FROM NARRATIVE MEDICINE TO APPRECIATIVE MEDICINE

A. Sandu[1,2,3], C. Neculau[3], S. Damian[4,5]

[1] "Stefan cel Mare" University from Suceava, Faculty of Law & Administrative Sciences, Romania
[2] LUMEN Research Center in Social and Humanistic Sciences, Iasi, Romania
[3] University of Oradea, Romania
[4] Legal Medicine Institute of Iasi, Romania
[5] Gr.T. Popa University of Medicine and Pharmacie from Iasi, Romania

Antonio Sandu, *Professor PhD, Scientific Researcher*
antonio1907@yahoo.com

Cătălina Neculau, *PhD Student,*
catalinaneculau@yahoo.com

Simona Damian, *PhD, Postdoctoral researcher, Senior forensic pathologist*
si_damian@yahoo.com

ABSTRACT — Narrative medicine is a way of addressing the doctor–patient relationship, considered to be conducive to increasing empathy through the patient's narrative of the disease and its associated symptoms [1]. The physician's role in narrative medical practice is to listen to the patient, who tells him about the symptoms of the disease he suffers of, their stories being loaded with meaning for the patients. The patient experiences the disease as a series of sufferings, whose story encodes the symptoms that contribute to the diagnosis. The narrative of the disease itself has therapeutic valences. The experience of the disease, especially of the chronic one, is an existential condition for the patient, an experience of his own bodily uniqueness. The present paper presents a series of possible correlations between narrative and appreciative therapy, brought together in the sphere of narrative medicine.

KEYWORDS — medicine, narrative medicine, therapy, appreciative medicine, stories, patient.

INTRODUCTION

Narrative medicine is a way of addressing the doctor-patient relationship, considered to be conducive to increasing empathy through the patient's narrative of the disease and its associated symptoms [1]. The physician's role in narrative medical practice is *to listen* to the patient, who *tells him* the symptoms of the disease he suffers of, *their stories* being loaded with meaning for the patients. The patient experiences the disease as a series of *sufferings* whose story encodes the symptoms that contribute to the diagnosis. The experience of the disease is denominated in the scientific literature as *wounded humanity* [2] by the loss, in various proportions, of the freedom of bodily limitations generated by the illness, the autonomy of a greater dependence on caregivers and the lack of knowledge necessary for proper management of self-care, as well as a change in self-image, including self-esteem in some situations [3]. The experience of the disease, especially of the chronic one, is an existential condition for the patient, an experience of his own bodily uniqueness. The narrative of the *disease* itself has therapeutic valences. Narrative medicine is an integrative approach that emphasizes the importance of anthropological, philosophical and literary studies in medicine practice. The practice of narrative medicine starts from the idea of honoring *stories of illness* [1], being an approach to patient-centered medicine. By increasing the empathic abilities of physicians, one pursues a *humanization* of the practice, and a personalization of it.

NARRATIVE PRACTICE

Narrative knowledge [4], [5] is the understanding of the meanings of messages embedded in the discourse, in the form of narratives filled with particular meaning for the narrator, and doubled by a specific emotional charge. The narrative approach to commu-

nication emphasizes the significance - often unconscious - with which the subject invests stories about their own experiences, or that of others, but which affects them significantly.

The narrative perspective focuses on the *narrative relationship* between the storyteller (emitter) and the listener (receiver). It is this relationship that *semantically invests* the story, the narrative context generating a phenomenon of *social construction* [6] and establishing meaning on narrated social reality. The experience of chronic illness, for example, becomes a narrated experience [7] when the subject describes the symptoms in an explanatory manner, *how they feel the symptoms*, what *associations* the subject makes with different events in his life, what sense he attributes them - the exhatological role of suffering, or rather the punishment for various sins, the pedagogical dimension of suffering, etc.

The social-constructionist perspective emphasizes the construction of the way in which the subjects of the various social interactions build their meaning on the *social reality*. Based on these, individuals organize their own action, taking note of events and explaining them, in the context of social interaction, and within the interpretative communities - groups of individuals who participate in *processes of negotiating the meaning* of a social event. The narrative perspective emphasizes the *subject* of the social interaction as a key character in constructing the meanings that it gives to its own *significant stories*. The two perspectives are complementary, both aiming to capture how the community, namely the individual, makes sense to social reality. Disease as a social reality is different depending on its definition by the patients themselves, by doctors and the society in general.

Narrative knowledge involves the subject's emotions and feelings, as such he is less susceptible to generalization [4] in the manner of classical epistemology. The narrative perspective, in complementarity with the socio-constructivist one, emphasizing the intersubjective side and the expressed identity, is inductively built, the universality being the result of an integrative process and not of one's own omission. The experience of patient-centered medicine [8] becomes convergent with the narrative one, as long as the experimental uniqueness of each pathology is admitted [9].

The narrative experience involves the existence of multiple perceptual positions. One and the same story, for example, the classic fairy tale, the same symbolic reality can be seen from radically different narrative perspectives, the experience narrated by the princess will radically differ from that of the Dragon and that of the Prince. The story permits the unification of perceptual positions, in a unique synthesis, that makes up the story. In medical practice, the perspective of the chronic patient can be combined with that of caregivers, be they family, care institutions, etc. Chronic conditions can be experienced starting from discomfort and pain, from the extent of disability and social dysfunctions in patient's life, from social pressure to and from caregivers, from care resources, and so on.

The narrative perspective allows the transformation of experiences into characters, facilitating the therapeutic process and mobilizing the motivational resources of the person. Pediatric practice can benefit from the narrative content, transforming the experience of the disease into a fairy tale, in which the child invested as a fairytale character faces the disease, but also the therapeutic discontent in the sense of initiatory attempts. Narrative medicine places the patient in the role of narrator — of his experiences in the actual life of the disease — and of a physician in the quality of co-constructing the narrative experience [10]. The construction of a narrative identity of the disease and the patient requires the fragmentation of the roles of the Capersian patient that assumes the different perceptual perspectives of their own story on the cornice condition.

The narrative perspective allows the transformation of experiences into characters, facilitating the therapeutic process and mobilizing the motivational resources of the person. Pediatric practice can benefit from narrative content, transforming the experience of the disease into a fairytale, in which the child, invested as a fairy tale character, faces the disease, but also the therapeutic discontent in the sense of initiatory attempts. Narrative medicine places the patient in the role of a narrator - of his experiences in the actual life of the disease - and the physician as a co-constructor of narrative experience [10]. The construction of a narrative identity of the illness and the patient requires the fragmentation of the patient's roles as a person who assumes the different perceptual perspectives of his own story on the chronic condition.

DEFINITIONAL CEREMONIES IN NARRATIVE THERAPY

A first perspective of narrative medicine is that *the stories of the patient are the ones that matter* [10], this approach being distanced by diagnostic protocols, which in the name of evidence-based standardization of medicine have sent the patient's experience to a peripheral position, incompatible with adequate management of self-care and real autonomy. The principles of narrative medicine, explained by Rita Charon et al. [11], are: (1) action towards social justice; (2) disciplinary rigor; (3) inclusiveness; (4) tolerance of ambiguity; (5) participatory and nonhierarchical methods; and (6) relational and intersubjective processes.

The term *definitive ceremony* was introduced by Barbara Myerhoff [12], [13], and implies providing self-expression possibilities for the individual to be seen and understood in his own terms, others being witnesses to his being. Michael White introduces the term in therapeutic practice, emphasizing the role of the outsider witnesses in authenticating the subject's experiences and constructions. The subject is invited to present significant stories about their own existence, an audience usually made up of subjects with whom they share similar experiences, and who play the role of external witnesses [14], [15].

Narrative therapy through the narrative definition ceremonies includes a series of stages:

Stage 1: The therapist or facilitator of narrative intervention requires the subject to respond to an interview that emphasizes the story of significant experiences. The other participant assists in the role of external witness.

Stage 2: External witnesses tell their own perception of the subject's story,

Stage 3: The subject is invited to express his/her own feelings, impressions, ideas etc. to the ones outlined by the external witness,

Stage 4: Participants discuss their own experiences, aiming to understand why they made a particular statement or put a particular question [14].

APPRECIATIVE MEDICINE

A particular form of narrative medicine is proposed by Tel Fanklin [16] as *appreciative medicine*. The origin of this technique can be identified in a method of organizational development called the appreciative survey proposed by Bushe and Coperrider in 1980 and then taken up in areas such as psychology, theology, sociology.

Cooperrider proposes the following operational definition of the appreciative survey: a co-transforming research of the positive from individuals and organizations. The appreciative survey is a transformation discovery of life-generating sources of living systems in their moments of maximum efficiency and maximum creative capacity in the economic, ecological, human field. The appraisal survey involves mobilizing interrogative capacity based on the principle of unconditionally positive questions. The extent of research is correlated with that of intervention by unleashing the innovative potential of creative imagination instead of denial and criticism [17].

Appreciative intelligence is defined as the ability to reflect and perceive generative potential in difficult situations and engage in intentional actions to turn potential into positive outcomes [18]. The three components of appreciative intelligence are: redefinition of the frame or "reframing"; appreciation of positive elements; how to evolve the future from the present [19]. Reframing is the change of perspective through which things are perceived. Positive appreciation is the ability to sense the positives in events, situations, obstacles, focusing from all the elements of an object on positive (affirmative) elements.

Providing unconditionally positive trust and appreciation of the achieved performance translates the subject's experience as a successful story, or one appreciated by the researchers as being successful in other areas of the subject's conduct, unlocking its creativity [20]. Example: A person's quality of perseverance can be appreciated and gradually transformed into a winning mentality, since in essence, the winning mentality implies perseverance and tenacity doubled by a fair view of the development of events.

The principles of appreciative medicine aim at identifying the patient own well-being, perfect health that includes self-satisfaction regarding his/her own quality of life. Patient relationship is transformed from a care relationship into a partnership for health. Tel Franklin [16] considers that alternative medicine, as well as allopathic medicine, are both tributaries and limited in a problem-centered paradigm, that is, on illness and suffering. In the face of the therapist, another paradigm, namely health-centered, should be opened as a positive and natural state of the living system, much more adapted to us, in our opinion, of the idea of holistic, transmodern medicine. The fundamental transformation proposed by Tel Franklin's appreciative therapy is to shift attention from the disease to a state of disorder of the living system, to the implicit order called perfect health [21].

IMPLEMENTING APPRECIATIVE MEDICINE AS A FORM OF NARRATIVE MEDICINE

Describing a narrative medicine program with patients, Robert Slocum [22], PhD, the narrative medicine facilitator at UK HealthCare, presents a narrative medicine program based on the appreciative specificity of the practice. Within this program, questions that facilitate practice are "What is your source of hope?" "Where do you get your strength?" Of course, patients are free to focus on other experiences, including concerns, memories, etc.

DEVELOPING NARRATIVE AND APPRECIATIVE THERAPY IN ROMANIA

Narrative therapy and narrative medicine began to develop in Romania starting from narrative practice programs developed through the Psytera Association

under the coordination of Associate Professor PhD Ovidiu Gavrilovici and his collaborators [23]. The appreciative inquiry was promoted by Professor PhD Ştefan Cojocaru, being mainly implemented in the sphere of social assistance. Starting from the appreciative inquiry, Professor PhD Antonio Sandu develops a series of appreciative practices, including appreciative counseling and appreciative therapy, combined under the appreciative ethics of care.

NARRATIVE AND APPRECIATIVE PERSPECTIVES IN PRACTICE

We present a series of possible questions that facilitate the narrative-appreciative dialogue with diabetic patients.

Interviewing: The operator informs the subject about the scientific-clinical purpose of his participation to the interview.

1. *Can you please tell me how did you find out that you suffer from this disease?*

Instructions for the operator — add clarifying questions about: *How long does he/she suffer from diabetes? The context in which diabetes was diagnosed. How did he/she get diagnosed? Who and how did tell him/her the diagnosis? How did he/she feel when he/she got the diagnosis of diabetes? What was the first reaction?* It insists on the significance of communicating the diagnosis, the subject and how it has changed the universe of values (the anticipated change at the time of diagnosis — he/she will not be able to consume certain dishes, he/she will be dependent on insulin injection, he/she will be stigmatized and marginalized, will have to take care of own person and health).

2. *Tell us about a day in your life that you think have had a great success in your health state.*

Instructions for the operator — add clarifying questions about: what it means for the subject to keep his/her health under control. *What does he/she consider to be a successful adaptation to life with diabetes. Success in other areas of professional, social, family life*. How can the successful strategy be transferred to the adaptation to the chronically ill condition. How can a successful strategy be used to increase the individual's social autonomy.

3. Tell us how you adapted yourself to the life of a person with diabetes?

Instructions for the operator — add clarifying questions about: *What lifetime activities he / she believes he had to give up. If, how and by whom was the decision to give up those activities influenced? If, how and from who was informed about the disease. He/she considers that special attention needs to be paid by others and additional rights are required, due to the health condition? If he/she considers themselves as being a disabled person. If he/she is viewed as a person with disabilities. How does he/she feel about it?* Give freedom to the subject to describe any experience that he/she considers to be an adaptation to the situation of a person with diabetes.

SIGNIFICANT STORIES TAKEN FROM PATIENTS' DISCOURSE

In the following, we will exemplify a series of significant stories from patient speeches, occasioned by research into the social construction of chronic diabetic disease.

> "I tell you that, I do not know, either there should be more diabetologists, or more doctors. Because I tell you, that's why I did not agree with it at all. I'm going there at 6 o'clock in the morning to take some exams, after I take the exams, then I go to the trio, I get an order number at 10:40, and I get to go to the doctor only at noon. So I'm losing a day or two to go to the diabetes specialist, and that's why I'm rarely going, because I do not ... It's a lot of people there, it's busy, I do not know what should be done, and the diabetes clinics... they are private and us pensioners cannot afford it."
> (*Diabetic Patient Interview*)

The patient expresses his/her dissatisfaction regarding the difficult access to a specialist, effectively telling the difficulties encountered when he or she needs to get to the doctor for a specialist consultation.

Another element narrated by the patient is the importance of spirituality and family support in the process of copying with his own chronic condition. In the process of telling exceptional events that make sense of their own existence, the patient has the opportunity to reflect on the significance attributed to the events, and facilitates the construction of a narrative identity of the subject, which allows him to assert his autonomy and responsibility towards his own health condition.

> "I was, for example, once at the grave of Father Cleopa (the tomb of a hierarch considered holy, place which has become a place for pilgrimage nn) with a nephew who is a priest there, and he told me to go there that he knew I had the Father Cleopa, to go tell him what I have to say, and of course ... back then I was a little bit nervous about my girl's smoking, I did not know much about diabetes. That's a long time ago. As long as I stayed at Mihai, for about two days or so, Ioana kept calling me and tells me to come home, because Mirela no longer smokes. "Yeah, right, Mirela doesn't smoke. How can she not smoke? I left home yesterday and now Mirela no longer smokes". She says, "Well, if I tell you she no more smokes. George offered her a cigarette and she threw it out of sight". I said she was crazy, they were lying to me to come

home, I did not think it was true. When I came home, Mirela did not smoke anymore, and then I said, "See, the help is great". And I asked Mihai if he did some more substantial prayers, and he said not to blame it on him. Father Cleopa did it. And I felt very much support, help, spiritually. When I go to church, when I return home, I feel as if I'm more unloaded." (*Diabetic Patient Interview*)

A NARRATIVE COMPETENCY TRAINING PROJECT IN THE FIELD OF NURSING

The training of narrative skills of doctors is generally pursued in some narrative medicine training programs [24]. The first such program was put into practice by Rita Charon, her being considered in fact the initiator of the idea of narrative medicine.

We continue to present a narrative training program of nursing training. The objectives of the research — intervention project based on narrative practice are:

The objective of the research is to identify the particularities of the social construction of the professional identity of nursing assistants in training. The research focuses on the role of social discourse that refers to the need for a certain emotional control over the patient and the real impact of stories that contribute to the formation of the professional identity of nurses. Among the objectives of the research are:

1. Identifying the main themes that influence the professional identity of nurses in training.
2. Identifying the social discourse of emotional neutrality that requires the separation of professional and personal identity from the work of health professionals that can influence the emotional management ability of the stories encountered in the clinical practice of future nurses.
3. Identifying stories as a way of social construction of reality in the medical field and professional skills developed implicitly.

The narrative medicine program is implemented in a post-highschool private health school as early as 2011, being adapted according to the model proposed by O. Gavrilovici [25] using techniques from the narrative approach, including the technique of the outsider witness and the technique of re-membering conversations. The narrative medicine program, as it is applied, creates a context that makes meaningful stories of the clinical practice of nurses in training, tales that are governed by certain speeches, dominant themes that can describe how the social context outlines the professional identity of nurses in training [26].

The narrative medicine program starts from the methodology proposed by Rita Charon (2006) that students complete some parallels charts in which they can write what they are not allowed to write in the official medical records, patients' accusations, the patient's consultation, his or her physician's concerns, personal situations that the patient's sight wakes up in the minds of doctors. Participating training nurses are invited to elevate such parallel cards during clinical practice, and then present them to co-researchers in informal meetings. The people in the audience will then note and express their ideas, the feelings, the perceptions, the expressions that have attracted their attention, the personal experience it has been evoked, the direction of action that has been suggested to it, etc. [26].

CONCLUSIONS

The use of the narrative perspective in medicine allows the medical staff to be sensitized to the patient's experience of their own health condition. The narrative approach also allows for a better reflection on their own medical practice, and can help reduce the burnout of medical professionals. These techniques can facilitate the identity construction of health-care professionals, improve their relationships with patients, and implement patient-centered medicine. Appreciative medicine, as a particular form of narrative medicine, emphasizes the strengths of the subject, whether patient or professional, identifying strategies to extend positive experiences to other aspects of personal or professional life, including patients, to self-care management.

ACKNOWLEDGMENT

1. The interview guide presented was adapted according to the interview guide created by Sandu Antonio and used in the Postdoctoral Program Ethics of Health Policies, implemented by Gr. T. Popa University of Medicine and Pharmacy from Iasi, with funding from the European Social Fund POSDRU. The result was a case study on the development of autonomy in young people with diabetes. The use of the methodology was approved by the Ethics Committee of the Gr. T. Popa University of Medicine and Pharmacy from Iasi.
2. The program for the training of narrative skills of nurses in training mentioned in the paper is under implementation, being conducted by PhD Candidate Catalina Neculau in the NE area of Romania, and included as an applicative part in her doctoral research entitled "The Social Construction of the Professional Identity at Medical Assistants in Training", being elaborated at the University of Oradea under the coordination of Professor PhD Antonio Sandu.

REFERENCES

1. **CHARON R.;** Narrative Medicine: Honoring the Stories of Illness, University Press, New York, 2006.
2. **PELLEGRINO E.D.;** Being ill and being healed: some reflections on the grounding of medical morality// Bull N Y Acad Med., 1981 Jan–Feb, 57(1): 70–9.
3. **JOHNA S.; RAHMAN S.;** Humanity before Science: Narrative Medicine, Clinical Practice, and Medical Education// The Permanente Journal, 2011, 15(4): 92–94.
4. **CHARON R.;** Narrative Medicine a Model for Empathy, Reflection, Profession and Trust// JAMA, 2001, 186(15): 1897–1902.
5. **CHARON R.; MONTELLO M.;** Stories Matter: The Role of Narrative in Medical Ethics, Routledge, USA, 2002.
6. **SANDU A.; UNGURU E.;** Several Conceptual Clarifications on the Distinction between Constructivism and Social Constructivism// Postmodern Openings, 2017, 8(2): 51-61. doi: 10.18662/po/2017.0802.04
7. **BRODY H.;** Stories of sickness, second edition. Oxford University Press, New York, 2003.
8. **HATEM D.; RIDER E.A.;** Sharing stories: narrative medicine in an evidence-based world// Patient Educ Couns, 2004, 54:251–253. doi: 10.1016/S0738-3991(04)00237-X.
9. **HANGANU B.; VELNIC A.-A.; MANOILESCU I.S.; IOAN B.G.;** Challenges to Forensic Medicine in the Postmodern Era - the Impact of the New Technologies// Postmodern Openings, 2017, 8(3): 12–23. doi: 10.18662/po/2017.0803.02
10. **PARKER J.;** Stories, narratives, scenarios in Medicine// Arts & Humanities in Higher Education, 2018, 17(1): 3–19.
11. **CHARON R.; DASGUPTA S.; HERMANN N.; IRVINE C.; MARCUS E.; COLÓN E.R.; SPENCER D.; SPIEGEL M.;** The Principles and Practice of Narrative Medicine, Oxford University Press, 2017.
12. **MYERHOFF B.;** 'Life history among the elderly: Performance, visibility and remembering.'// In J. Ruby (ed), A Crack in The Mirror: Reflexive perspectives in anthropology. University of Pennsylvania Press, Philadelphia, 1982.
13. **MYERHOFF B.;** 'Life not death in Venice: Its second life.'// In V. Turner & E. Bruner (eds), The Anthropology of Experience. University of Illinois Press, Chicago, 1986.
14. **CAREY M.; RUSSELL S.;** Outsider-witness practices: some answers to commonly asked questions// The International Journal of Narrative Therapy and Community Work, 2003, 1:3–16.
15. **LEAHY M.M.; O'DWYER M.; RYAN F.** Witnessing stories: Definitional Ceremonies in Narrative Therapy with adults who stutter// Journal of Fluency Disorders, 2012, 37(4): 234-41. Doi: 10.1016/j.jfludis.2012.03.001
16. **FRANKLIN T.;** Expect a Miracle... You Won't Be Disappointed!// Center for Appreciative Medicine, USA, 2003.
17. **COOPERRIDER D., WHITNEY D.;** A Positive Revolution in Change: Appreciative Inquiry, Corporation for Positive Change Taos, NM, 1999.
18. **THATCHENKERY T.; COOPERRIDER D.L.; AVITAL M.;** Positive Design and Appreciative Construction: From Sustainable Development to Sustainable Value, Emerald Publishing, 2010.
19. **THATCHENKERY T.; METZKER C.** Inteligența apreciativă. Cum să descoperi calitățile de la temelia creativității și succesului, Editura Codecs, București, 2009.
20. **SANDU A.;** Some Considerations on the Social Construction of Multiple Intelligence. Appreciative Intelligence// Postmodern Openings, 2017, 8(2): 22-39. doi: 10.18662/po/2017.0802.02
21. **SANDU A.;** O abordare afirmativ-apreciativa// Seminarii Apreciative, Editura Lumen, Iasi, 2010.
22. **SLOCUM R.;** What is narrative medicine? Our expert explains, UK HealthCare, 2017. http://ukhealthcare.net/blog/what-is-narrative-medicine/
23. **PSITERRA;** Întâlnirile narative psittera, 2016, https://www.slideshare.net/OvidiuGavrilovici/psiterra-2016
24. **CHRETIEN K.C.; SWENSON R.; YOON B.; JULIAN R.; KEENAN J.; CROFFOOT J.; KHEIRBEK R.;** Tell Me Your Story: A Pilot Narrative Medicine Curriculum During the Medicine Clerkship// Journal of General Internal Medicine, 2015, 30(7): 1025–1028. doi: 10.1007/s11606-015-3211-z.
25. **GAVRILOVICI O.;** Narrative therapy in Romania. Postmodern challenges in translation// Central and Eastern European LUMEN Conference Proceedings: New Approaches in Social and Humanistic Sciences, 2015: 229–30.
26. **NECULAU C.;** Construcția socială a identității profesionale la asistenții medicali în fomare// Public presentation within the doctoral school of sociology, University of Oradea, 2017.