

Can narrative medicine education contribute to the delivery of compassionate care? A review of the literature

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INTRODUCTION

Narrative Medicine has emerged as a discipline from within the medical humanities¹ and takes inspiration from philosophy, literature, poetry, art and social sciences theories. In particular, it is underpinned by philosophical approaches such as phenomenology, postmodernism and narratology, proposing that clinicians must attend to the lived experience of their patients and apply the science to the person.² Meanwhile, the link between medicine and literature is evident in the growing volume of texts written about professionals', or lay people's experiences of illness and disease.³⁻⁸ In exploring this link further, Charon⁹ has contributed greatly to consolidate the theory of Narrative Medicine. She defines it as 'medicine practiced with the narrative competencies to recognise, absorb, interpret and be moved by the stories of illness'.⁹ She suggests that, in exploring texts and reading them closely, one finds the tools of language such as metaphor, plot, character and temporality. She suggests that learning such skills enables clinicians to recognise that same language when it appears in clinical interaction practice. This 'narrative competence' can be fostered through education initiatives that particularly explore literature, creative and reflective writing, storytelling and poetry.⁹

As Lewis² explains, the question is about what kind of healthcare we want to deliver. Those who practise Narrative Medicine suggest that the adoption of this approach may help marry the art and science, thus improving quality in delivering a more person-centred type of care.^{2 10} With its emphasis on the patient experience, Narrative Medicine complements the current dominance of productivity, efficiency and evidence-based care. Similarly, Narrative Medicine contributes to attempts to go beyond the positivist dominance in healthcare that threatens quality of care, as science alone cannot help us to understand the unpredictability and frailty of people.¹¹⁻¹³ To secure support for Narrative Medicine education, there is a need for evidence to prove that it is indeed effective. Therefore, this literature review aimed to determine whether education in Narrative Medicine might result in more compassionate care (bearing witness and care to others' pain and suffering) for adults in need of healthcare.

METHODOLOGY AND METHODS

A literature review, as a type of secondary research, is a way of critically, systematically and synthetically obtaining an overall picture of a topic or issues

based on a set of primary research evidence. For example, this literature review aimed to examine whether education in Narrative Medicine might result in more compassionate care for adults in need of healthcare. Thus, the main steps followed to complete this literature review are discussed.

Scope

The search of the literature for this review began with a broad reading around Narrative Medicine to achieve a good understanding of the theory and its suggested application in practice. The Cochrane and the evidence for policy and practice information and coordinating centre databases were searched, and it was found that no systematic reviews had previously been undertaken on the subject. Some literature reviews addressing the effectiveness of humanities in medical education were found but these did not explicitly explore Narrative Medicine. This is one of the first reviews to relate Narrative Medicine with compassionate care.

A systematic literature search was then performed using the databases of Sage publications, EBSCOhost and the Greenwich University library catalogue. Search terms were informed by the prior reading and included the following: Narrative Medicine and, in turn, creative writing or reflective writing or poetry or storytelling. The words 'medical education', 'evaluation' and 'study' were also used until saturation was reached and no new articles emerged. The search was limited to English language items published between 2000 and 2015 to ensure that up-to-date sources were obtained. Reference lists of identified material were also checked and a key author search was performed. This primary search identified 20 possible sources.

Inclusion and exclusion criteria

- ▶ Primary studies that demonstrated explicitly an attempt to evaluate an educational initiative related to Narrative Medicine. This could include a specific Narrative Medicine course or a creative and/or reflective writing initiative, including poetry.
- ▶ Studies targeted at clinicians and related to adult care only.
- ▶ Studies published after 2000.
- ▶ Studies that took the form of opinion or commentary pieces were excluded, as was grey literature or unpublished work.
- ▶ Other arts-based medical education such as film, photography, drama or theatre were excluded, as were any sources with no obvious educational element and any relating to children.

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Box 1 Studies appraised by this review

Study

Quantitative study

1. Tsai and Ho¹⁶

Combined quantitative and qualitative studies

2. Shapiro *et al*¹⁹

3. Misra-Hebert *et al*²⁰

4. Lancaster *et al*²²

Qualitative studies

5. Clandinin and Cave²⁴

6. Lazarus and Rosslyn²⁸

7. Arntfield *et al*²⁶

8. Gull *et al*²⁹

9. DasGupta and Charon²⁷

Nine studies were selected; one was quantitative, three combined quantitative and qualitative research and five were qualitative (box 1). The majority of the studies focused on medical students at different stages in their training as part of medical humanities education. There were three studies involving qualified physicians; however, there were none involving nurses or other members of the healthcare team as recommended in the literature. The majority of the research was from North America, but two studies were from the UK and one was from Taiwan, suggesting a wider appeal of Narrative Medicine than exclusively North America, although it remains limited at a global level.¹² All the studies demonstrated positive outcomes associated with a Narrative Medicine intervention at a small scale and none included a patient-reported outcome measure. Each study was appraised using tools and guidance designed by the evidence for policy and practice information and coordinating centre¹⁴ and the critical appraisal skills programme.¹⁵

RESULTS AND ANALYSIS

Quantitative study

In a quantitative study, Tsai and Ho¹⁶ used a quasi-experimental design to examine whether Narrative Medicine could enhance clinical performance as measured by objective, structured, clinical examination (OSCE). While this design lends itself to the comparison of a randomly selected intervention group with a case-matched control, this study did not employ a pre-intervention OSCE measurement in either group which might have strengthened the approach.¹⁷ A t-test of significance was conducted, which is suitable for a small sample with groups of unequal sizes.¹⁸ The results showed that the case group performed better on the two communication stations ($p=0.03$), but there was no difference across the 12 stations when taken as a whole ($p=0.24$). Tsai and Ho¹⁶ demonstrated that Narrative Medicine can improve performance in terms of communication and, critically, this is one of the few studies to have demonstrated an objective behavioural outcome. There are, however, significant limitations and questions regarding rigour, not least because the study is relatively brief. There is no explanation of volunteer recruitment, ethical approval and consent process or why a quasi-experimental design was chosen. Neither do the authors provide any details on how the training course was facilitated and by whom. There are no tables detailing the rating items or questions for the OSCE scores; hence, there is minimal ability to appraise the findings as reported. Adding a qualitative measure to the study might have increased the validity of the

findings, incorporating students' experiences through an analysis of their narrative accounts. The authors recommend further studies to assess the impact of Narrative Medicine education on patient-reported outcomes and, on the basis of this study, plan to expand their training.

Combined quantitative and qualitative studies

In a combined study, Shapiro *et al*¹⁹ mixed qualitative analysis of subjective, objective, assessment and plan notes (SOAP) with a quantitative analysis of OSCE outcomes. In contrast to Tsai and Ho,¹⁶ they measured learning rather than a behavioural outcome in the OSCEs. They used a five-point Likert scale response to one question concerning empathy and another addressing the impact on treatment plans. Likert scales are methods of ascertaining attitudes in research and they require 10–15 statements to be robust.¹⁷ Meanwhile, Shapiro *et al*¹⁹ used only two statements, which is a significant limitation. Rather than t-test analysis, they use a non-parametric exact test (Wilcoxon signed rank test), which is also appropriate for a small sample but more appropriate where distribution is non-normal.¹⁷ This was also favoured by Misra-Hebert *et al*²⁰ in their analysis of empathy scores. The qualitative analysis appears robust with clear thematic analysis conducted and validated by both researchers. They were able to demonstrate statistical significance and suggested improved empathy from the SOAP notes analysis. However, the results must be interpreted with caution as their sample size was reduced by a change to the course set up during the study years. This prevented them from implementing the humanities education for the first half of the year in 2002–2003. The study was further limited by the absence of any control group and the lack of a long-term follow-up to measure any sustained impact. The results cannot be generalised beyond this particular medical school but are certainly transferrable. However, this research does seem to demonstrate an impact of a feasible amount of Narrative Medicine education on students' ability to empathise and plan care. Additionally, the study is well written with details and data presented in tables and appendices, thus allowing transparency in all aspects of the study. The authors sought appropriate ethics approval and acknowledged their funding source.

In their study, Misra-Hebert *et al*²⁰ applied the Jefferson scale of empathy (JSE) to 40 physicians pre-Narrative Medicine, intra-Narrative Medicine and post-Narrative Medicine education. This is a validated 20-item scale designed to assess empathy in medical students.²¹ It has been extensively tested and is therefore considered an appropriate tool for this study. The non-parametric method of statistical analysis suits the small sample and the findings showed significantly increased scores on the JSE in the intervention group but not in either of the control groups ($p=0.02$). However, this must be interpreted with caution as it is plausible that the JSE scores may have improved purely as a result of peer support from the Narrative Medicine group sessions. Credible qualitative analysis was made using a grounded theory approach involving a comprehensive iterative analysis and coding system of the reflective writings by all three researchers. The participants received CPD accreditation. It is a small sample ($n=40$) within one institution and cannot therefore be generalised but instead potentially transferable to other contexts as is the case with qualitative research. More significant results might be generated by a larger sample, making differences between the intervention group and the controls more apparent. The study is transparent with tables and appendices showing the data, coding form and details of reflective sessions offered. However, the authors do not express their

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257 personal interest in Narrative Medicine nor do they state in
258 what way they are qualified to facilitate reflective writing ses-
259 sions. Although ethics approval was granted, the authors do not
260 specifically indicate that consent was sought from participants to
261 publish extracts of their writing within the paper.

262 In another study, Lancaster *et al*²² used a nominal group tech-
263 nique to evaluate a special study module (SSM) for medical stu-
264 dents in literature and medicine. This is a robust method of
265 evaluation involving group decision-making in social research.²³
266 Although labour-intensive, this method increases the validity, as
267 it has both quantitative and qualitative elements. However, the
268 study is small with a self-selected sample of five cases. The use
269 of ranking in the evaluation process results in an average view as
270 opposed to a consensus, which limits the findings. In a similar
271 way to the other studies involving modules for medical students,
272 this study relates to a short intervention with no long-term
273 follow-up or ability to demonstrate a behavioural outcome in
274 students. The university clearly benefited from having a visiting
275 lecturer with comprehensive experience of teaching Narrative
276 Medicine. This raises feasibility issues for anyone seeking to rep-
277 licate such an initiative and is likely to have favoured a more
278 positive evaluation by the students. This study is unique in
279 making specific mention of social theoretical perspectives that
280 relate to Narrative Medicine and the potential to include this in
281 future module design. The article includes comprehensive
282 tabular information about the evaluation process and themes,
283 thus affording transparency, although the authors do not make
284 specific reference to their personal interest in Narrative
285 Medicine.

286 **Qualitative studies**

288 In a qualitative study, Clandinin and Cave²⁴ used parallel reflect-
289 ive charts in their study with four medical students. This
290 approach is advocated by Charon⁹ as a powerful reflective tool
291 for promoting Narrative Medicine. They describe and analyse
292 one parallel chart using narrative methodology to demonstrate
293 the outcomes of the study. Narrative research is rooted in con-
294 temporary humanism and suits the analysis of individual case
295 studies such as this.²⁵ Throughout the analysis, reference is
296 made to the parallel chart and the dialogue from the discussion
297 as evidence of the findings—many examples are quoted in an
298 attempt to validate themes. The authors suggest that Narrative
299 Medicine education for doctors facilitates reflection in practice
300 and helps them develop their own professional identity, thus
301 contributing to their personal growth. The study contains a
302 small sample size and the researchers interpreted their data by
303 ‘close reading’. The researchers are keen to promote narrative
304 inquiry and are themselves skilled in narrative reflective practice,
305 thus demonstrating the traditions in qualitative research of
306 acknowledging and accepting that bias can exist. They make spe-
307 cific reference to supporting doctors with regard to the ethical
308 concerns raised by the Narrative of Medicine process. This is
309 important and reflects the findings of other studies reporting the
310 need for small groups well facilitated by skilled educators.^{26 27}

311 In their study, Lazarus and Rosslyn²⁸ evaluated a SSM where
312 a significant component was devoted to poetry and literature
313 and students were required to keep reflective journals. This is
314 the study in which there was an unusual emphasis on strength-
315 ening students’ ‘knowledge and understanding of people’s
316 experiences and emotions’ when they are ill.²⁸ In the first year,
317 evaluation was conducted by group discussion which was used
318 to develop a five-point Likert scale questionnaire for the second
319 year (but with only five statements). However, the small number
320 of evaluations in the second year (n=10) meant that no

321 statistical analysis was possible, suggesting that the development
322 of a Likert scale during the first year was an oversight as the
323 small numbers would have been known in advance. Instead, the
324 authors interpreted their data qualitatively by using a thematic
325 analysis. The authors clearly state their interest and previous
326 experience in relevant Narrative Medicine education and
327 acknowledge a grant from the university with which to fund the
328 project. No ethical approval is mentioned nor is there evidence
329 of explicit consent from the students to include excerpts from
330 their contributions in the paper. There is a clear recommenda-
331 tion, however, for long-term follow-up of educational initiatives
332 like these and the measurement of actual rather than potential
333 impact in clinical practice.

334 In the meantime, Arntfield *et al*²⁶ thoroughly evaluated a
335 Narrative Medicine module for fourth-year medical students.
336 The module was facilitated by lecturers experienced in
337 Narrative Medicine and 12 students participated. The lectures
338 included close reading of literature, reflective writing exercises
339 and discussion within small groups. The authors evaluated the
340 intervention using grounded theory involving an initial anonym-
341 ous survey followed by a focus group. They used the emergent
342 themes to develop a ‘concept map’, which is in keeping with a
343 grounded theory approach in generating new concepts and the-
344 ories from the data.¹⁷ They uniquely attempted some long-term
345 follow-up using an email survey, although the response rate was
346 low at 25%. They used an iterative thematic analysis of all the
347 data together, coding independently and then collectively
348 returning to the raw data to resolve any discrepancies. They
349 increased the validity by using triangulation, returning to tran-
350 scripts and notes taken during the groups. Uniquely, they expli-
351 citly identified the need to overcome a perceived counterculture.
352 For example, Narrative Medicine was considered ‘fluffy’ and
353 non-essential by peers, yet those who undertook the course
354 unanimously believed that Narrative Medicine training would
355 make them better doctors. The findings are consistent with the
356 evidence of the benefits of Narrative Medicine education, corro-
357 borated in this literature review. The study accomplishes sound
358 ethical considerations mentioned throughout the paper, includ-
359 ing participants’ consent, ethics approval and confidentiality
360 within the group discussions. Funding is also acknowledged.
361 The authors highlight the need to measure actual rather than
362 perceived changes in attitude and behaviour but suggest that the
363 appetite for this will depend on the extent to which Narrative
364 Medicine education is incorporated into curricula.

365 In another study, Gull *et al*²⁹ conducted a pilot study evaluat-
366 ing creative writing workshops with hospital staff in the UK.
367 They freely admit that they had no experience of delivering
368 such an initiative but were seeking a more creative approach to
369 teach medical students in future. Thus, a participant observation
370 methodology is suitable for gaining insights into the first-hand
371 experience.¹⁸ Uniquely, the participants were interdisciplinary,
372 which the authors reported as a strength in their findings,
373 echoing Charon’s⁹ claim that Narrative Medicine fosters com-
374 munity and understanding of others. Interestingly, the most
375 favoured workshop concerned expressions of illness and death
376 in which the authors noted much self-reflection. Rather than
377 seeing this as a strength, they report that it is something to be
378 cautious of in future initiatives, citing the difficulties of man-
379 aging emotions raised by Narrative Medicine methods. They
380 warn against too much reflection within the process, even
381 though this was highly valued in their findings.²⁷ They con-
382 ceded some difficulties in managing a relatively large mixed
383 group, stating the need to revisit initial ground rules to help
384 manage this. The researchers achieved some soundness in their

385 results by having participated in, recorded, discussed and coded
386 their themes; furthermore, the participants viewed their paper
387 and were able to make comments and modifications prior to
388 finalisation. There is no clear mention of whether ethics
389 approval was sought or any funding allocated. As a result, the
390 main lesson learnt here is that Narrative Medicine initiatives are
391 enjoyable but must be well planned and carefully implemented.

392 Finally, DasGupta and Charon²⁷ evaluated six reflective
393 writing seminars undertaken with second-year medical students.
394 The seminars were facilitated by DasGupta and evaluation was
395 by questionnaire after the last seminar. No specific methodology
396 is stated but a robust iterative thematic analysis was undertaken
397 by the authors. Once again, the seminars were well received, a
398 now common thread across most studies. Both positive and
399 negative themes emerged in the analysis, for example, words
400 such as 'enlightened', 'relief' and 'healing' and also 'embarrass-
401 ing', 'confusion' and 'vulnerability'. Most reported a perceived
402 enhanced empathy, having gained insights from both patients
403 and their own experience shared within the group. The sessions
404 were recommended as part of the curriculum but within small
405 safe groups, which is another recurrent finding in the literature.
406 The study's size comprised n=11 questionnaires. Additionally,
407 there was an increased response rate in the second year. Of note,
408 all the participants were women although, in mitigation, the
409 authors report that findings from other comparable seminars
410 involving both genders have reported similar outcomes. Ethical
411 considerations are emphasised in respect of ground rules and
412 confidentiality afforded to participants in the groups, but there is
413 no mention of consent to include quotes from their evaluations.

415 Thematic analysis

416 Four key themes emerged from the literature reviewed here and
417 were consistently reported among the findings and discussion of
418 the studies. They also reflect the broader literature on Narrative
419 Medicine and its potential for developing a more person-
420 centred approach to healthcare.

422 Communication

423 Communication is used here as an umbrella term for the find-
424 ings, indicating an ability to attend, represent and affiliate with
425 patients.³⁰ Predominantly, this was reported in the studies in
426 terms of empathy which, it is argued, is enhanced by Narrative
427 Medicine education.³ For example, Lancaster *et al*²² found that
428 students reported increased empathy as the most valuable aspect
429 of studying literature. In a similar way, Arntfield *et al*²⁶ found
430 that students overwhelmingly reported enhanced communica-
431 tion characterised by empathic skills such as listening and
432 valuing different perspectives or worldviews. Although the quali-
433 tative studies gave rich examples of how this was reported by
434 participants in terms of narrative, objective measurements are
435 also demonstrated by Tsai and Ho¹⁶ and Misra-Hebert *et al*²⁰ in
436 the outcomes of the OSCE and JSE scores, respectively. While
437 empathy was most powerfully demonstrated in those studies that
438 included narrative reflective writing, even the studies with less
439 intense Narrative Medicine education showed a positive impact
440 on empathy and communication, for example, Shapiro *et al*.¹⁹

442 Personal and professional growth

443 Every study included in this review reported on personal
444 growth as a positive outcome of the study intervention. This
445 was embodied by an ability to become conscious of thoughts,
446 feelings and possible prejudices through the Narrative Medicine
447 education processes. Professional growth also demonstrated an
448 ability to show a greater understanding of peers fostering the

449 sense of 'community' suggested by Charon.³⁰ Once again, the
450 studies that included reflective writing seemed to demonstrate
451 the more profound effect on personal growth, thus supporting
452 the argument that it is the writing of experiences that fosters the
453 greatest impact.^{27 31} In writing about personal experiences of
454 illness or case studies, participants reported greater awareness of
455 their own humanity as well as that of their patients. This 'per-
456 sonal knowledge' development reveals the two-way relationship
457 between clinician and patient, with each affecting the other.
458 Such a skill is said to be fostered by Narrative Medicine educa-
459 tion, promoting more compassionate care (bearing witness to
460 others' pain and suffering) and job satisfaction.^{32 33}

462 Pleasure

463 All but one study reported some aspect of pleasure as an
464 outcome of the intervention. This included simple enjoyment,
465 stress relief and a break from science curricula or heavy work-
466 loads. In the interventions with medical students, there was an
467 overwhelming recommendation for the course, often with a sug-
468 gestion that it should be mandatory.^{22 25 28} In the meantime,
469 Gull *et al*²⁹ have hypothesised that the enjoyment of Narrative
470 Medicine may improve self-confidence as writing allows repre-
471 sentation of self and others. More broadly, the pleasure theme
472 attests to the ability of Narrative Medicine to foster holistic care
473 and compassion. It is a reminder of the reason for becoming a
474 clinician, thus corroborating the wider supporting literature.^{9 34}
475 This review suggests that the time afforded to reflect in this way
476 is welcomed by both students and qualified clinicians.

477 Educational structure

478 The last theme relates to practical considerations regarding
479 Narrative Medicine content and structure. Participants seemed
480 to value small group sessions facilitated by skilled facilitators
481 experienced in Narrative Medicine. Indeed, Gull *et al*²⁹
482 struggled to manage a larger group, commenting specifically on
483 the need to manage the reflective process carefully. There is a
484 practical ethical consideration here as Narrative Medicine
485 clearly requires personal disclosure and involves potentially dif-
486 ficult or sensitive issues. The feasibility of resourcing such initia-
487 tives in both medical schools and clinical practice is questioned
488 by Lancaster *et al*.²² This formed part of the argument by
489 Shapiro *et al*¹⁹ in favour of using smaller amounts of Narrative
490 Medicine interspersed in the medical student curriculum,
491 although they warn that students may have benefited less as a
492 result of reduced exposure.

495 CONCLUSION

496 This literature review has considered whether there is sufficient
497 evidence to demonstrate that Narrative Medicine education
498 results in compassionate care (bearing witness and care to
499 others' pain and suffering) based on nine primary research
500 studies. Although the studies suggest that Narrative Medicine is
501 beneficial, there is insufficient large-scale data to establish a
502 higher clinical value. This is because there is a paucity of
503 evidence demonstrating any behavioural outcomes in terms
504 of follow-ups to individuals trained in Narrative Medicine or
505 their long-term assessment, let alone the impact on patients.
506 Additionally, studies have focused predominantly on medical
507 education and doctors, and there is no representation of nursing
508 or other members of the multidisciplinary health team. This
509 does not reflect Charon's⁹ recommendations for the application
510 of Narrative Medicine in an interdisciplinary way to promote
511 collaboration, nor does it reflect the role of nursing in person-
512 centred healthcare.³⁵ In the same way, theory influences how

513 practitioners choose to conduct and interpret research
 514 and provides the foundation on which practice is based.³⁶
 515 Unfortunately, all the studies reviewed lack recognition or a theo-
 516 retical link detailing the relationship between the research con-
 517 ducted with phenomenology, narratology, critical theory or
 518 postmodernism from which Narrative Medicine derives inspira-
 519 tion. Nonetheless, the findings in this review are in keeping
 520 with other literature reviews concerning results in humanities-
 521 based education: increase communication between doctors and
 522 patients, personal growth including self-reflection and enjoy-
 523 ment in learning Narrative Medicine, and the benefit of educa-
 524 tion in small groups.^{37 38}

525 **Competing interests** None declared.

526 **Provenance and peer review** Not commissioned; externally peer reviewed.

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