WHEN THE RELATIONSHIPS CURE: EDUCATIONAL PERSPECTIVE IN THE NARRATIVE-BASED MEDICINE

QUANDO LE RELAZIONI CURANO: PROSPETTIVE EDUCATIVE NELLA NARRATIVE-BASED MEDICINE

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ABSTRACT

English

Paraphrasing the title of one of John Gottman's fundamental books, *"The Relationship Cure",* this article proposes a theoretical reflection on the use of narrative in medical education, as a particularly fertile space for pedagogy to intentionally promote medics training that considers the quality of the relationships established in the doctor-patient relationship. The chosen perspective is thus epistemological, aiming to synthesize complexity theory, pedagogy, and medicine by focusing on the subject as a whole.

Italiano

Parafrasando il titolo di uno dei fondamentali libri di John Gottman *"The Relationship Cure"*, l'articolo intende proporre una riflessione teorica circa l'utilizzo della narrazione in ambito medico, quale spazio particolarmente fecondo per la pedagogia per promuovere intenzionalmente una formazione dei medici che tenga conto proprio della qualità delle relazioni che si stabiliscono nel rapporto medico-paziente. La prospettiva prescelta è così di natura epistemologica, allo scopo di compendiare teoria della complessità, pedagogia e medicina, focalizzando l'attenzione sul soggetto nella sua interezza.

KEYWORDS
Education; Pedagogy; Narrative-Based Medicine; Medics Training
Educazione; Pedagogia; Narrative-Based Medicine; Formazione dei medici

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1. An Epistemological Premise

The epistemology of complexity represented a decisive turning point in the theory of knowledge, sparking a paradigmatic revolution that undermined obsolete interpretations of phenomena in the study of the complex characteristics that distinguish postmodernity. It was thus highlighted that the complexity of a system is not so much composed of its intrinsic and objective characteristics, but rather of its properties and interrelationships, constituted both by the observer and by the latter, which constitute the terrain within which an increase in knowledge in various fields of knowledge takes place.

Scientific research into the study of complex systems has, therefore, significantly influenced general theories of knowledge, so much so that it has broken down the rigid barriers that for years have separated antinomic fields of knowledge, citing reasons attributable both to their different epistemological statutes and to the diversity of research methodologies used (Prigogine, Stengers, 1979).

Starting from this epistemological point of view, unprecedented alliances have been established (Gell-Mann, 1995) between scientific knowledge, on the one hand, and humanistic knowledge on the other. In essence, if in a certain phase of Western thought, "strictly scientific" and humanistic culture were relegated to separate spheres, with the human sciences accused of failing to achieve a certain and exact knowledge of reality – also due to Cartesian dichotomous thought, initially, and then a prevailing positivism, which also favored the spread of work practices focused mostly on a technical-operational dimension (Galimberti, 1999), in some ways still very present in various work environments – in the current historical climate the situation seems to have transformed decisively.

This important shift was also influenced by a critical-rationalist philosophical perspective, which radically revisited the empiricist and inductivist positions that had aspired to arrive at certain and irrefutable scientific truths. In this sense, this perspective supports a notion of hypothetical and probabilistic knowledge, rather than proven and stably certain, in the sense that scientific theories represent indicative and temporary keys to reality. Complexity thinking, then, embraces a perspective that is attentive to interconnections. For this reason, it does not separate a material from an immaterial dimension of knowledge. It supports highly

interacting scientific knowledge, partly due to a social need linked to globalization, which urge scientific knowledge to consider a series of aspects that previously had no reason to exist.

All this has had important consequences for the general theory of knowledge, rightfully placing the humanities within a scientific context. Ultimately, the humanities essentially differ in their application of method, but precisely because of their methodological rigor and the logical organization and structuring of the knowledge, they can both be defined as sciences.

We now understand that all sciences foster an increase in knowledge through the creation of models, driven by humanity's tendency to solve the problems that continually emerge from environment in which it is embedded and from which, obviously, it can never detach itself, being itself a “system within systems” (Montefoschi, 1985). This species-specific trait of survival and adaptation to the environment finds in contradiction a fundamental element for human progress, even in the scientific field. It is precisely in a continuous process of trial and error that it is possible to pursue study and research paths that are often unprecedented and generate new forms of knowledge (Popper, 1969).

2. Epistemology of Complexity, Pedagogy & Medicine: An Educational Alliance

The epistemology of complexity heralds an approach increasingly oriented toward the construction of multiple knowledge, also prompted by the complex needs emerging from populations. In this sense, holistic, ecological, and neo-humanist research approaches, to name just a few, are welcome, precisely because they seek to emphasize not only the inseparability of the human-environment relationship, but also to support the importance that educational processes have for the human being who seeks to govern such systems.

Since the World Health Organization has broadened and progressively revisited this concept over time (1948, 1978, 1986), no longer intending health as the absence of disease, but as a state of complete physical, mental and social well-being, we have witnessed a paradigmatic change also in this area of knowledge, thus accepting the challenge of complexity.

From a pathogenic model, primarily concerned with the study of disease causes, we have moved to a salutogenic model, with the aim of highlighting those personal and environmental components capable of producing health and, therefore,

preventing risk factors and behaviors detrimental to individual and social well-being. According to some scholars (Antonovsky, 1996), health is a process of continuous oscillation between well-being and ill-being that can be jeopardized throughout the human life cycle by various factors. In this sense, the search for a constant balance between these two poles represents a true lifelong learning experience that encourages individuals to connect themselves, their behaviors, and their life history, considering them as a complex whole.

This perspective directly calls into question pedagogy, as the focus shifts from a factual state (illness) to a hopefully achievable one (well-being), through the promotion of personal resources and healthy lifestyles capable of producing health (Cunti, Bellantonio, 2023). All of this closely concerns learning processes. If it is true that learning is essentially a process of behavior modification, then it is necessary to leverage transformative learning (Mezirow, 1991) that can significantly promote and support health-related behaviors.

To foster individual & social well-being it is necessary to address a series of aspects that decisively foster the individual's bio-psycho-social balance (Engel, 1977). For this reason, formal training contexts – which influence ways of doing, being, and feeling – represent true contexts of orientation, and therefore, of thought formation. A systemic vision of this kind requires a transdisciplinary approach to knowledge, representing a true epistemological challenge (Bocchi, Ceruti, 2007), which in the training context becomes an educational priority.

The shift that has given the individual the role of primary actor in promoting their own state of well-being and health has obviously directly affected medicine, which, in recent years, has highlighted the need to implement a true process of humanization. Indeed, this paradigmatic shift is not entirely new. Just think of the *ethos* of the Hippocratic physician, where philanthropy (from the Greek *φιλία, philía* – love and *ἄνθρωπος, ànthrpos* – man) appeared inextricably linked to *philotechny* (from the Greek *φιλία, philía* – love and *τέχνη téchni* – art). In this sense, the physician was seen as the possessor of technical knowledge but, at the same time, he was also recognized as a philanthropist.

Speaking today of humanization of medicine would seem superfluous, as medicine is human by its nature. In fact, the argument is not so obvious because it involves the different ways in which the human body has been considered over time and which have produced different visions of it, such as the body-as-machine, for example, contrasted with others in which the individual component has been valorized and emphasized, as in the case of the body-as-subject (Galimberti, 2002).

All of this has had enormous repercussions on medicine, generating diversified ways of understanding not only medical knowledge, and therefore the concepts of well-being/illness and health/illness, but also the human relationships in a broad sense (Gottman, 2001), even between doctor/patient and between healthcare professionals/patient.

Already at the end of the First World War there was a movement to support and emphasize a holistic and integrated approach to medicine. From this interpretative horizon, anthroposophical medicine was born, the result of a blending of medical, philosophical, and anthropological perspectives, which already then proposed a salutogenic vision of man. The underlying idea was that disease could be countered by drawing on all those forces present within the organism, including psychological ones, with the aim of "putting them at the service" of the healing process (Steiner, Wegman, 1925).

In this way, the therapeutic approach was viewed from a non-pharmacological perspective, resorting to physical and artistic therapies supported by anthropological and pedagogical ideals. According to the anthroposophical perspective, the human being is composed of a material dimension, the physical body, and three immaterial dimensions: the etheric body, or the set of biological forces that shape life; the astral body, or feelings; and the egoic body, which, finally, indicates the spirit. The balance between these psycho-physical components produces a state of widespread well-being, while a lack of harmony between them generates illness. Essentially, illness is the disruption of an equilibrium that affects both the physical and mental spheres (Steiner, Wegman, 1925).

Rather than for its advances in medical knowledge, which still today do not allow anthroposophical medicine to be considered a true medicine in all respects but, rather, a pseudo-medicine on a par with homeopathy, anthroposophical medicine is mostly remembered for having initiated a significant effort to integrate metaphysical and ethical principles into the medical field.

Viewing the body as a set of inextricably linked psycho-biological factors also fosters a subjective understanding of the body and a more humanized approach to medicine. These perspectives, as is well known, later gained considerable traction in some mid-twentieth-century philosophies. Phenomenology and existentialism, in fact, emphasized the subjective dimension of the body; in this sense, the body perceived by the subject is very different from the body observed by others.

From this perspective, the body significantly reveals its importance in the subject's existence. From *Körper* it becomes *Leib*, a place where emotions "inhabit" a trace

of one's existence in the world, a tool for self-knowledge, as well as for constructing and consolidating one's identity. Starting from this distinction made by phenomenology, the concept of corporeality recovers the dimension of experience, within which the connections between the exposed body, the perceived body, emotion, and cognition are substantial. Phenomenology, then, distinguishes the body itself from the physical body (Husserl, 1950), and corporeality recovers the very unity of the human being, emphasizing the inseparable link between body, emotion, and cognition, and expresses the subject's awareness of being-in-the-world (Merleau-Ponty, 1945).

Speaking today of the humanization of medicine means addressing a very sensitive issue, one that closely affects patients, doctors, and healthcare providers in the broadest sense. Thus, it is urgent to recover an authentic and empathetic relationship in healthcare, the result not only of the patient's need to be recognized for their indisputable uniqueness and wholeness, to paraphrase Beck (1997), but also of some doctors and healthcare providers who are intolerant of certain aspects of their work practices that, despite their highly specialized nature, end up impoverishing the complexity and uniqueness of individuals and interpersonal relationships.

3. Telling the Self through Illness: The Narrative-Based Medicine Turning Point

The development of relational skills in the medical-healthcare field is a topic that has begun to occupy a decidedly important space within the pedagogical literature (Acone, Marciano, 2023; Bertolini, 1994; Castiglioni, 2016; Zannini, 2008), not only as a consequence of a widespread opinion that disregards certain professional practices in this work context, which are not very dedicated to establishing an empathetic and authentic caring relationship with the patient, but also due to the intolerance of a portion of medical-healthcare professionals who, from within, complain about a progressive process of dehumanization of their professional practices.

All of this is certainly a consequence of the period of widespread crisis that has also affected public healthcare in recent times, where the lack of facilities, funding, and personnel, as well as a scale of priorities that discredits some aspects of care intervention in favor of other, more strictly therapeutic, aspects, has given rise to professional practices that, at times, generate hasty and superficial behaviors that support the idea of the patient as a subject bearing one of many cases of illness,

rather than as a subject who has the right to be the beneficiary of a unique and truly authentic care relationship.

Pedagogy is the science concerned with the study of human development, both at different stages of the human life cycle and in the diverse life contexts and experiences in which we are immersed – individual and social, professional and otherwise – by highlighting critical issues and suggesting educational proposals that hopefully can overcome them. Pedagogy is obviously interested in reflecting on those aspects that can promote well-being with oneself and others, even more so in times fraught with a certain degree of drama, such as pain and illness, which represent highly complex experiences that involve the emotional-affective, relational, and behavioral spheres.

These experiences require pedagogical attention (Bertolini, 1994). In this sense, the quality of the relationship that develops between healthcare professionals and the patient represents an important dimension that decisively influences not only the ways in which the individual faces this experience, but also the general state of well-being which, in some cases, seems temporarily jeopardized, while in others, due to the severity or chronicity of the disease, it may even be lost forever. It is no coincidence that chronic-degenerative diseases, as well as very serious and disabling ones, have been defined as a true biographical rupture, in the sense that they represent a breaking point in one's life story, an unexpected moment that interrupts the flow of one's daily life and to which the individual struggles with great difficulty to give meaning and significance (Malvi, 2011).

At the core of pedagogical attention, then, is the educational relationship established between the healthcare professional and the patient experiencing distress. Well-being in one's living environment is obviously linked to the processes of co-adaptation that push the individual to continually seek new balances within it. This two-way adaptive relationship between the individual and the environment, while obviously linked to personal aptitudes and propensities, is also inextricably linked to the quality-of-life events experienced by the individual and the educational mediations involved, which prove highly significant in influencing the quality of future behaviors (Marone, Garrino, 2022).

To be nurtured, an authentic caring relationship requires both adequate and specific time and specific training in this type of competent practice. Therefore, it is essential to bring awareness to the actions enacted in daily professional practice, especially when these involve life events that strongly and intensely impact the individual on an existential level (Marone, 2020).

Very often, however, in the medical-healthcare field, good patient interaction is not attributed to a specific competence of the interlocutor, but rather to individual

aspects related to temperament and personality traits. Knowing how to manage the relationship, however, relies on a specific competence of the healthcare professional. In this sense, the need for training in so-called relational skills arises, through which the professional assumes an educational responsibility aimed at the emancipatory change of the recipient of the care process (Zbranca et al., 2022).

At this point, from a pedagogical perspective, the question arises: what is the starting point for rethinking the educational relationship in the medical-healthcare field and what are the most appropriate training strategies to achieve this ambitious and urgently needed educational project? An interesting shift in perspective that can be considered a starting point for designing pedagogical training in the medical-healthcare field has been underway for several decades. A segment of medicine has, in fact, begun to establish important collaborative relationships with certain human sciences, with the aim of broadening the scope of intervention for traditional medicine (Frenk, 2010; Reich et al., 2008).

Alongside Evidence-Based Medicine, that is, a medicine that is based exclusively on irrefutable scientific evidence, the so-called Narrative-Based Medicine perspective (Greenhalgh, Hurwitz, 1998) has progressively established itself. This perspective was born with the aim of placing the care relationship and the value that the patient's life story and awareness of it in a therapeutic process at the core of health and well-being.

This renewed way of understanding medicine takes into consideration a series of aspects that until a few decades ago had been completely excluded, such as the patient's personality traits, the history of the illness and previous experiences, nourishing a certain quality of the relationship that is established between the doctor and the patient, so as to make it rise to the level of an authentic care practice (Launer, 2002).

At first glance, one might confuse narrative medicine, which not only focuses on the patient's illness history but also on potential new intervention strategies, with Narrative-Based Medicine, which instead focuses on the ability to acquire, interpret, and respond to illness stories (Charon, 2006). This latter approach is often used in professional education and mostly involves simply listening to the patient. Narrative medicine aims not only to give the patient a voice but also to understand the illness in its psychological, anthropological, and social aspects, thus assuming an important educational role; narrative medicine thus becomes a new professional way to approach illness from an educational and training perspective.

Narrative medicine is supported by two main actions: the first refers to the narration of the illness according to a narrative-based perspective, while the second concerns the planning and design of the therapeutic or rehabilitative plan also

through narration; regarding the latter aspect, we speak in terms of *therapeutic emplotment* (Mattingly, 1994). In other words, we refer to the construction of a therapeutic project that starts not only from medical objectives, but also by thinking about a healing story capable of supporting the meaning of the therapeutic actions that the patient must perform, with important repercussions on intrinsic motivation and, at the same time, also on improving the actual chances of success of the therapy itself.

At the heart of an increasingly necessary process of integrating medical-specialist skills with educational-narrative ones lies the ability to produce case-based clinical judgments and improve patient adherence to treatment, allowing patients to feel their needs and concerns are addressed. In this sense, the first fundamental step in narrative medicine is to interpret the patient's narrative and plan the therapeutic intervention based on the diagnostic categories most suited to the purpose (Brody, 2003).

The recognition of a narrative and hermeneutic component of medical science is not all that new in professional practice in this context. Consider the great caution with which therapies based on generalizations emerging from research data are often applied, prompting doctors to consider each patient as a true single case. This modus operandi, however, often ends up being purely technical. In other words, individual aspects of the case are evaluated, but these are rarely brought into relation to a level of relational awareness supported by an educational approach. Precisely for this reason, narrative lends added value to traditional medicine, referring simultaneously to diagnostic, therapeutic, and communicative outcomes, where both doctor and patient engage in a co-constructive dialogue to piece together the history of the illness.

According to other authors (Hurwitz et al., 2004), a doctor-patient relationship of this type is configured as a true therapeutic relationship, where the doctor must be able to interpret the patient's narrative and translate the collected data into a biomedical language of disease. From this point of view, a meeting point between both parties in the relationship regarding the therapeutic actions to be initiated may be desirable, and in this sense, narrative medicine can serve as a fundamental tool for improving patient adherence to treatment.

4. Educating who Care, Educating to Take Care: Towards a Narrative That Cures Relationships

The acquisition of communication skills takes on particular importance in the medical field (Garista & Strohmenger, 2007). From this perspective, teaching

communication skills is a cornerstone of medical training (Kurtz, Silverman & Draper, 2016; Rider & Keefer, 2006). For all this to be achieved, communication aspects must not be overlooked. Some research (Guadagnoli, Ward, 1998) has shown that a clear and empathetic communication style positively influences patient behavior, who will feel more motivated to implement the proposed therapy ad literam, with a significant impact on the outcome of the treatment itself. The quality of communication, then, has important repercussions on the patient's understanding of the disease (Osterberg, Blaschke, 2005), on the decision-making process regarding the therapy to be undertaken (Guadagnoli, Ward, 1998) and, finally, on patient trust (Fiscella et al., 2004).

While on a more operational level, the substantial difference between narrative medicine and the narrative-based approach primarily concerns the conception and design of further intervention strategies that refer to a systemic understanding of the patient's illness, it is also worth remembering that the fundamental difference between these two approaches can be traced primarily to the theoretical, philosophical, and epistemological foundations on which narrative medicine is rooted, which lead the practitioner towards an authentic and profound understanding of the patient. In this sense, the delineation of phenomenological processes becomes the fulcrum of the narrative medicine care relationship, and from a hermeneutic perspective, understanding the patient becomes a process of co-construction of meanings relating to the subject, the context, and the experience (Zannini, 2008).

The guiding principles of narrative-based medicine, therefore, draw on phenomenological and hermeneutic philosophical perspectives (Husserl, 1950), with the aim of supporting the idea that medicine is in many ways a cultural system, in the sense of a set of symbolic meanings that literally "shape" the patient's experience. From this perspective, illness takes on different shades of meaning: disease refers to illness according to the biomedical approach; illness refers to the subjective experience and experience of illness; and finally, sickness refers to illness as a social recognition (Kleinman, 1988).

Narration represents the core of a renewed understanding of professional practice in the healthcare field. Some healthcare professionals are gradually beginning to recognize the effective use of narration. Moreover, the so-called “narrative turn” has given narration a prominent role in human life, becoming one of the fundamental tools through which to attribute meaning to experience. Narration fosters recollection, demonstrating the ongoing interaction between reporting and remembering. The memory of experiences is structured according to certain forms and, therefore, significantly influences the ways in which those experiences are

narrated. However, the situation in which one finds oneself narrating, the goals one sets for oneself, the person of the interlocutor and their attitude also led to the selection and restructuring of the memory (Smorti, 2007).

From a pedagogical perspective, narrative becomes a very useful training tool for redefining identity, both during and after the experience of illness. It also offers the opportunity to contextualize clinical data and the patient's needs, providing new insights and treatment perspectives that can enhance the course of illness and recovery. Narrative practice is therefore characterized by a dual educational dimension, involving both the healthcare professional, about those aspects relating to the development of their own reflective and self-emancipatory work practice, and the patient, regarding those aspects relating to the construction and reconstruction of identity, as well as the structuring of the self. Finally, the social impact that narrative practice can have should not be overlooked. Indeed, research (Wilcock et al., 2003) has highlighted how narratives collected from patients and their families can represent the starting point for developing projects to improve healthcare in some countries.

Given that narrative-based medicine is a fundamental and undoubtedly effective tool for understanding illness, the question arises as to how healthcare professionals can acquire narrative and hermeneutic skills.

An answer can be found in the Medical Humanities (Evans, Greaves, 1999). The Medical Humanities refers to all those fields of knowledge concerned with understanding humanity through the human sciences and that focus primarily on the uniqueness of the individual. The inclusion of the Medical Humanities in medical education aims to heal the epistemological rift between the human sciences and the so-called exact sciences, restoring philosophy to a leading role in reflecting on the moral, ethical, and deontological aspects of medical knowledge and granting pedagogy a decidedly important place in the design and implementation of training programs that are part of this type of educational project.

On a practical level, the Medical Humanities utilize cultural products that employ diverse languages, such as artistic, cinematic, poetic, and literary, capable of interpreting the biographical and narrative approach in an exemplary manner (Marone, 2023). Through these languages, it is possible to encourage decentralization and reflection in subjects. Although in the medical and healthcare field, they are often labeled as secondary and useless compared to other, more pragmatic and technical, teachings, they make a professionally significant contribution to training in this area of knowledge.

These aspects of training should therefore be considered a challenge to the certainties of traditional medicine, as they combine technical intervention with attention to the context and its social actors, with the aim of fully understanding the human experience of pain and illness. Only in this way will it be possible to develop educational skills capable of nurturing a truly grounded healing relationship.

In conclusion, for healing relationships to be desirable, it is necessary to adopt a patient-centered perspective using working practices inspired by the principles of narrative-based medicine. In this sense, narrative becomes the modality capable of integrating clinical investigation with data pertaining to subjectivity—relational, cognitive, and emotional—essential for optimal clinical outcome of the disease. Moreover, the conscious and responsible use of narrative practice within medical and healthcare professional practice promotes the quality of care, the patient's reintegration into social life, and their sense of well-being within themselves and with others during a very delicate and unique phase such as illness.

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