imagine the interviewer expects them to say.

It’s a tool which its application can last about two hours (depending on the story behind the disease and the interactive processes between who asks and who answers the questions), and for the interviewer, a previous contact with the script and the theoretical basis is needed.

As a methodological tool of recollection of narratives of illness, the MINI, applied in medical academic formation, allows the students to develop narrative abilities through the interview with their patients, from listening their narratives.

The emergency of the stories of illness found in these three models of explanation that mean, sometimes, similar episodes, and the student’s contact with the moment of the constructions made through these narratives as they interview each patient, motivates them to develop a new posture before new patients, quite differently from the posture that usually takes place in the classical anamnesis interview, when the focus is mainly on signs and symptoms, the story of a disease, not of a patient, of his illness and his suffering.

With all that considered, the student’s initial contact with the patient tends to be richer because, in MINI, since it is a tool of open question, the rhythm of the interview is molded by the patient, as it gets deeper in the facts. The narratives about the illness that emerge are different from the ones the students learn inside the biomedical model, which also tends to learn narrative about illness.

Even being able to use their own biomedical knowledge, which are more and more part of their culture, the patients subjectify what they already know, creating their own meaning to it, things that the medical students have to deal with when they are in the place of listening and building an intersubjective relationship with them.

#### **4. Second Person Perspective**

The change in the intersubjective relationship of the doctor with the patient that is expected from models such as the Patient-Centered Medicine and the Narrative Medicine, especially when utilized in the context of medical academic formation and future doctors, can be explained conceptually through the phenomenological model of Perspective of First, Second and Third-Person.

Northoff and Heinzl (2003) presented this concept of First, Second and Third-Person as a way to explain the different approaches and understandings of academic disciplines that Neuroscience, Psychiatry and Philosophy have from the same object of study: the concept of *self* and self-consciousness. The authors listed the concept explaining each perspective:

First-person perspective – it's the experience that was already lived, pre-reflexive, from their own mental and body states, the so-called "raw" feelings. It's a purely subjective experience, with no relation to others.

Second-person perspective – it's a place for the reflexive experience, intersubjective and intercorporeal, no longer individualized. The experience is known (not merely lived), mediated by the relations between the subjects inserted in a certain culture, through a certain language, whose bodies meet also mediated in a relation of lived body and objective body. The intersubjectivity allows the communication and the exchange of experiences between individuals, building the space of narrative construction and the narrative subject that can modify their own living experience (Serpa Júnior, 2011).

Third-person perspective – it's the perspective of behavior and body taken objectively, in search of factual certainty, marked by the fragmentation of the experience and by the phenomenal irresolution. It's the own perspective from the biomedical knowledge and from a science that searches the study of facts in a most objective and universal way (Serpa Júnior et al., 2007).

The medical formation through the use of tools of Narrative Medicine and lead by the model of doctor-to-patient relationship proposed by the Patient-Centered Medicine, with the patient's empowerment and with enough space for subjectivity, can be understood in the field of second-person perspective.

It aims to generate the doctor's abilities of communication to their patient, but a communication that occurs in the intersection field between the three perspectives, in the space of intersubjectivity, in which doctor and patient meet, just as teacher and student do, inserted into a linguistic community that allows exchanges. The student and the doctor are the subjects of experience, which is the contact with the other, the patient. It's the dislocation of a neutral observer position or an undetermined subject of narrative to the subject of experience, of language, implied in the relation with others inside a community.

The valorization of narrative and experience of illness in the academic medical formation allows that sociocultural and subjective aspects become a goal of clinical attention, especially in the context of integrity in matters of health care. Through the perception and the interpretation of meaning of the process of getting ill, the health professional incorporates new enunciation to their interpretative range of skills and, just as well, increases the dimension of dialogue, hermeneutic and full of knowledge and clinical practice (Favoreto and Camargo Jr., 2011), that can make an intersubjective journey to the patient's world, that is, get closer to their experience, putting themselves in the second-person perspective.

In the educational process, the narrative investment in medical formation, that is, in the development of narrative skill, through the use of tools such as the McGill Illness Narrative Interview, is an investment in medical schools to the Patient-Centered Medicine work field, aiming full care of ill subjects, in which its implication and the professional's responsibility are made necessary with the change in the doctor-to-patient relationship.

When invited to acknowledge their places in the narratives that actually listens to the patients through the processes of interactive narrative and the second-person perspective, the medical student is exercising this position of implication and responsibility according to the environment they are in, the awareness of what they learned, of their work and the care for others.

## **5. The research**

This study aimed to present a experience of use a narrative tool, the MINI, in the academic formation of medical students at the *Centro Regional de Formação Permanente Prof. João Ferreira da Silva Filho* (Regional Center's Medical School of Permanent Formation named after the Professor João Ferreira da Silva Filho) from UFRJ (Federal University of Rio de Janeiro) in the campus of Macaé, Brazil, that takes part in health programs such as the Educational Program for Health Work (*Programa de Educação pelo Trabalho para a Saúde/PET Saúde*<sup>1</sup>) where students participate in an university extension program on mental health, crack, alcohol and overall drugs addiction, also from the Federal University of Rio de Janeiro in Macaé.

In the research field, qualitative methodology was used, with the achievement of focus groups formed by students in two moments:

- Moment 1: the students still had no experience whatsoever of straightforward contact with patients, nor did they give a MINI interview before, but had already read medical records and had been studying the concepts of Narrative Medicine with the teacher responsible for the project.

- Moment 2: after the experience the students obtained with the MINI and the contact with the patients.

This matter of research aimed the analysis of the student's narratives before and after the contact with MINI. This division looked for the comprehension, through the narratives of experience of the students, of making new relationships possible between them and the patients involved in the process. Their work was focused on the mental health field, from their experiences of listening the narratives of illness from the patients and the participation of the university extension program on mental health, crack alcohol and drugs addiction, developing new ways of teaching and learning in health education.

The recordings of the focus groups and interviews were transcribed by others and these transcriptions were revised and analyzed by the researcher, using the methodology of Interpretative Phenomenological Analysis.

With the analysis, categories were identified to allow the comprehension of meanings ascribed by the students to the themes proposed in the focus groups, aimed to the experience they would get from the contact with the patients in a mental health service, from contact and use of MINI.

The following content lists some of the categories that were studied and considered relevant to this work:

**The patient's particularity and their story** – the students reported noticing how “very receptive” the patients were—with many different and quite particular stories—who could not just be stereotyped as “drug

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<sup>1</sup> This specific program studied aimed the training of health students in mental health field, more specifically in the care of alcohol and drug users. The activities of the program took place at the university campus and at a Psychosocial Community Center for alcohol and drug users (CAPSad), and involved theoretical and practical studies, always stimulating an active participation of the students.

users". The students referred to expressed feelings like "being afraid of saying something wrong and insecurity", but also of interest in "being in the other's place" with such contact. When it came to the reading of the medical records, the students understood how different it was from the straightforward contact with the patient, still remarked that some of the written reports were more detailed, emotional, with greater "sensitivity to tell a story".

**It's not just about treating the disease** – this category came up as an answer to the question "What is treatment?". The students mentioned the use of medications and even committal as a way of treatment, but recognized that treatment is "a complex action, that involves social matters". They mentioned the social environment in the case of reinsertion and taking over their lives back, realizing that treatment is something that goes beyond the relief of signs and symptoms, making care and monitoring of their lives trajectories necessary, especially in the case of substance dependence, in which relapses can happen sometimes and the concept of cure is not really considered in this kind of treatment.

When it came to questions about the MINI tool, it was identified, among others, the following categories:

**Feelings and reactions of students and Reactions and feelings of patients** – these two categories of analysis are related and talk about the concern that moves students about reactions and feelings that the MINI interview may cause to the patients, interlaced with the fear of demonstrating their own reactions and the idea that there is some sort of more "correct" and indicated way to deal with the empathic relation between student and patient. The students showed insecurity and apprehension in the way they should behave, especially before the reaction and the demonstrations of emotion from their own patients. But they identified too that these concerns decreased through the appointment with each patient, mediated by the MINI interview – Narrative of Illness, and the establishment of a relationship with the patients.

**Patient's participation** - The students also acknowledged the importance of every patient's participation in the development of the interview. They defined the course of it, if it was faster or longer, with more or less details.

## 6. CONCLUSION

The studied experience brings up a possibility to an ideological change in medical schools, aiming the academic formation of doctors in which they can be taught how to "listen to others, respect different opinions, allow themselves to considerate that not every thought is fully conceited—that there isn't just one way of looking at things, that there are good possibilities in different fields of actions that may work as well in their own field, that the answers that doctors give can be improved" (Da Ros, 2004).

In the example studied, the use of the MINI tool mediated the contact with patients, stimulating the listening of narratives from students, being more than a search of complaints, symptoms or quick explanations. Likewise, the students kept in touch with life stories and of illness, in which elicited the patients to open up through the application of the MINI interview.

It was possible to apprehend, through qualitative research, the concern of students about how the patients felt, and also of how much they were affected by their own experience, establishing an empathic intersubjective relationship.

The narratives analyzed indicate a possibility of displacement of the place where students relate to the patient to a more reflexive and intersubjective place, giving space to a broader communication and the exchange in the relationship between student and patient, and the formation of doctor with better narrative skills.

For the students, the MINI interview is a tool that can contribute in the long-term monitoring of health, since it allows wider participation in the patient's process of health care (protagonism), besides a relationship that the student may show more interest in the patient, listening to his life story and his experience in getting ill, and not just collecting objective facts about the illness itself.

For that matter, there is a displacement of attention, of Biomedicine, about an objectified body and mortified, to the possibility of listening to a humanized subject. This availability to listen to the other arose in the narrative of students, revealed as an intersubjective interest, interest of actually having a *conversation* with the patient pervaded in the medical formation, but was still marked by the fear of not knowing how to act in front of what the patient offers in his own narrative, dealing with his emotions, and dealing with what affected them with the same.

The experience studied is, therefore, about the investment in a doctor-to-patient relationship that is more humanized, that elapses, as it's understood, in a change of perspective on behalf of the students. Inserted in the context of a medical school which its curriculum has the use of active teaching in their methodologies, that participates in a specific project of extension that utilizes concepts and a tool of narrative in Medicine, it became possible the displacement of medical students to intersubjective relations, going through the perspective of the third-person (objective, impersonal) to the second-person one.

With such displacement, the students started to listen to the narratives of their patients and qualified their own narratives and attitudes, including in this action the critical knowledge of treatment, of medical diagnosis and the need to include the patient in the construction of the therapeutic project of health care and treatment.

This change in the intersubjective relation (third to second-person) can cause more implication and responsibility of the students when it comes to the patient, in the process of education and learning, and the range of health services that each of them may be part of, when he also has to assist in the development of some skills and abilities expected from a doctor.

These are students that put themselves in a critical position in the environment they are in and show themselves capable of dealing with singular and particular human suffering, using in relational and creative ways the biological knowledge they own, just as the pharmacological, anatomical, and of general and universal biomedicine.

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