Educ Res Med Sci. 2021 December; 10(2):e119457. doi: 10.5812/erms.119457.
Published online 2022 February 9. **Research Article**

Challenges of Implementing the First Narrative Medicine Course for Teaching Professionalism in Iran: A Qualitative Content Analysis

Saeideh Daryazadeh [1], Payman Adibi [2] and Nikoo Yamani [1,*]

[1] Medical Education Research Center, Isfahan University of Medical Sciences, Isfahan, Iran
[2] Gastroenterology Research Center, Isfahan University of Medical Sciences, Isfahan, Iran

[*] *Corresponding author*: Medical Education Research Center, Isfahan University of Medical Sciences, Isfahan, Iran. Email: nikooyamani@gmail.com

Received 2021 September 11; **Revised** 2022 January 15; **Accepted** 2022 January 17.

Abstract

Background: The narrative approach emerged in the late 19th century to humanize medicine, and narrative medicine was proposed to cultivate four skills, including empathy, reflection, professional commitment, and trust.
Objectives: The present study aimed to describe the challenges of implementing the first narrative medicine course in Iran.
Methods: This qualitative study was conducted using an inductive approach in 2020. In total, 18 medical interns were selected via purposive sampling and enrolled in the study. Data were collected via in-depth semi-structured individual interviews. Data analysis was performed in the MAXQDA10 software.
Results: In total, 523 codes were extracted, and the identified challenges were classified into three main categories and eight subcategories, including individual barriers (learners' attitudes, individual identity, and opposition to the clinical teacher), educational barriers (unsupported change, disorganization of sessions, educational atmosphere, and hidden curriculum), and environmental barriers (physical factors).
Conclusions: According to the results, the narrative approach in medicine could be used efficiently through subsequent courses in various medical universities. It is recommended that expert opinions be considered in the implementation of such courses.

Keywords: Narrative Medicine, Professionalism, Empathy, Reflection

1. Background

Emphasis on professionalism dates back to the late 1960s in the form of bioethics and professional ethics (1). In addition to the acquisition of clinical knowledge and skills in medicine, the development and improvement of values, attitudes, ethical norms, social skills, and other human characteristics of a physician are paramount. As such, special attention should be paid to professionalism as an essential competence in medicine (2). Since the principles of professionalism are not inherent in individuals, they must be learned properly. On the other hand, mere attention to teaching knowledge and skills to medical students without considering professionalism will lead to the training of physicians who lack the characteristics and professional responsibilities of an efficient physician, which is a serious threat to society (2, 3).

Although the dimensions of professional identity are clear today, we are faced with a significant lack of tools for promoting professionalism (4). Despite an emphasis on professionalism in numerous universities, professionalism training remains a challenging subject in medical education (2). Narrative medicine (NM) is a method of teaching and evaluating professionalism, which has recently gained popularity (5, 6).

It is mentioned that the NM approach was introduced by Dr. Charon, and its goals were expressed in the form of four skills, including empathy, reflection, professional commitment, and trust (7). Quoted to Charon, NM is the ability to identify, absorb, understand, interpret, and critically narrate a patient's illness story (8). As such, a narrative approach encompasses the knowledge and learnable skills that could help healthcare professionals understand patients' stories and conditions (9). Previous studies in this regard have provided various narrative approaches with different educational goals to groups of learners and evaluated the effectiveness of the training courses (10-16).

For the first time in Iran, an NM program was implemented in the present study in order to teach empathy and reflection to medical interns as part of the professional ethics course at Isfahan University of Medical Sciences in 2019. The participants practiced reflection and empathy by telling the patients' illness stories, and the clinical teachers

received this feedback (17). Furthermore, reflection practices were accomplished using an educational tool (18).

2. Objectives

The present study aimed to elaborate on the challenges of implementing the first NM training course in Iran from the perspective of medical interns.

3. Methods

3.1. Study Design

This study was part of a research aimed to explain the experiences of the participants about the challenges of the first NM course in depth. The study was conducted using a qualitative approach. The participants of the study were medical interns who were enrolled in the NM course at Isfahan University of Medical Sciences. Active participation in the sessions was the inclusion criterion, and those who were not willing to be interviewed were excluded from the study. The participants were selected via purposive sampling.

The researcher was one of the course planners. After obtaining informed consent from the participants, the interview question was asked, as follows: "what were the challenges in implementing the NM training course?" Follow-up questions were also asked in the next stages (eg, “were there any problems in implementing this training course? Were these problems solvable?”).

The interviews continued until reaching data saturation, and the duration of each interview was 20 - 40 minutes depending on the time and patience of the participants, the obtained information, and the willingness of the participants. Notably, the interviews were recorded with their permission of the participants. In-depth semi-structured interviews were conducted individually to assess the participants' perspectives, and some of the participants were invited to be re-interviewed if necessary. In addition, the interview transcripts were returned to the participants so that they could provide their comments and make corrections.

3.2. Statistical Analysis

Data analysis was performed simultaneously with data collection in the MAXQDA10 software using qualitative content analysis and an inductive approach. In addition, the content analysis method proposed by Graneheim and Lundman was used for data analysis (19). The rigor and reliability of the data were evaluated based on the criteria of Lincoln, including transferability, reliability, and conformability (20).

4. Results

In total, 18 medical interns of both genders (10 males and 8 females) with the mean age of 25 $\pm$ 0.38 years were interviewed. After analyzing the interviews and eliminating duplicate codes, 523 codes were extracted in three main categories and eight subcategories. The main categories were individual barriers (subcategories: learners' attitudes, individual identity, and opposition of clinical teachers), educational barriers (subcategories: unsupported change, incoherence of sessions, educational atmosphere, and hidden curriculum) and environmental barriers (subcategory: physical factors) (Table 1).

4.1. Main Category One: Individual Barriers

4.1.1. Learners' Attitudes

The subcategories of learners' attitudes included the negative view of education, unwillingness to write, and the attitude toward extracurricular classes. Some of the participants' comments in this regard are as follows:

"In internship, scores are not important." (P2);

"Not everyone likes to write a story." (P10);

"I think there is an extra class. We have so many of these classes that waste our time." (P18)

4.1.2. Individual Identity

The subcategories of individual identity included academic burnout and formed professional identity. Some of the participants' comments in this regard are as follows:

"I think because we are interns, we do not think about coming to class and learning anything anymore, and we are really bored." (P5);

"I think internship is too late for teaching NM." (P7);

"Our foliage has now formed, and we have become a tree. We could have been formed sooner than this when we were a seedling." (P17)

4.1.3. Opposition of Clinical Teachers

The subcategories in this theme included the lack of justification for the importance of the course, lack of feedback, inconsistency in small groups, disinterest in the training course, and delay in attending the sessions. Some of the participants' comments in this regard are as follows:

"Using clinical teacher who are justified in this course and are interested in NM is helpful. It was really problematic when we were told to come to class at 7 in the morning, but some teachers came at 7:30!" (P4);

"We talked to our peers. Some teachers were more active, and the interns were interested. However, some of them did not even provide feedback." (P1)

Table 1. Subcategories and Main Categories Challenges in NM Implementation

Main Themes	Categories	Subcategories
Individual barriers	Learners' attitudes	Negative view of education
		Unwillingness to write
		Attitude toward extracurricular classes
	Individual identity	Academic burnout
		Formation of professional identity
	Opposition of clinical teachers	Unjustified course importance
		Lack of feedback and inconsistency in small groups
		Disinterest in training course
		Delays in attending sessions
Educational barriers	Unsupported change	Short training course
		Lack of continuous change
		Insufficient justification
		Resistance to change
	Incoherent sessions	Interference with internship
		Schedule of theory classes
	Educational atmosphere	Few opportunities and negligence of learning
		Not taking education and evaluation seriously in internship
		Principles of professional ethics between teachers and students
		Emphasis on specialized education
	Hidden curriculum	Degree of observing professionalism principles
		Prevailing atmosphere of moral values
		Incompatibility of ethical principles with actual performance
Environmental barriers	Physical factors	Physical space
		Problems with cooling systems

4.2. Main Category Two: Educational Barriers

4.2.1. Unsupported Change

The subcategories of unsupported change included short training courses, lack of continuous change, insufficient justification, and resistance to change. Some of the participants' comments in this regard are as follows:

"I think the class time was very short. Just as we got to become familiar with the course, it was over." (P9);

"We were just learning how to express our feelings and let ourselves go, and then it was over." (P13);

"This course has had a good impact, but many said that it should have been longer." (P8);

"The point is that new teaching styles are always resisted in the beginning." (P11)

4.2.2. Incoherent Sessions

The subcategories of coherent sessions were interference with internships and the schedule of theory classes. Some of the participants' comments in this regard are as follows:

"For this class, even though it was early in the morning, those who were not on duty came to the class." (P14);

"Well, the problem is that we have little time to study in internship. That is why we are tired." (P12);

"The large number and initial resistance of interns and the time of the class made proper justification implausible." (P17)

4.2.3. Educational Atmosphere

The subcategories of educational atmosphere included few opportunities and the negligence of learning, not taking education and evaluation seriously in internship, principles of professional ethics between teachers and students, and emphasis on specialized education. Some of the participants' comments in this regard are as follows:

"We are at the end of the course and are really tired of the atmosphere of education and hospitals." (P15);

"This class should be held for the teachers first. They behave very badly and should be a role model in terms of dealing with patients and students." (P5);

"The best time for holding NM is during clerkship." (P3);

"The number of students is very large, which causes problems in managing the class." (P1);

"In internship, we are stressed about being admitted in the residency exam. So, this course must be held in lower levels." (P3)

4.2.4. Hidden Curriculum

The subcategories of hidden curriculum included the degree of observing professionalism principles, prevailing atmosphere of moral values, and incompatibility of ethical principles with actual performance. Some of the participants' comments in this regard are as follows:

"The health system is not healthy! That is why some students do not attend classes and clinical rounds and are on-call. In the Olympiad, for example, they have a 50% acceptance quota in the residency and do not participate in internship theory courses at all." (P9);

"There is a bad atmosphere. For example, last night I was on duty, and a patient fainted. I performed resuscitation with all my might, but when the patient returned to consciousness, the residents and nurses asked me why I came to resuscitate the patient so soon! I wondered what I should have done!" (P7);

"Unfortunately, the doctor sees the patient only as a product or a source of income. I really do not know if it is because of the work pressure that they forget these training or they really do not have a working conscience." (P15)

4.3. Main Category Three: Environmental Barriers

This category had only one subcategory of physical factors.

4.3.1. Physical Factors

The subcategories of physical space and problems in the cooling system were identified in the final main category. Some of the participants' comments in this regard are as follows:

"Medical school classrooms are very large, and we are also a large population. Sometimes the professors' voice cannot reach us at all. I think we should have sat closer to each other." (P11);

"Because of summer and due to energy saving, class started half an hour earlier, and this made the students resist more and sometimes come later." (P6)

5. Discussion

The analysis of the challenges associated with the implementation of NM resulted in the following main categories.

5.1. Individual Barriers

From the interns' viewpoint, implementing NM in internship was an important challenge. It seems that providing NM from pre-internship clinical courses and integrating this subject into the formal curriculum could effectively improve the challenges faced by individual learners. Furthermore, selecting trained and interested teachers to educate students was considered an issue in this regard.

5.2. Educational Barriers

According to the innovative NM approach, it is essential to consider the steps of presenting change to enhance the effectiveness of the training course by resolving educational challenges. Although the issues associated with hidden curriculum is less flexible to change, changing teaching methods, proper training, and informing teachers on the principles of professionalism could provide a more appropriate context.

5.3. Environmental Barriers

Undoubtedly, physical space and appropriate time are influential in motivating and improving the quality of education. It is possible to provide a favorable physical space to resolve this issue by considering the round arrangement of the chairs and using special halls in order for the audience to interact through eye contact.

To date, no studies have directly addressed the challenges of conducting NM. However, similar studies have examined the general results of providing NM to various groups of learners in terms of educational effectiveness (10-16). This was the first study in Iran to review the experiences of a training course evaluation in this regard (17).

A qualitative study was conducted by Vafadar and Parandeh to explain nursing students' experiences of clinical education through the narrative reflection method. The mentioned study introduced the general theme of 'understanding self-worth in active clinical learning', as well as four main categories, including self-awareness, promoting self-efficacy and motivation, participatory and active learning, and self-expression. The authors recommended the narrative approach and reflection training in clinical education for the professional development of students (21). Their findings are consistent with the results of the present study in terms of the general purpose of providing a narrative approach to cultivate the emotional domain of

learners. However, they did not address the challenges of implementing this approach.

In another study by Boudreau et al., a narrative approach was developed to promote reflection in teachers. The feasibility and value of the implemented workshops were confirmed by the participants, and it was reported that reflective writing could effectively promote reflection and could be used by healthcare professionals (22). This is consistent with the current research in terms of the feasibility of implementation and acceptance by participants. However, the mentioned study is not in line with the general objective of our research.

The study by Arntfield et al. aimed to evaluate the effectiveness of NM. The students stated that the educational approach used in teaching narrative was necessary owing to its benefits, and NM was considered effective and important in this regard. However, the interpretation and meaning of the narrative was associated with cultural conflicts in terms of communication skills, participation, and professional development (23). The mentioned study is consistent with the results obtained by Huang et al. (24) regarding the presentation of a narrative approach; it is also in line with our study.

Studies regarding NM education, which had long been mandatory for medical students before internship, have proposed beneficial educational outcomes (16, 25-27). The prolonged training courses in these studies are considered significant in continuing the practice based on a narrative approach. According to the results of the present study, the general viewpoint of the interns toward extracurricular and optional classes was not quite positive, and they did not partake in these courses persistently. A solution in this regard would be to consider lower educational levels or start a medical course to offer NM. However, some studies have provided NM to residents, faculty members, and general practitioners, reporting favorable educational efficacy (23, 28-30).

5.4. Suggestions

Most of the studies regarding NM have been conducted in Western countries (especially the United States), and the effectiveness of NM may be associated with the cultural acceptance of medical students (24). Therefore, the impact of the acceptance of NM must be considered from a cultural perspective, and it is essential to conduct similar studies in other communities given the differences in the culture of Eastern societies. Furthermore, using an NM framework along with opinion of experts is recommended for NM implementation (31).

5.5. Limitations

Although our findings could be generalized to other educational groups to some extent, they may differ in other educational levels, and accurate and practical educational planning are required before offering NM. Our study was based on the analysis of one group of interns who participated in the first NM course in Iran. Other challenges should be addressed if these courses are to be repeated.

5.6. Conclusions

The analysis of the participants' experiences indicated that although positive results were attained in the NM course in terms of educational effectiveness, some challenges were faced in terms of educational innovation. Addressing these issues could make NM implementation more effective in subsequent courses in other universities.

Acknowledgments

Hereby, we extend our gratitude to the participants for assisting us in this research project.

Footnotes

Authors' Contribution: Study concept and design: S. D.; Analysis and interpretation of data: S. D., and N. Y.; Drafting of the manuscript: S. D.; Critical revision of the manuscript for important intellectual content: S. D. and N. Y. and P. A; Statistical analysis: and S. D..

Conflict of Interests: The 2 of authors (AP and YN) were faculty members and DS was researcher and PhD student in medical education at Isfahan University of Medical Sciences.

Ethical Approval: This project was carried out with the financial support of the Vice Chancellor for Research of Isfahan University of Medical Sciences, Isfahan, Iran with the approved code 299137, and the ethics code IR.MUI.RESEARCH.REC.1399-530 (Link: ethics.research.ac.ir/EthicsProposalView.php?&code= IR.MUI.RESEARCH.REC.1399.530)

Funding/Support: This research project was financially supported by the Vice Chancellor for Research of Isfahan University of Medical Sciences in Isfahan, Iran.

Informed Consent: Written informed consent was obtained from all participants.

References

1. Nemati SH, Saberi A, Heidarzadeh A. Medical professionalism and its education to medical students. *Res Med Educ*. 2010;**2**(1):54–61.
2. Yamani N, Liaghatdar MJ, Changiz T, Adibi P. How Do Medical Students Learn Professionalism During Clinical Education? A Qualitative Study of Faculty Members' and Interns' Experiences. *Iran J Med Educ*. 2010;**9**(4).
3. Coulehan J. Viewpoint: today's professionalism: engaging the mind but not the heart. *Acad Med*. 2005;**80**(10):892–8. doi: 10.1097/00001888-200510000-00004. [PubMed: 16186604].
4. Branch WJ, Frankel R. Not all stories of professional identity formation are equal: An analysis of formation narratives of highly humanistic physicians. *Patient Educ Couns*. 2016;**99**(8):1394–9. doi: 10.1016/j.pec.2016.03.018. [PubMed: 27019993].
5. Consorti F, Notarangelo M, Potasso L, Toscano E. Developing professionalism in Italian medical students: an educational framework. *Adv Med Educ Pract*. 2012;**3**:55–60. doi: 10.2147/AMEP.S31228. [PubMed: 23762002]. [PubMed Central: PMC3650871].
6. Daryazadeh S. Application of narrative in medical ethics. *J Med Ethics Hist Med*. 2019;**12**:13. doi: 10.18502/jmehm.v12i13.1642. [PubMed: 32328226]. [PubMed Central: PMC7166250].
7. Rosti G. Role of narrative-based medicine in proper patient assessment. *Support Care Cancer*. 2017;**25**(Suppl 1):3–6. doi: 10.1007/s00520-017-3637-4. [PubMed: 28220317]. [PubMed Central: PMC5357296].
8. Murphy JW. Primary Health Care and Narrative Medicine. *Perm J*. 2015;**19**(4):90–4. doi: 10.7812/TPP/14-206.
9. Charon R. At the membranes of care: stories in narrative medicine. *Acad Med*. 2012;**87**(3):342–7. doi: 10.1097/ACM.0b013e3182446fbb. [PubMed: 22373630]. [PubMed Central: PMC3292868].
10. DasGupta S, Charon R. Personal illness narratives: using reflective writing to teach empathy. *Acad Med*. 2004;**79**(4):351–6. doi: 10.1097/00001888-200404000-00013. [PubMed: 15044169].
11. Grossman E, Grosseman S, Azevedo GD, Figueiro-Filho EA, McKinley D. Flipped classroom on humanities: medicine, narrative and art. *Med Educ*. 2015;**49**(11):1142. doi: 10.1111/medu.12861. [PubMed: 26494071].
12. Kissler MJ, Saxton B, Nuila R, Balmer DF. Professional Formation in the Gross Anatomy Lab and Narrative Medicine: An Exploration. *Acad Med*. 2016;**91**(6):772–7. doi: 10.1097/ACM.0000000000001093. [PubMed: 26796087].
13. Weiss T, Swede MJ. Transforming Preprofessional Health Education Through Relationship-Centered Care and Narrative Medicine. *Teach Learn Med*. 2016;**31**(2):1–12. doi: 10.1080/10401334.2016.1159566. [PubMed: 27141931].
14. Armstrong GW, Wald HS. Fostering reflective capacity with interactive reflective writing in medical education: Using formal analytic frameworks to guide formative feedback to students' reflective writing. *Med Teach*. 2013;**35**(3):258. doi: 10.3109/0142159X.2013.759646. [PubMed: 23350841].
15. Pearson AS, McTigue MP, Tarpley JL. Narrative medicine in surgical education. *J Surg Educ*. 2008;**65**(2):99–100. doi: 10.1016/j.jsurg.2007.11.008. [PubMed: 18439528].
16. Charon R, Hermann N, Devlin MJ. Close Reading and Creative Writing in Clinical Education: Teaching Attention, Representation, and Affiliation. *Acad Med*. 2016;**91**(3):345–50. doi: 10.1097/ACM.0000000000000827. [PubMed: 26200577]. [PubMed Central: PMC4721945].
17. Daryazadeh S, Adibi P, Yamani N, Mollabashi R. Impact of narrative medicine program on improving reflective capacity and empathy of medical students in Iran. *J Educ Eval Health Prof*. 2020;**17**:3. doi: 10.3352/jeehp.2020.17.3. [PubMed: 31986248]. [PubMed Central: PMC7061215].
18. Daryazadeh S, Yamani N, Adibi P. A modified tool for "reflective practice" in medical education: Adaptation of the REFLECT rubric in Persian. *J Educ Health Promot*. 2020;**9**.
19. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;**24**(2):105–12. doi: 10.1016/j.nedt.2003.10.001. [PubMed: 14769454].
20. Lincoln YS. Naturalistic Inquiry. *The Blackwell Encyclopedia of Sociology*. Wiley; 2007. doi: 10.1002/9781405165518.wbeosn006.
21. Vafadar Z, Parandeh A. Nursing Students Experiences of Narrative Writing-Reflection in Clinical Education: A Qualitative Study. *Iran J Med Educ*. 2019;**19**:78–89.
22. Boudreau JD, Liben S, Fuks A. A faculty development workshop in narrative-based reflective writing. *Perspect Med Educ*. 2012;**1**(3):143–54. doi: 10.1007/s40037-012-0021-4. [PubMed: 23316470]. [PubMed Central: PMC3540349].
23. Arntfield SL, Slesar K, Dickson J, Charon R. Narrative medicine as a means of training medical students toward residency competencies. *Patient Educ Couns*. 2013;**91**(3):280–6. doi: 10.1016/j.pec.2013.01.014. [PubMed: 23462070]. [PubMed Central: PMC3992707].
24. Huang CD, Liao KC, Chung FT, Tseng HM, Fang JT, Lii SC, et al. Different perceptions of narrative medicine between Western and Chinese medicine students. *BMC Med Educ*. 2017;**17**(1):85. doi: 10.1186/s12909-017-0925-0. [PubMed: 28490362]. [PubMed Central: PMC5424351].
25. Miller E, Balmer D, Hermann N, Graham G, Charon R. Sounding narrative medicine: studying students' professional identity development at Columbia University College of Physicians and Surgeons. *Acad Med*. 2014;**89**(2):335–42. doi: 10.1097/ACM.0000000000000098. [PubMed: 24362390]. [PubMed Central: PMC4002760].
26. Cunningham H, Taylor D, Desai UA, Quiah SC, Kaplan B, Fei L, et al. Looking Back to Move Forward: First-Year Medical Students' Meta-Reflections on Their Narrative Portfolio Writings. *Acad Med*. 2018;**93**(6):888–94. doi: 10.1097/ACM.0000000000002102. [PubMed: 29261540]. [PubMed Central: PMC5976514].
27. Wald HS, Borkan JM, Taylor JS, Anthony D, Reis SP. Fostering and evaluating reflective capacity in medical education: developing the REFLECT rubric for assessing reflective writing. *Acad Med*. 2012;**87**(1):41–50. doi: 10.1097/ACM.0b013e31823b55fa. [PubMed: 22104060].
28. Sands SA, Stanley P, Charon R. Pediatric narrative oncology: interprofessional training to promote empathy, build teams, and prevent burnout. *J Support Oncol*. 2008;**6**(7):307–12.
29. Al-Imari L, Yang J, Pimlott N. Peer-support writing group in a community family medicine teaching unit: Facilitating professional development. *Can Fam Physician*. 2016;**62**(12):e724–30.
30. Wesley T, Hamer D, Karam G. Implementing a narrative medicine curriculum during the internship year: an internal medicine residency program experience. *Perm J*. 2018;**22**.
31. Daryazadeh S, Yamani N, Adibi P. Development of a checklist to validate the framework of a narrative medicine program based on Gagne's instructional design model in Iran through consensus of a multidisciplinary expert panel. *J Educ Eval Health Prof*. 2019;**16**:34. doi: 10.3352/jeehp.2019.16.34. [PubMed: 31805625]. [PubMed Central: PMC6895376].