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The Practice of Narrative Medicine in Primary Care: A General Practitioner Perspective Post-print

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Abstract

Primary health care provided by general practice serves as a crucial safeguard for achieving universal health coverage. With the continuous deepening of the new medical reform, primary care in China has witnessed substantial improvements in the number of institutions, general practitioners, and outpatient visits compared to a decade ago. As the principal implementers of general practice, general practitioners align with the tenets of narrative medicine through their patient-centered approach and simultaneous attention to patients' psychological and social factors. Narrative medicine is practiced by clinicians possessing narrative competence; however, a pronounced disparity between robust theoretical development and limited practical application currently exists in China. This paper, from the perspective of general practitioners, demonstrates the positive influence of narrative medicine practice in primary care on general practitioners through the use of parallel charting.

Full Text

Discussion on the Practice of Narrative Medicine in Primary Care from the Perspective of General Practitioners

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Abstract

Primary health care provided by general practitioners is an important safeguard for achieving universal health coverage. With the continuous progress of new medical reforms, the number of primary care institutions, general practitioners, and outpatient visits have increased significantly compared with a decade ago. General practitioners, as the main implementers of general practice, align with the concept of narrative medicine in their patient-centered approach and attention to psychological and social factors. Narrative medicine is medicine practiced by clinicians with narrative competence, yet in China it currently suffers from strong theoretical development but weak practical application. From the perspective of general practitioners, this paper demonstrates the positive impact of narrative medicine practice in primary care on general practitioners through the use of parallel medical records.

Keywords: General practice; Narrative medicine; Parallel medical records; Primary health care

Achieving universal health should focus on two key aspects: the entire population and the entire life cycle. General practice, oriented toward communities and families, encompasses health issues across all populations and life cycles, aiming to integrate overall health promotion and maintenance while merging individual and population health. It also integrates the horizontal development of medical disciplines with relevant humanities. In China, primary care is currently dominated by general practitioners who play a crucial role in safeguarding residents' health. Narrative medicine emphasizes attentive listening, empathy with patients, and attention to managing negative emotions in both doctors and patients, followed by reflective writing to create parallel medical records that embody both medical objectivity and narrative subjectivity, thereby demonstrating warmer medical care. General practitioners also embody the humanistic aspects of narrative medicine to some extent during diagnosis and treatment, but the lack of systematic theoretical learning affects clinical practice effectiveness. This paper, from the first-person perspective of general practitioners providing primary care, shares parallel medical records to illustrate the application of narrative medicine in general practice and its positive effects, hoping to draw more colleagues' attention to narrative medicine and explore the integrated development of narrative medicine and general practice.

1. Current Status of Primary Care

With the deepening of medical reform, the release of the "Healthy China 2030" Planning Outline, and the increasing demand for high-quality medical services, China's primary care situation has improved significantly. According to the 2022 China Health Statistics Yearbook, the number of general practitioners has increased substantially compared with ten years ago, while the number of primary care institutions and outpatient visits have also risen accordingly, with the number of general practitioners per 10,000 population reaching three. Under the guidance of the bio-psycho-social medical model, an increasing number of medical workers no longer focus solely on disease itself but adopt a patient-centered approach that simultaneously considers psychological and social factors, using a comprehensive thinking pattern to address problems. Successful and appropriate intervention in social and environmental factors is crucial, and general practice has emerged with its greater emphasis on psychological, social, and environmental factors. As "gatekeepers" of residents' health, general practitioners play an increasingly prominent role in the healthcare system.

2. Brief Introduction to Narrative Medicine

To practice narrative medicine, one must understand and master three core elements: attention, representation, and affiliation. Through close reading, clinicians develop the habit of attending to details, focusing on patients' or family members' expressions, movements, postures, and emotions during clinical encounters. Through reflective writing, they give form and order to what they hear, see, and perceive, thereby creating meaning. Rita Charon notes that when listeners provide positive feedback during this process, confirming that their understanding aligns with what the other person has expressed and continuously ensuring no misinterpretation occurs, an affiliative relationship is established—essentially a partnership built with patients through the earlier processes of attention and representation.

Narrative medicine was proposed by Dr. Rita Charon, an internist with dual doctorates in medicine and literature from Columbia University. In her 2006 monograph, she defined narrative medicine as medicine practiced by clinicians with narrative competence—the capacity to recognize, absorb, interpret, and be moved by the stories of illness. Narrative medicine represents a practical medical approach that focuses on human beings within the context of technology-centered, positivist, and rationalist medicine. Practitioners of narrative medicine attend not only to diseased organs but to the whole person, while also focusing on doctor-patient interaction. This leads to three focal points: first, doctor-patient interaction based on physicians' attentive listening to patients' illness stories; second, physicians' ability to view problems from patients' perspectives and empathize after fully listening; and third, attention to negative emotions in both doctors and patients.

Patients hope to be seen as whole persons. When physicians emphasize lis-

tening to patients' illness stories during diagnosis and treatment, it not only facilitates history taking but also helps understand patients' perspectives on disease, enabling more comprehensive grasp of patients' needs across physical, psychological, and social dimensions. This builds harmonious and stable doctor-patient relationships and lays the foundation for patient participation in medical decision-making. Empathy is a continuous reflective process that combines subjectivity and objectivity through listening to and conversing with patients. It requires physicians to stand in patients' shoes, share their suffering, and provide encouragement, aiming to reasonably predict patients' actions based on compassion and understanding. The stronger a physician's empathic intention, the more willing they are to listen to patients' stories; the more attentively they listen, the better they can view problems from patients' perspectives, creating a mutually reinforcing relationship.

Negative emotions encompass not only the pain, helplessness, despair, and fear brought by disease but also the suppression, anxiety, and depression caused by increasing work pressure among medical staff, as well as guilt, doubt, and confusion over clinical errors, and anger, frustration, and sadness from lacking patients' and families' trust. Attending to patients' negative emotions can deepen understanding of their disease cognition and inner emotional experiences, thereby improving doctor-patient relationships and reducing conflicts. Reading literature related to negative emotions can enhance understanding of these feelings, while writing about inner experiences can alleviate negative emotions. Facing medical staff's own negative emotions requires not only acknowledging, revealing, examining, and judging them but also considering how to accept and utilize these emotions. Narrative medicine provides general practitioners with the theoretical foundation for developing narrative competence. Moreover, general practitioners in primary care institutions, having established long-term, fixed contractual relationships with residents, are better positioned to exercise narrative competence than specialists.

3. Case Analysis of Narrative Medicine in Primary Care

Clinical physicians increasingly emphasize integrating humanistic concepts with "technology supremacy." Narrative medicine was introduced to China relatively recently and has received attention and welcome from the Chinese medical community. However, the current situation of strong theory but weak practice urgently needs addressing. General practice emphasizes a "people-centered, comprehensive care model," which aligns perfectly with narrative medicine's essence of "holistic view," "benevolence," and "humanity," as well as its injection of intangible strength into medical practice. From the perspective of general practitioners and incorporating accumulated knowledge of narrative medicine, this paper elaborates on the practice of narrative medicine in primary care through parallel medical records.

3.1 Narrative Medicine Practice in Primary Care Helps General Practitioners Establish Stable and Long-term Doctor-Patient Relationships One winter day near noon, an elderly couple entered the clinic. The husband, walking unsteadily, approached me limping with his wife's support. The husband appeared calm, while the wife looked visibly nervous, her speech revealing anxiety and unease: "Doctor, please look at my husband. This morning I noticed his walking posture seemed off." I immediately stood up to help the patient sit down, carefully observing him while asking, "Do you feel any discomfort?" The patient answered clearly, "I don't think it's serious. I just feel weakness in my left leg, but my wife insisted on bringing me to the community clinic." I quickly used the FAST (Face-Arm-Speech-Time) pre-hospital stroke screening tool and found that during bilateral arm raising, the left side was slightly lower than the right. Combined with other symptoms, I rapidly considered a high possibility of ischemic stroke. Due to limited diagnostic conditions at the primary care institution, prompt referral to a higher-level hospital was necessary. I arranged for oxygen administration, vital sign monitoring, blood glucose measurement, and ECG examination, while informing the family about the need for referral. At this point, the wife had completely lost her composure, repeatedly murmuring, "Our children aren't home. What should we do?" The patient comforted his wife, "Look, I'm fine. My blood pressure and blood sugar are okay. Doctor, going to a big hospital costs more and is troublesome. Can't I just be treated here at the community clinic?" I understood the couple's concerns but was even more aware of the dangers of delayed treatment. Therefore, I patiently explained the limitations of community care, the benefits of early treatment for possible diseases, and potential sequelae from delayed treatment. Simultaneously, I proactively contacted their children to inform them of the condition. Eventually, the referral recommendation was accepted by the patient and family. One month later, the patient returned for a follow-up visit and immediately recognized me, saying gratefully, "Thanks to your strong recommendation to go to the hospital last time, the doctors said the treatment was very timely. I'm really grateful. As you can see, I have basically no sequelae and walk much more steadily now. Our whole family trusts you and wants you to be our family doctor." Thereafter, we established a family doctor contract relationship and enrolled the patient in chronic disease management, providing precise health services through regular follow-ups, physical examinations, health consultations, and health education, thereby building a stable, long-term relationship.

Reflection: In this encounter, helping the elderly patient sit comfortably made both patient and family feel valued, narrowing the doctor-patient distance. Through attentive listening, I learned that the family was very worried about the patient's condition, while the patient himself was reluctant to undergo further examination at a large hospital due to fear of hassle. I understood that the concept of "difficult medical access" is deeply rooted in patients' minds, especially among elderly people unfamiliar with hospital layouts, department locations, and payment systems. However, matters must be prioritized. As a

doctor, I must be responsible for patients' health. By experiencing the patient's mental world and resonating with his feelings, the doctor-patient relationship became closer. After analyzing pros and cons, the patient ultimately accepted my recommendation. I was relieved afterward. The disability rate of stroke is well known. I used professionalism to "appeal to reason" and humanistic care to "move emotions," accurately assessed the condition, promptly addressed the patient's concerns, treated him with sincerity and heart, and gradually established a stable doctor-patient relationship. This not only saved the patient's ability to live and work but also maintained family integrity and harmony. Meanwhile, my communication skills improved to some extent, professional identity emerged spontaneously, and more importantly, such positive feedback enhanced my motivation to learn and apply narrative medicine.

3.2 Narrative Medicine Practice in Primary Care Helps General Practitioners Develop General Practice Clinical Thinking One afternoon, a middle-aged woman entered the clinic. She had a well-proportioned figure, stylishly permed hair, and red lipstick that made her skin appear fairer. She walked elegantly to the desk and said, "Hello, doctor. Since having COVID-19, I've always felt short of breath. It's been two months. One of my relatives had the same symptoms, and they found pneumonia upon examination. Could you also order a chest X-ray for me?" As usual, I carefully inquired about the patient's history, quickly reviewing various possible causes of dyspnea in my mind—pulmonary, cardiac, hematological causes. Based on the history, I ruled out acute dyspnea. According to the patient's mental status and current vital signs, I excluded critical conditions. Just as I was about to use my stethoscope, the patient refused: "Doctor, don't bother with all that trouble. Just order the test for me. I still need to attend community choir rehearsal later." The patient, based on her own disease experience, insisted on a chest X-ray and stubbornly rejected my further suggestions. I reluctantly accepted her decision but did not give up exploring the cause of her symptoms. The next afternoon, the patient returned with the chest X-ray report: "Doctor, I can't understand this. Is it pneumonia?" "Your chest X-ray only shows a small calcification in the right lower lung. There's no clear sign of pneumonia. Combined with your lack of cough, fever, or other symptoms, pneumonia is unlikely. Since you left in a hurry yesterday, I didn't complete some examinations. It's not only pneumonia that can cause shortness of breath. Could I do some further examination for you?" With gentle but firm persuasion, I obtained her consent. The patient also explained that she had been in a hurry yesterday because the cultural performance was about to begin. She didn't want to fall behind or miss this rare opportunity. It seemed this patient was also a strong-willed person who only sought medical attention because shortness of breath was affecting her singing. Given no chronic disease history and based on current history and physical examination without clear cardiopulmonary indications, I suggested a necessary blood routine test first. The results soon came out, showing hemoglobin at 76 g/L, meeting the criteria for moderate anemia. Recalling the initial diagnosis,

I had overlooked an important clue—what was the color of her lips beneath the lipstick? Had I noticed this, I would have had more direct evidence to persuade the patient more efficiently. After tentatively determining that dyspnea might stem from anemia, I inquired about common bleeding causes and learned that the patient was in menopause, having menstrual periods for nearly 20 days per month with heavy flow for the past three months. Knowing that menstruation can be irregular during menopause, she had ignored it. Through this experience, the patient realized her health problems. As a general practitioner, I proactively referred her to the gynecology department of the leading hospital in the medical consortium, enabling timely and effective treatment.

Reflection: In patients' minds, general practitioners at primary care institutions lack the authority of specialists, and diagnostic capabilities are inferior to those of large hospitals. During the initial encounter, this "resolutely determined" patient refused advice and other examinations, indicating that the doctor's narrative competence needed improvement and that further communication was not achieved. Fortunately, after assessing the condition, no critical situation was found; otherwise, the consequences could have been disastrous. During the follow-up visit, the patient brought the normal chest X-ray and showed stronger curiosity. Her own experience failed to solve her problem, and she placed hope in the doctor. At this point, I seized the opportunity to consider various related possibilities using general practice diagnostic thinking, eventually finding clues in the blood routine results. Upon reflection, I realized that due to inadequate close reading, I had overlooked the story behind the patient's makeup, failing to identify the problem immediately. This provided an insight: general practitioners must enhance narrative competence. Besides continuously honing solid basic skills to accurately judge patients' conditions, they must consciously cultivate the ability to attentively listen to patients' illness stories and closely read patients' non-verbal information. Only by truly listening to patients can doctors achieve empathy, appropriately handle negative emotions in both doctors and patients, more easily gain patients' trust, accumulate experience from lessons, strive forward through reflection, and develop good narrative competence that enables full utilization of general practice clinical thinking.

3.3 Narrative Medicine Practice in Primary Care Helps Alleviate General Practitioners' Job Burnout The same hypertensive patient not taking medication can be handled completely differently by doctors. Narrative medicine and general practice both emphasize a patient-centered approach while attending to psychological and social influencing factors, and narrative medicine provides more specific methods and means. However, the current situation is that narrative medicine is not yet widespread, with few knowledgeable people and even fewer practitioners lacking standardization and systematic approaches. Parallel medical records are the clinical practice of narrative medicine, representing the 归纳总结 of patient narratives and encompassing physical, psychological, social adaptation, and cultural aspects. They not only help identify key problems but also facilitate sharing of diagnosis and treatment processes

and insights. However, parallel medical records are also in the developmental stage in China, with research mainly concentrated on concept introduction, theoretical 梳理, and preliminary practice. Due to the time consumption added by writing parallel medical records and the uneven narrative competence among doctors, the clinical efficacy of parallel medical records is difficult to evaluate, and promotion is challenging. Encouragingly, the Emergency Branch of the Chinese Geriatrics Society established a Narrative Medicine Professional Committee and founded the *Narrative Medicine* journal in 2018. Narrative medicine was also added to the standardized residency training textbooks. Additionally, Peking University officially established the "Peking University Medical Humanities College" in 2019, providing a learning foundation for students. Research by Luo Yingquan et al. indicates that adding narrative reflection education to the training process for graduate students and clinical residents is necessary, as it can improve students' learning abilities and positively impact humanistic spirit and professional cognition. For practicing general practitioners, improving narrative competence requires joint efforts in two aspects: first, health administrative departments should take the lead in establishing a narrative medicine training system through continuing education and incorporating it into assessment systems to form incentive mechanisms; second, general practitioners should attach importance to cultivating their own narrative medicine practice abilities just as they do to improving their professional technical skills, continuously strengthening close reading and reflective writing abilities, constantly learning and gaining experience in clinical practice, comprehensively improving general practitioners' job competency, meeting the requirements of primary care institutions in China at the current stage, establishing harmonious doctor-patient relationships through narrative medicine practice, and thereby providing high-quality, efficient, economical, and reliable medical and health care services for individuals, families, and communities.

Case 1: A middle-aged male neighborhood committee worker who frequently stayed up late and ate irregularly during the pandemic, gaining nearly 20 pounds over two years, particularly with a large belly, and having a smoking habit. With no chronic disease history, he was diagnosed with hypertension three months prior at a district hospital through ambulatory blood pressure monitoring and prescribed losartan potassium hydrochlorothiazide tablets. After one week of medication, he self-measured his blood pressure at 100/65 mmHg and stopped the medication on his own. Two months after discontinuation, his blood pressure reached 160/100 mmHg. He contacted his contracted general practitioner via WeChat to consult about "fluctuating blood pressure." The convenience of online communication further narrowed the doctor-patient distance, and the general practitioner initiated a chat mode, subtly integrating healthy lifestyle guidance into the conversation and instructing the patient on how to measure blood pressure at home while adjusting medication based on monitoring results. After two weeks of joint efforts by both doctor and patient, the patient's blood pressure reached ideal levels, and he expressed his decision to quit smoking after fully realizing the harms of smoking. The patient could receive the doctor's

response whenever encountering problems, and close communication improved treatment compliance, thereby maintaining blood pressure control.

Case 2: A young female company employee who discovered elevated blood pressure half a year ago. She was overweight, favored heavy-flavored foods, enjoyed sweets and fried foods, and did not exercise. During her initial visit, she expressed reluctance to take antihypertensive medication. The general practitioner took her to a health cabin, performed a physical examination, measured her height, weight, waist circumference, and body fat, formulated a weekly low-salt, low-fat, low-sugar diet plan, and created an exercise prescription. The patient reported her diet and exercise implementation weekly. The doctor adhered to the principle of 循序渐进 and invited the patient to jointly formulate an acceptable non-drug treatment plan. After three months, the patient lost more than ten pounds, and her blood pressure has basically remained at 120/80 mmHg to date.

Reflection: General practitioners working long-term in primary care institutions mostly face patients with common or chronic diseases. Their work is full of monotony and repetitiveness. With increasing years of practice, general practitioners inevitably experience job burnout. Using different treatment plans for the same hypertensive patients while integrating narrative medicine into the diagnosis and treatment process, doctors continuously reflect on the suffering that diseases bring to different patients and empathize with different patients, undoubtedly adding freshness to monotonous work and effectively alleviating general practitioners' job burnout while increasing their sense of achievement.

Conclusion

Narrative medicine and general practice both emphasize a patient-centered approach that simultaneously attends to psychological and social influencing factors. However, the current situation is that narrative medicine is not yet widespread, with few knowledgeable practitioners and even fewer who practice it systematically and standardly. Parallel medical records, as the clinical practice of narrative medicine, represent the synthesis of patient narratives covering physical, psychological, social adaptation, and cultural dimensions. They not only help identify key issues but also facilitate sharing of diagnosis and treatment experiences. Nevertheless, parallel medical records remain in the developmental stage in China, with research primarily focusing on concept introduction, theoretical organization, and preliminary practice. The additional time required for writing parallel medical records and the uneven narrative competence among doctors make clinical efficacy difficult to evaluate and hinder widespread promotion.

Encouragingly, the Emergency Branch of the Chinese Geriatrics Society established a Narrative Medicine Professional Committee and launched the *Narrative Medicine* journal in 2018. Narrative medicine has also been added to standardized residency training textbooks. Furthermore, Peking University established

the "Peking University Medical Humanities College" in 2019, providing foundational education for students. Research by Luo Yingquan et al. demonstrates that incorporating narrative reflection education into the training of graduate students and clinical residents is essential, as it enhances learning abilities while positively influencing humanistic spirit and professional cognition.

For practicing general practitioners, improving narrative competence requires dual efforts. First, health administrative departments should take the lead in establishing a narrative medicine training system through continuing education, integrating it into assessment systems with incentive mechanisms. Second, general practitioners should value the cultivation of their narrative medicine practice abilities as much as they value improving their professional technical skills, continuously strengthening close reading and reflective writing abilities, constantly learning and gaining experience in clinical practice to comprehensively improve their job competency. This will meet the current requirements of China's primary care institutions for general practitioners, establish harmonious doctor-patient relationships through narrative medicine practice, and provide high-quality, efficient, economical, and reliable medical and health care services for individuals, families, and communities.

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