Main POINTS for JS Narrative-Medicine Informed Research

Introduction: My role is to make explicit how our study exemplifies the concept of narrative medicine-informed research. I will use Rita Charon's classic model of the 3 "practices" of narrative medicine – attention, affiliation, and representation - as well as some of the principles they embody - to illustrate how these can be incorporated into qualitative research.

ATTENTION: Attention as you know refers to close reading, which is essentially what we did in our textual analysis. Close reading involves careful consideration of the text itself, hopefully without preconceptions. This means paying attention to individual words and phrases in a process that "unpacks" the text through CODING, or categorizing, individual words and phrases.

The next phase after coding is INTERPRETATION of results. Interpretation also involves attention because it requires accuracy and creativity, both principles of narrative medicine. It also includes being able to evaluate the interpretations of others, and to defend one's own interpretations based on textual evidence.

In the interpretative phase, after unpacking the text, we try to return to an appreciation for the story as a whole. Interpretation involves "listening" to the whole narrative to try to apprehend the intent of the author. It also includes recognition that multiple interpretations and understandings can coexist.

AFFILIATION: Close reading fosters affiliation, or empathic connection between researcher and text. Reading the students' stories creates respect for the personhood and humanity of all involved, those who created the text and those whom the text describes. Personhood is also a key NM principle. Further, there is recognition of the embodiment of the text, another NM principle, by which I mean a ongoing awareness that the text is created by human beings and describes human beings.

Affiliation is about INTERSUBJECTIVITY AND RELATIONALITY, additional principles of narrative medicine. It means there is empathy for the relationality described in the text that emerges between students, patients, and preceptors, as well as the intersection of the stories in the texts and the stories of the researchers, our own stories.

REPRESENTATION: Representation refers to how the text is portrayed, both publicly and privately.

Public representation – presentation of stories at conferences, in publications

Private representation – how we think about and talk about the people we study in informal settings, such as a team research meeting.

In both cases, we have a duty to do justice to the stories students are telling

Representation also involves a commitment to structural justice, an awareness of the unequal power circulating among the various characters in these stories, as well as the power of researchers to "control" the story they tell.

Representation includes acknowledgment of uncertainty, another narrative medicine principle, the admission that stories are inherently indeterminant, so representation is not a final answer. Ultimately representation, like the earlier interpretation of results, must incorporate accuracy (being fair, honest, true to text) and creativity, an openness to discovering new insights and meanings

REFLEXIVITY: All aspects of narrative medicine-informed research require reflexivity, a basic principle of narrative medicine.

Reflexivity includes awareness and interrogation of personal biases and assumptions

It also encompasses researchers' mutual awareness of agreement or disagreement with each other, the possibility of understanding or misunderstanding each other; and attributions of intentionality, feelings, and beliefs to each other.

I'm now going to turn over the rest of our presentation time to our remaining team members who will discuss reflexivity from their individual perspectives.