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# An integrated narrative nursing model: towards a new healthcare paradigm

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**Abstract.** In the traditional biomedical model of clinical practice, which assumes a medicine focused on disease, diseases are considered as biological or psycho-physiological universal entities. This explanation, although necessary, is not enough. Several authors have recently become interested in the use of narrative practices in the medical care setting, underlining the increasing importance of "a patient-centered approach", a "relationship -centered care" and "narrative medicine". Even in Nursing, the challenge was to combine two models that seemed incompatible: the Evidence-Based Nursing Model and the Narrative-Based Nursing Model. The first one is based on the disease and is capable of reaching measurable objectives. It is marked by rationality, objectivity, determinism, unilateralism and linearity, and its methods emphasize logic, control, measurement and deduction. The second model is based on a global approach, resulting in a psycho-social perspective which stresses the importance of individuality, interpersonal relationship, and the illness and sickness as significant parts of healthcare. Through a short examination of different narrative models in medicine, we underlined some principles which can be used in nursing practice and we suggested a new healthcare paradigm based on integrated narrative nursing. It represents a groundbreaking new normative approach, deriving from different epistemological (positivist paradigm and interpretive paradigm) and methodological approaches that integrate quantitative data already normally detected on the patient, with subjective information obtained from the person and his family, and by the social impact that the disease causes. The integrated narrative nursing makes use of quantitative (e.g. scales and scientific evidence) and qualitative tools (e.g. narratives, autobiographies, therapeutic emplotment and patient's agenda). This approach, based on holistic comprehension, hermeneutic dialogue and a high degree of narrative skill, produces different ways of understanding and offering cure, care and assistance. This could allow a targeted assessment, a precise diagnosis and a personalized education. The benefits coming from the use of this paradigm are several, as for example, to disseminate a personal experience in a perspective of humanization, to improves quality of life and to create a positive effects on patient care outcomes.

**Key words:** bio-psycho-social perspective, narrative nursing, integrated nursing model, new healthcare paradigm, nursing practice

Having its foundation on Cartesian dualism, which makes a distinction between body and mind, the contemporary medicine has often considered techno-scientific aspects and the know-how at the center of the care process. It focused on "disease" without giving due importance to "illness" and "sickness", as personal experience by patients and their relatives, together with the social perception of disease (1). In the traditional biomedical model of clinical practice, which assumes a medicine focused on disease, diseases are considered as biological or psycho-physiological universal entities (2). This explanation, although necessary, is not enough. In his bio-psycho-social medicine model, even Engel (3) had already adopted a systemic approach: the patient-centered medicine which concerns the subjective meaning which illness has for everyone.

Nursing also makes an effort to integrate the Evidence Based Narrative Model, as unique care model, which is undoubtedly effective in reaching measurable objectives, with the Narrative-Based Nursing Model. If we admit that personal narratives, emotions and subjective perceptions must be taken into account by healthcare professionals, we have to integrate "curing" with "caring". It as well integrate the "concept of disease, as a group of signs and symptoms", with that of illness […], which includes personal emotions, desires, expectations and personal social context (4), and with that of sickness, as a social role and a status which is the external and public mode of unhealth.

## 1. Traditional healthcare model

Even if we find recentley a patient-centered medicine, a personalized medicine and a narrative medicine, the traditional healthcare model refer to bio-medicine, which focuses on cellular and molecular mechanisms and on reductionism that is on the division of body in its basic components.

On this background, the related nursing care model is typified by rationality, objectivity, determinism, universalism and linearity; its methods tend to emphasize logic, control, measurement and deduction (5). This model dates back to natural sciences and embodies totality paradigm, which starts from logical empiricism and from a strictly scientific concept of world directed to explain phenomena, giving special attention to observation and experimentation. Method of choice is represented by scientific problem-solving and in the nursing process the main instrument is given by the Care Plan (either paper or electronic) whose scope is determined by needs/problems of their patients. In this traditional healthcare model, the person keeps a biological meaning. In healthcare, the field of analysis is represented by bio-physiological needs/problems which are solely connected to the disease (6). If "disease" is intended as organic lesion and aggression by external agents, "health" is intended as the absence of biological damage to organs, cells and tissues in an organicistic frame of reference (7). Therefore, disease must be considered as an event which can be objectified and measured by professionals, using organic physical and chemical parameters (8). As a consequence, the patient plays a passive role in this process, as he relies on healthcare professionals who treat him (9, 10).

Even the environment which surrounds the patient is intended as clinical, physical and objective context (hospital), while the relationship with one's family groups, community, and society in general remains irrelevant to the healthcare process (3, 11). This framework means that according to the traditional nursing model is "centered cure" in all three phases of nursing process: acceptance, assistance and education (12). In the "acceptance phase", the nurse collects information using organic chemical and physical parameters which lead to the classification of bio-physiological and clinical problems. The scientific method used in nursing is problem-solving (13), while operative instruments are given by protocols and procedures and nursing interventions ("assistance phase") are based on Evidence-Based Nursing. The "educational phase" is limited to the mere transfer of bio-clinical information from professionals to patients.

In healthcare, evolution of treatment and care systems stressed the need to use a more global approach towards health problems, as many researches have underlined (for instance, 14, 15, 16, 17, 18). Sakalys (19) states that a relational reshaping of patient-nurse relationship is necessary in the nursing process, and it must occur passing from a "monological" approach to a "dialogic" approach, thus encouraging patient's role in an inter-dependent care process, which is mutually respectful. This process tends to achieve its fulfillment (that is the nature and the quality of care to be given and instruments to be used) starting from skills and resources of each "social actor" in a given setting (20, 21).

In this direction, as it happens in all healthcare professions, the relationship becomes a constitutive and essential component of nursing, an "essential requirement" of nursing itself.

According to Parse (22) nursing is based on relationship. This principle, which is the founding value of nursing, integrates a perspective of cooperation in healthcare, that is to cure, with the goal of taking care of person, that is to care, through a genuine connection based on communication (23). As a matter of fact, the dimension of disease must include a biophysical profile (disease), a psychological profile (illness) and a social relational profile (sickness).

## 2. Different narrative approaches

Several authors became recently interested in the use of narrative practice in the medical - care setting. For example, Charon (24) underlines the increasing importance of "a patient-centered approach" a "relationship -centered care" and the "narrative medicine", all of which based on the experience of illness and narratives. Many authors have recently analyzed the use of narrative in healthcare environments, trying to use humanistic assumptions, with very different approaches and objectives. Interest for phenomenological approaches in medicine and healthcare seems to grow in Italy too. The Consensus Conference Meetings on narrative medicine (1) represent an example of this interest. The following sections show some basic features, in an attempt to underline what pattern can be used in nursing and healthcare.

### *2.1 Therapeutic approach*

According to therapeutic approach, narratives play a fundamental role and have a great meaning in treatment, particularly in the following fields: psychology, psychotherapy, psychoanalysis, psychiatry, neurology and neuro-psychiatry. Experts talk about a real "narrative therapy", as in the last few years narrative shifted from the classical clinical description for educational reasons to a therapeutic pathway (25). An example is given by Mohrmann and Sheperd (26) who focus on the "duty of welcoming the patient" and the improvement of "truly capacious attention and openness to the other that is essential for appropriate, compassionate medical care". Other authors state also the importance that all team members recognize the therapeutic function of narrative and ritual and be prepared to accompany the patient through a gateway to memory and meaning (27). On this background, narrative has gained an essential role, above all in a psycho-therapeutic change-oriented approach. Psychotherapist's duty is to change psychological processes which are rooted in personal beliefs, in the relational and emotional patterns, in the way of thinking or organizing perceptions, and in the schemes of assigning meanings or relational patterns. According to this trend, meaning is investigated with an emphasis to discursive/narrative sense of human reality. There is no human reality which is independent from the subjective meaning given to it. Sometimes, people are prisoner of their narratives which can become instruments of change for the therapist. Nevertheless we will not further analyze this approach, because it doesn't belong specifically to nursing, as it is the case with the three models below described.

### *2.2 Humanistic narrative approach*

Humanistic narrative approach stems from the encounter of Medicine with Medical Humanities, and it tries to recover interest for emotional and cultural dimension of care, respect for patient's peculiarity and ethical commitment by professionals (28). A medicine which is exclusively related to science does not suffice, as medical action is both scientific and humanistic: without scientific dimension, medicine would be "blind", not knowing where to go; without humanity, it would be "empty". Indeed, if scientific evidence gives an explanation, the narrative focuses on comprehension.

Since 2000, Charon has been analyzing narrative in the clinical setting and she has been using narrative to improve practice, in the light of a new awareness reached thanks to the study of narrative theory (29). Narrative medicine does not represent a different type of medicine; it is a medicine performed with narrative skills (24). It can identify four complex situations, where narrative skills can develop: sympathetic involvement as regards physician-patient relationship; a reflexive approach of healthcare professionals with themselves; the relations of healthcare professionals with their co-workers; the physician-society relations, based on mutual trust.

In the perspective of the humanistic narrative approach, the integration model proposed by Silva and Charon (30) aims to integrate Narrative Medicine and Evidence-Based Medicine. Within this frame, clinical problems, actions, choices and therapeutical goals are identified and preferential needs and priorities are developed within the clinical relationship.

Even in nursing, this approach emphasizes the humanization of care and the quality of patient, family and professional relationships.

*2.3 Hermeneutic phenomenological approach*

Starting point in this approach is represented by a radical attack of the reductionism supported by neo-positivist medicine and a need to overcome mind-body Cartesian dualism (31). Everyone lives experiences where he is really and intentionally included. So he is "related to the other" and his interactions develop with other people and environment. According to Heidegger (31), the phenomenological perspective of things must be overcome through an understanding of the Entity that is behind all entities or "Existential Phenomenology". Even Ricoeur (32) tried to constructively reach the integration of Hermeneutics and Phenomenology. According to him, not only an epistemological integrated Heidegger's hermeneutics must be achieved, but a complete phenomenological review of language and life must be performed too, a choice that Heidegger had previously rejected, by making an immediate shift from comprehension to ontology.

In general, according to Ricoeur, the Heidegger's short way "does not allow an epistemology of interpretation and semantics of comprehension of languages". This means the possibility of multiple meanings and points of view expressed through patient's narrative. Narrative intertwining in the clinical setting can be considered "mutual construction of meanings" which relies on the behavior of healthcare professionals and the degree of contact and comprehension created by them with their patients. According to this approach, narratives have the potential either to help the patient or to harm him; this depends on how narratives are expressed and interpreted by the listeners (33). For this reason, patients and professionals bear a moral responsibility related to how the narrative is expressed and the subsequent choices. Some Israeli researchers (34) define a narratological distress, which is marked by the internal dispute between two narratives: the narrative of physicians and other professionals, who tend to reduce and ignore the experience of pain, as it is not detectable from a diagnostic point of view; and the narrative of the patient himself, who acknowledges the pain (35). The practice of narrative listening, as a moment by moment non-judgmental awareness of interaction with the other, offers a method to focus healthcare professionals' attention on patients' narrative together with the instruments of the clinical practice. This active listening, in nursing, allows to establish relationships of trust, to understand each other, to share the meanings of experiences and to construct a common cure and care pathway.

*2.4 Socio-anthropological approach*

Socio-anthropological approach is based on the application of social sciences, sociology and anthropology to the study of medicine. The main authors, Good and Kleinman to mention some of them, define medicine as "cultural system", that is a group of meanings which shape clinical reality and the illness experienced by the patient. Kleinman (36) created the above-mentioned distinction between disease, illness and sickness. The word disease focuses attention on organic lesion, which is an objective measurable event; the word illness focuses attention on subjective experience based the on patient involvement in his uneasiness; the word sickness stresses attention on the understanding of a disorder in its general meaning, among people related to micro-social forces (economic, political and institutional powers). Narratives do not only describe and tell experiences; they build them ever since they confer them the meaning disease has reached in a given cultural setting. Clinical and nursing narratives are not a remodeling of personal experience but a result of a process of "negotiation of meanings" between professionals and patients. Their encounter can produce a new understanding of disease, through listening to each other and remodeling one's own versions.

If the hermeneutic phenomenological approach focuses on different points of view, the socio-anthropological approach refers to the plurality of actors involved in clinical encounter (physicians, nurses, healthcare professionals, patients, caregivers) who have different points of view. Instead of focusing on interpreting their meanings, this approach concentrates on cultural contents expressed by patients, according to their different social roles. The illness-disease-sickness triad becomes the main instrument to overcome the Cartesian dualism, by setting different genres and narratives within a reference framework and by analyzing them, keeping into account the social setting which produced them.

The threefold division of narrative proposed by Frank represents an example of how narrative can be studied according to social settings (37). He divides narratives into three models: restitution narrative, chaos narrative and quest narrative. An English research (38) puts this kind of classification into practice, focusing on the idea that narratives do not only involve patients past experiences but can be useful to create experience in those who listen. For this reason, we can consider narrative as a social action and the act of narrating as a social activity which involves not only the narrator but all those who listen.

At last, according to the anthropological researches such as that of Mattingly (39), narrative reconstruction allows to work out "therapeutic emplotment" (that is to create a therapeutic plot). Therapeutic emplotment comes out from interpretive activities during therapeutic encounter between healthcare professionals and patients. It deals about therapeutic narrative through which healthcare professionals create and negotiate a plot by interpreting patient's story within care emplotted time, when therapeutic action takes place.

Narrative competence, intended as the skill to listen, understand, interpret and co-create stories of disease, must be necessarily supported by narrative practice, intended as skill to set up care pathways based on narrative competence. This represents a "paradigmatic shift: from stories 'as told' to stories 'as tools' (40), and it underlines the link between narrative structure and experience, and between narrative structure and therapeutic actions, identified and negotiated based on individual narrative structure (39, 41).

## 3. Usefulness of narrative approaches to nursing: an innovative perspective

Thanks to this short digression of different models of narrative medicine, we try to stress some principles which can be used in nursing practice and refer, above all, both to the socio-anthropological approach and the hermeneutic-phenomenological one.

The clinical encounter represents a system of social interaction caused by disease and attended by one or more healthcare professionals, who are allowed to act because of their skills, and by other social subjects who take part to this process, according to their different skills. Each professional has his own point of view on the disease, which is related to different perspectives: we talk about illness with reference to patient, disease with reference to healthcare professionals and sickness with reference to other social subjects involved. These three different perspectives produce and express three different types of knowledge: they produce equally different types of narratives; all of them are rightful and complementary; from their interaction, clinical encounters stem and develop in their different phases. The interpretive dimension is strictly related to clinical encounter, as it is an encounter of different narratives and the related meanings they give to disease. This approach based on holistic comprehension, putting into action a hermeneutic dialogue which allows the enhancement of the different skills involved, in order to integrate them, to create a proper relationship-centered care, not only for patients, but also (as the socio-anthropological model underlines) for other social actors taking part in the care process (physicians, nurses, healthcare professionals, patients, caregivers). This approach requires a narrative skill by healthcare professionals. The humanistic narratological model suggests that narrative practice must entail a high degree of skill (narrative skill), which leads to an empathic involvement in the nurse-patient relationship, in a reflective practice by healthcare-professionals, in the relationship of professionals with their co-workers and between healthcare professional and society, based on mutual trust. Moreover, it is possible to get another suggestion as regards the attempt by Charon to integrate an Evidence-Based Approach with the purely Narratological Approach.

## 4. Towards a new paradigm for health: the integrated narrative nursing

According to the above-mentioned suggestions and by resuming Charon's proposals, we suggest an integrated healthcare model, which tries to combine the bio-medical positivistic approach, which has a formal, objective and systematic nature, (6), with the phenomenological, interpretive anthropological and cultural approach (42). As Marcadelli and Artioli stressed (16),

the effort means to combine two models that seemed incompatible: Evidence-Based Nursing Model and Narrative-Based Nursing Model. The first one is capable of reaching measurable objectives, it is marked by rationality, objectivity, determinism, unilateralism and linearity and its methods emphasize logic, control, measurement and deduction. The second model is based on a global approach, resulting in a bio-psycho-social perspective which stresses the importance of individuality, of interpersonal relationship and the illness and sickness as integrating parts of healthcare.

This integration could solve an apparently overwhelming contradiction: that between absolute individual distinctions and the need to standardize the method through hermeneutics, which implements the method itself (43). This could allow a targeted assessment, a precise diagnosis, thanks to an integration of scientific and humanistic methods, a patient-tailored healthcare aimed at keeping multidimensional health and the possibility of more appropriate clinical pathways, thanks to the development of an advanced nursing (44). The integrated model makes use both of cases (as data/information collected by traditional assessment) and patients' narratives, in order to get a nursing diagnosis. The integrated use of cases and narratives highlights three increasing steps of diagnostic definition: in the first step, narrative information confirm traditional information in defining nursing diagnosis; in the second step, narrative information further explore traditional information; in the third step, narrative information play a paramount role in understanding the problem, a result that traditional assessment would not reach (45).

Within this perspective, the integrated model makes use of a bio-psycho-social approach. People are unique and their consciousness of a "psychological inner-self" and that of an "external body" join to form a "unit of meaning". Environment is not only intended as external, physical, objective entity, but also as relational and subjective entity gained through experience. Health gets both a clinical and a psychosocial dimension because, next to the disease, we meet a patient who lives a subjective and personal experience (illness), and this experience is socially acknowledged (sickness).

Given such complexity, healthcare means to cure/care for persons and the nurse makes use of narrative-based interviews as preferential technique in the three phases of nursing:

1. a multidimensional assessment of patient and family, in order to emphatically understand bio-clinical and psycho-social relational needs (acceptance phase);
2. a therapeutic communication, thanks to the use of communication and relational strategies, active listening and observation, in order to build a mutual setting up (nurse- patient and family) for a patient-tailored therapeutic plan, with the involvement of caregivers (assistance phase);
3. to encourage behaviors aimed at patient's health (patient and caregiver educational phase).

In this sense, problems must be faced in a holistic perspective (46) where experiential knowledge allows interventions on the "biographical disruption" caused by disease (47). This model was for example effectively used in the cardiovascular setting (12).

Therefore, we can state that the model suggested by integrated narrative nursing represents a breaking-new normative approach, coming from different epistemological approaches (interpretive paradigm and positivist paradigm). Integrated narrative nursing means an assistance methodology that supplement quantitative data, already normally detected on the patient, with subjective information obtained from the sick person and his family and by social impact that the disease causes. Indeed, the integrated narrative nursing makes use not only of quantitative tools (evaluation scales and scientific evidence), but of qualitative tools too (narrative interviews, autobiographies, therapeutic emplotment and patient's agenda). To achieve a global and bio-psycho-social approach to the person and of his' life-world, this epistemological approach produces various ways of understanding and offering cure, care and assistance (Table 1).

## 5. What future for the integrated narrative nursing?

As previously explained, narrative nursing means new ways of offering care in all of the three different phases of nursing (12) and requires an implementation both in practice and research. Moreover, narrative practice plays an important educational role for

**Table 1. A comparison of different Nursing Model**s

| | Traditional model | Narrative Model | Integrated Model: based on traditional and narrative models |
|---|---|---|---|
| **Disease** | Disease | Illness and Sickness | Disease, Illness and Sickness |
| **Health** | Bio-clinical dimension | Psycho-social dimension | Bio-psycho-social dimension |
| **Environment** | Objective, physical, external | Subjective, relational, intimate | Objective and Subjective |
| **Approach** | Patient cure | Patient care | Patient cure and care |
| **Goal** | Solve a problem related to the disease | Understand the person, the family and what they feel | Solve a problem related to the disease, understand the person, the family and accompany them when the problem can no longer solve |
| **Instruments** | Technical and quantitative | Relational and qualitative | Mixed: qualitative and quantitative |
| **Role of patient** | An “object” waiting to be given a role (that of patient) | A “Subject” who lives a disease; he is an illness expert that lives sickness | A “Subject” who lives a disease; he is an illness expert that lives sickness |
| **Role of relative/caregiver** | He plays a marginal role in the healing process | Patient and relative build a single nursing “unit” | Family takes part to dialogue between professionals and patients |
| **Role of healthcare professionals** | Sole and undisputed expert of disease | Not expert in illness and sickness | In dialogical encounter, shared meanings are developed between professionals and patients |

healthcare professionals, giving them not only the instruments to understand patients, but also to think about the meaning of one’s clinical practice (28). In the same way as patients do, also physicians, nurses, and other healthcare professionals can express through words what they experience during their daily activity: in addition to scientific papers, all healthcare professionals write narratives dealing with the meaning of human interaction and describe even emotional and personal features about the treatment of specific patients through narrative practice (words, diaries, autobiographies and therapeutic emplotments).

Some researchers stress that this type of narrative writing helps them to better understand the experience of disease and the life of their patients. They support the assumption that writing about themselves or about their patients enriches medical practice with a knowledge which cannot be obtained in any other way (24).

In this sense, the goals of integrated narrative nursing can be expressed as follows:

- to make nurses aware of the dignity of their profession;
- to collect documents which precisely define the nursing skills;
- to give instruments to enhance nursing and assess the quality of interventions;
- to underline the importance of patient and nurse relationship, improving its quality;
- to highlight good practice in daily activity and relationships;
- to point out best examples in nursing;
- to disseminate - at a social level - a professional image which takes into account relational standards;
- to promote an atmosphere which improves good nursing practice;
- to improve the image of nursing.

The benefits coming from the use of narrative nursing are different and, among them, at three levels. The first level is to disseminate very personal experienc-

es in a perspective of humanization; to create stronger connections among the members of the nursing team; to experience well-being and relief; to give professional value to a practice spontaneously born from the idea of using oneself as first healing instrument; to highlight the importance of nursing; to create a path of constructive self-criticism, thus improving professionally; to prove that healthcare organizations must be tailored on patients and their relationship with relatives.

The second level improves the quality of life. In fact, this integrated model would be useful: to work in a best-quality organizational environment, which allows to devote the right time to narrative nursing; to create a working team with co-workers and staff at higher level, in order to have a well set-up hierarchy and to work out ways to propose the narrative approach to patients' relatives. They represent the first level of negotiation, by giving them more freedom of action within the hospital unit and sharing the narrative worked out with them (41), creating a closer relationship to their sick relatives (48).

The narrative of hospitalization experiences belongs to patients' needs and narrative nursing represents a rehabilitation instrument in the phase of psychological recovery (49, 50).

Therefore, at third level, the narrative nursing integrated represents a high-added value to nursing, because of positive effects on outcomes of patient care outcomes, in addition to an improvement in their quality of life. For example, the results of an experimental randomized controlled trial on 352 patients in 6 European countries (49) showed a decreased incidence of post-traumatic stress disorder within the intervention group, which made use of follow-up diaries, while the control group didn't use any diary. Patients and their relatives defined narrative as a kind of support in order to understand, accept or get accustomed to their serious illness, the experience of hospitalization, and to bring back to mind information about illness. The interpretation of such events helped patients to collect their memories with diary narratives and to understand what really happened (51-55). Even the use of pictures during narration, together with the examination of diary contents during follow-up counselling, was described by some patients as useful instrument to gain awareness (41, 49, 51, 56, 57).

Interpreting events occurred during hospitalization is considered by patients as an instrument to re-think what happened and to "put such experience aside", to the extent possible.

In Italy, recent studies in cardiovascular setting have shown the impact of bio-psychosocial nursing approach in patients' compliance (58); they confirm the use of narratives as one of the main instruments towards a multidimensional and integrated nursing, which employs narrative interviews to implement adherence to treatment (59). The narrative approach must be improved through a specific educational pathway, by integrating the bio-medical with the psychosocial nursing in the professional practice (60). For this reason, the different areas which can use narrative approach require a professional in-depth study about this topic and a special educational pathway, which until now has been too much underestimated.

At first, narrative nursing may seem easy-to-apply, but an improvement in the present narrative skills turns out to be necessary. In northern Europe, where this method is frequently followed (see 51, 53, 61), narrative nursing shows deep roots, following properly set up guidelines.

In the wide Italian healthcare setting, a significant omission must be recorded in the use of this method; nevertheless, the biomedical model, which has not yet been integrated, remains the main reference model (58).

Because of a scarce dissemination of narrative nursing in Italian healthcare and University environments and due to hospital management experiences more concerned about shorter waiting times and reduced costs, the lack of an adequate training together with insufficient experiences in this area stress the need for an important cultural change. In Italy, a high degree of interest for the narrative approach is recorded. Nevertheless, the Italian nursing needs ad-hoc training courses and projects in order to adequately know and practice this healthcare approach.

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