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1 The Use of Illness Narratives in Undergraduate Physiotherapy,
2 Medicine, and Nutrition: Innovative Experiences at a University
3 in São Paulo

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6

7 **Abstract**

8 With the purpose of consolidating the implementation of the National Curriculum Guidelines
9 in the health area, an innovative project involving higher courses in Physiotherapy, Medicine
10 and Nutrition was conceived at a University located in the city of São Paulo. This qualitative
11 research brings the perceptions of the participating students about the project, regarding the
12 analysis of the content of reflective portfolios and transcripts of conversation circles carried
13 out after the collection of illness narratives by those undergraduates. The students were able
14 to reflect on themes such as the multidimensionality of falling ill, comprehensive care, the need
15 to incorporate psychosocial aspects for the person's understanding, how much emotions are a
16 factor in the illness experience and the need to broaden the perspective of such process. This
17 activity is considered to have brought important reflections to those undergraduates towards
18 the achievement of the current guidelines, contributing to a more humanistic and
19 interdisciplinary approach in such professions.

20

21 **Index terms**— higher education. curriculum. humanization of assistance.

22 **1 Introduction**

23 With the advent of the 21st century, higher education in the health area has been widely debated in Brazil as well
24 as in the world. This debate considers, as a premise, that future professionals do not have critical, reflective
25 nor innovative training, much less one that is focused on the health needs of the people who will seek them.
26 This is a premise supported by both the dissatisfaction of users and the health service workers themselves, since
27 the scenario of diseases and health problems today is very different from what was observed until the middle
28 of the last century, when most of the current curricular models of the undergraduate courses in the area were
29 constructed.

30 Since the 17th century, professionals involved in health care have had their training based on a model considered
31 increasingly technical, where the focus is not on the person who gets sick, but, rather, on the organs affected
32 by the various diseases. Authors 1,2 emphasize that the health sciences, based on an universal vision present in
33 modernity, are guided by the fragmentation of the being, by hyperspecialization and by reductionism, following
34 a model primarily based on the biological sciences and that is predominant in the training of health workers, be
35 they doctors, nutritionists, physiotherapists, among others.

36 This rationality was definitely incorporated and taken as a standard for the professional health education from
37 1910 onwards, with the advent of the Flexner Report. This report brings a model of health organization focused
38 on cure and treatment, based on diseases, centered on the hospital and on the figure of the doctor, with strong
39 investment in technologies and hyperspecialization. Based on this report, professionals such as physiotherapists,
40 nutritionists and doctors, among others, began to be trained to work, primarily and almost exclusively, in the
41 hospital environment, a role strengthened, in Brazil, by the National Higher Education Guidelines and Framework
42 Law of 1968 ?? .

43 Despite the undeniable improvements to people's quality of life, today, the Flexner model has been criticized
44 for excessive medicalization, high costs and the abusive use of technologies, in a process that, over the years,

3 METHODOLOGY

45 has excluded considerable portions of the world's population from having access to health care. It is a model of
46 power, where the health professional determines the rules and norms of conduct that must be passively followed
47 by the people who seek them. In this way, the protagonism is removed from the person and the professional
48 becomes the only holder of knowledge about the body, dictating all standards 4 . Such criticism highlights
49 the professional inadequacy for the current epidemiological scenario dominated by health problems and non-
50 communicable diseases, especially mental health problems and the high prevalence of disabilities related to them,
51 which require a graduate profile different from that prioritized by the Flexner model. This new framework
52 highlights the need to train health professionals with a more caring perspective, possessing skills that make
53 them capable of innovating and qualifying the current mode of care, while being critical and having the capacity
54 for reflection, management and producing more positive results in the professional-ailing relationship. In this
55 new context, bonding, communicational relationships, empathy, compassion, teamwork and respect for users'
56 diversity, rights and autonomy are fundamental 4 .

57 In order to implement changes in the profiles of graduates in the health area, the new National Curriculum
58 Guidelines (NCG) were approved in 2001.

59 These, in addition to changing the curriculum, highlight the role of active learning and practice, in addition
60 to the need for the undergraduate student to understand that falling ill is a process inscribed in the culture,
61 historically determined and conditioned by socio-economical parameters. Undergraduate courses should enable
62 those students to experience teamwork and favor the formation of bonds and respect for the diversity and
63 autonomy of those who seek the health service. Another common point to be highlighted is the need to train
64 professionals to work in Primary Health Care (PHC), thus, shifting the hospital spotlight, seen as a priority
65 teaching center [5][6][7][8] .

66 Training professionals to work in PHC implies prioritizing bonding and communication technologies. Under-
67 standing health as a positive concept, and not just the absence of disease, the professional's perspective starts to
68 include, in addition to diagnosis and treatment, health promotion, disease prevention, rehabilitation, reception,
69 monitoring, care and, when necessary, palliation. PHC focuses on the different family arrangements and on the
70 active participation of the subjects, assuming the co-responsibility of the professionals who make up the health
71 teams and the people they serve, stimulating the protagonism of users, in addition to interprofessional work 9 .

72 Based on the Dawson Report, an English counterpoint to the Flexner model, the PHC organizes and
73 coordinates the health system, guaranteeing universality, equity, integrality, society's participation and problem-
74 solving capacity of care, thus, transposing to the Brazilian practice, the principles of the Unified Health System
75 (UHS-SUS -Sistema Único de Saúde) listed in the Federal Constitution. Due to its characteristics, it demands
76 generalist professionals, in line with the profile of graduates established in the NCG.

77 Several authors report difficulty in training physical therapists, doctors and nutritionists in Brazil who want
78 to work in the PHC. Authors 10 emphasize that most physiotherapists are still trained for the individual,
79 rehabilitative work performed in the hospital. Thus, it is necessary to expand the focus of action and, for
80 this change to properly materialize, it is important to build new teaching paradigms in the undergraduate area.

81 In turn, the Federal Nutrition Council 11 emphasizes that most nutrition courses in the country still work
82 separating the biological aspect from the social one, theory from practice, being overly standardized, not
83 prioritizing the specificities of each region, nor the country's inequalities. As a consequence, graduates generally
84 do not want to work in the UHS.

85 As for the medical courses, the medical demography, a national survey promoted by the Federal Council of
86 Medicine, shows the permanence of newly graduated doctors in large Brazilian cities, in hospital work and with
87 excessive specialization 12 , far from the profile of graduates desired by the NCG.

88 In order to consolidate the implementation of the new NCG and sensitize undergraduates to work in PHC-UHS,
89 having the above explained as context and justification, the project "Innovate-UHS Narrative-Based Teaching"
90 ("Inova-SUS Ensino Baseado em Narrativas") was conceived involving courses on Physiotherapy, Medicine and
91 Nutrition at a University located in the city of São Paulo.

92 Illness narratives have proved to be a valuable resource in medical education, where they have been used
93 in different contexts for over 30 years. Considered as transforming care practices, they promote empathy,
94 accountability of the graduating student towards the sick person, bond formation, active listening and favors
95 the expansion of the view on the process of becoming ill. Thus, they break the Flexner rationality, adding
96 humanistic skills [13][14][15] . Although there is no description in the literature about the use of narratives with
97 students from undergraduate courses on Nutrition and Physiotherapy, the project proposes their inclusion.

98 Being based on what has been observed so far, this research aims to present the perceptions that emerged
99 from the undergraduates participating in the project "Innovate-UHS Narrative-Based Teaching".

100 2 II.

101 3 Methodology

102 This is a qualitative research that presents the perceptions of the undergraduates participating in the project
103 "Innovate-SUS Narrative-Based Teaching" developed during the years 2018 and 2019.

104 The population of this study is made up of 22 students enrolled in the Physiotherapy, Medicine and Nutrition
105 courses at a University located in the city of São Paulo, selected according to the criteria contained in a public

106 notice. Those approved signed a Free and Informed Consent Term, in which they became aware that their personal
107 production (portfolios, participation in conversation circles and groups) would be analyzed and published.

108 After those steps, the project was initiated. The students collected illness narratives from people with chronic
109 conditions in a health service also located in the city of São Paulo. For the collection of those narratives, we
110 decided to use an instrument which deviates from the traditional model for collecting the stories of diseases
111 used by professionals in the health areas, commonly referred to as anamnesis. The instrument chosen, adapted
112 and cross-culturally validated for Brazil, called McGill MINInarrative of Illness, is a semi-structured, qualitative
113 script that allows the apprehension of events or problems related to health, guiding the narrative of the subject's
114 experience about health and disease, their explanations for their illness, the information and words they use to
115 describe their experience, their relationships with the various health services and their professionals. This script
116 was used so that the undergraduates could have some guidelines, since they had never conducted open interviews,
117 and because it is an instrument that has been used in medical courses in Brazil to facilitate the first contact of
118 the undergraduates with narratives collected outside the traditional anamnesis scripts in the courses 16,17 .

119 After collecting the narratives, the participating undergraduates were welcomed by tutors in conversation
120 circles, which were recorded and transcribed, and reflective portfolios were also prepared. Those transcripts,
121 considering only the speeches of the students, together with the content of the reflective portfolios, composed the
122 corpus used for this research.

123 The corpus was submitted to lexical analysis using the free IRaMuTeQ® software (Interface de R pour les
124 Analyses Multidimensionnelles de Textes et de Questionnaires), created by Pierre Ratinaud in Python language,
125 with features provided by the R statistical software 18 .

126 It is an auxiliary software for the analysis of social representations that considers the word as a unit. Social
127 representations, normally considered as constructions shared by and reproduced socially, help form and shape
128 individuals, molding their role in society. Understood as common sense, they provide ways of interacting with the
129 world, being important for the comprehension of the collective and the construction of people's personal history.
130 They are externalized in speeches and embodied in behaviors and attitudes that guide people, even if they do not
131 correspond to social reality 19 . For health professionals, these reproduce the culture and rationality understood
132 as being representative of that professional training.

133 IRaMuTeQ® generates descriptive statistics, such as the calculation of the number and frequency of words,
134 and enables the performance of multivariate analyses, such as the Descending Hierarchical Classification (DHC).
135 This classification works with clusters, allowing a classification in which the words are distributed in homogeneous
136 lexical classes. In this step, the software performs chi-square tests (? ?), seeking the associative strength between
137 the terms and their respective class, analyzed when the test is greater than 3.84, representing $p < 0.0001$. From
138 the classes, a dendrogram is generated, a graphic representation of the different clusters, which translates social
139 representations common to the studied group 18 .

140 In addition to the dendrogram, the software generates a phylogram of words per class, graphically translating
141 the main terms that form them, where words located at the top of the list, highlighted by size, have greater
142 influence in that class. It is also possible, for variables with at least three modalities (in the case of this research:
143 course where the student is enrolled), to carry out the Correspondence Factor Analysis (CFA), a method that
144 represents the relationships in a two-dimensional factorial plan, whose results are useful for identifying oppositions.
145 For this study, we also used the Analysis of Specificities, or Analysis of Contrasts, which allows comparing the
146 distribution of linguistic forms according to categorical variables, in this case, the gender mentioned by the
147 students 18 .

148 The use of the software, however, does not complete the analysis of the corpus, remaining the need to interpret
149 the information generated by the researcher. This interpretation was carried out through Content Analysis 20
150 with the following steps: prior analysis, exploration of material, inference and interpretation from the current
151 theoretical-scientific framework. This analyze enables a deeper understanding of the representations that emerged
152 from the corpus.

153 This research was approved by the University Center Research and Ethics Committee.

154 4 III.

155 5 Results

156 Of the 22 participating undergraduates, 4 (18%) belong to the Physiotherapy course, 11 (50%) belong to the
157 Medicine course and 7 (32%) to the Nutrition course; 14 are women (63%) and 8 (37%) are men. 13 (59%)
158 students were in the last semesters of the course.

159 The corpus was composed of 22 reflective portfolios and transcripts of welcoming conversation circles (Initial
160 Context Units-ICU), material separated into 1257 text segments (Elementary Context Units-ECU), which
161 contained 15,380 words, of which, 554 had a single occurrence. For a corpus to be considered representative
162 of the social group studied, more than 70% of the ECUs must be used, as was the case for this research, where
163 the use was 79.63%. The entire corpus was analyzed. However, only the most representative speeches within
164 each class will be presented.

165 After the DHC was performed, two subcorpora called "Health Professionals" and "Listening to Stories"
166 emerged, the former expressing 51.1% of the ECUs and the latter 48.9%. Each of these was composed of two

6 "THIS SURPRISED ME BECAUSE I DON'T BELIEVE I COULD GET
THIS LEVEL OF DETAIL FROM THE INFORMATION IF I KEPT
INTERRUPTING THE PATIENT. I FELT GOOD TOO, BECAUSE FOR THE
FIRST TIME I FELT EFFICIENT WITHIN A MORE REAL AND IDEAL
SITUATION, WHERE THE PATIENT TEACHES ME WHAT HE HAS
EXPERIENCED AND I CAN LEARN FROM HIM, I CAN HELP HIM." (A9,
MEDICINE, SCORE 107.63)

The Health professionals subcorpora concentrates the largest number of text segments, thus having greater prominence. Here the students expose how they experienced the collection of illness narratives, highlighting aspects related to the recognition of the other, seen as a subject and not just a carrier of the disease, as well as the emotions that this contact brought to the surface. The "The person" class, which represents 22.8% of the text segments of this subcorpora, had as representative words: person, sense, see, illness, look and happen. It is a class that demonstrates how these students were able to perceive the need to not stick only to the disease, trying to reach the sick person. It also deals with how the disease affects the lives of the people they interviewed and the perception that the disease does not have a single causality, being multidimensional. These undergraduates demonstrate in the texts that the narratives showed them life and illness experiences that made them reflect on their future as people and professionals. The highest scores in this class were achieved by the students in the Physiotherapy and Nutrition courses, demonstrating the impact of the narratives for those students.

"I think that we cannot just look at the disease, we have to realize that behind the disease there is a person, there are their life plans, their desires, and, many times, because of the illness, they end up giving up what they would like to do." (A22, Physiotherapy, score 108.87) "[...] it allows us to perceive what the person feels, because we have this vision for treating the disease and not the person, but there is a lot behind this person." (A16, Nutrition, score 80.45) "It was a very enriching moment, looking at patients in the eye, looking beyond their problem, getting to know their life, their routine. I believe that this is extremely important for the team that will assist them, because it makes them feel more comfortable and it facilitates our understanding, it makes it easier for us to understand them as an individual and not limit them to a disease". (A18, Physiotherapy, score 70.69) Related to this is the "Emotions" class, with 28.3% of the text segments and whose content is expressed by the words: year, time, take, hold and medicine. In this class, it is highlighted how much the collection of narratives aroused affections and emotions. The expectations of which professional these undergraduates want to be are also exposed here, as well as the concern of invading the privacy of patients when collecting the narrative. There was reference to chronic diseases in the family and how much the narratives referred them to these situations. In this class, the highest scores were achieved by students of Medicine and Nutrition.

"Now, I feel like being a doctor. I think that's what's missing, it's not enough to stay there and say I'm going to make your diagnosis, now take the medicine you have to take, now you can leave. I don't want this, if that's the way it is, I don't want to be a doctor at all" (A6, Medicine, score 76.51) "I was more concerned with my emotion. I swallowed many times. I was a little emotional at certain times when she was too, so I tried to hold back a little bit, I also have chronic problems in my family so it ends up interfering." (A20, Physiotherapy, score 66.53) "In this narrative, I could see that Medicine will really be a long and challenging path, for several years; however, it is up to us students and future health workers, before just prescribing medicines and following protocols, to put ourselves in the other's shoes and try to understand how that affects the life of each person and only then will we be able to create a more humanized and integrative Medicine." (A4, Medicine, score 62.86).

In turn, the second subcorpora: "Listening to stories", is well differentiated in terms of the percentage distribution for the classes that compose it, with the first, "Active listening", representing 30.5% of the corpus, demonstrating how the need for this became evidenced for these participating students.

This class introduces the words patient, get, talk, lead, bond, story, and tell. The texts are about the importance of letting the ailing person talk and listening carefully, while highlighting how the narratives brought information far beyond the traditional anamnesis that these undergraduates learn in their courses, especially with regards to the importance of family and social groups. They also highlighted the importance of narratives for their learning and for the understanding of reception and integrality.

The participating undergraduates highlighted how they learned to "take the story from the patient" and how to properly interrupt in order to optimize the listening experience related to the illness, alongside the traditional logical reasoning they must employ to put their profession into practice. The speeches of Medicine and Nutrition students obtained the highest scores on this class.

217 6 "This surprised me because I don't believe I could get this
218 level of detail from the information if I kept interrupting the
219 patient. I felt good too, because for the first time I felt
220 efficient within a more real and ideal situation, where the
221 patient teaches me what he has experienced and I can learn
222 from him, I can help him." (A9, Medicine, score 107.63)

223 "Well, I think the anamnesis I did in Nutrition, at least in the first consultation, was very restricted like that,
224 it had these questions and I directed it to be able to meet the time limit and finish all the questions". (A17,
225 Nutrition, score 81.63) "The narratives" class, with the lowest percentage weight in this subcorpora (18.4%),

226 has the textual elements experience, narrative, strength, participate, feeling, technique and bring, as statistically
227 significant. It is a class closely related to the previous one, where students bring back the differences between
228 traditional anamnesis in contrast to the narratives, but with an emphasis on the experiences, uniqueness and
229 feelings of the people interviewed. It is clear that, for this group, the use of narratives complements the anamnesis,
230 bringing psychosocial aspects to the table. Again, the feelings brought forward by the students are what stands
231 out in the texts.

232 **7 "[?," when comparing to the common anamnesis, which does
233 not go that far, does not entertain feelings, it is more
234 technical, more objective, it focuses on the disease and not
235 on the whole. The narrative collection is deep and goes**

236 beyond the technical, it goes beyond the body, it just listens." (A20, Physiotherapy, score 112.27) "[...],
237 undoubtedly deeper, about the illness process, the patient's life process, this really impressed me with that
238 narrative." (A7, Medicine, score 100.80) "The narrative brought an experience that we don't see so much in
239 undergraduate courses, at least in Physiotherapy. We end up being very technical and the narratives are much
240 more subjective. The illness process is never the same, everyone has their own, so respecting this illness process is
241 something that the narrative brought to me". (A22, Physiotherapy, 89.32) "From this experience on, I think I will try
242 to modify my approach. I think it would basically be about understanding that person's life story. I think I will try
243 to understand not only the clinical or biochemical data, but also the personal, the human ones." (A13, Nutrition,
244 79.38) When analyzing the CFA, it is noted, at the factorial level, that the classes that make up the "Listening to
245 Stories" subcorpora are well interrelated with each other and with the "The person" class, while the "Emotions"
246 class is somewhat more distant, with less interrelation with the others. It can be inferred, from the lexical
247 analysis, that the collection of narratives allowed these participants to experience active listening, to understand
248 that the patient is not just a disease to be treated and to value psychosocial and cultural aspects that otherwise
249 would not be significantly considered. In turn, the collection brought forth affections and emotions, with causing
250 students to sometimes be uncomfortable with such fact, despite the importance given to the experience.

251 Differences were also noted in the factorial plan according to the participating courses, as seen in Figure 3.
252 The CFA makes it possible to verify, in the factorial plan, the words that differentiate and characterize each
253 group of students according to the course in which they are enrolled. For the students of the Medicine course,
254 the text segments with greater force were located in the class, and it can be inferred that the emotions aroused
255 by the collection of narratives were the points that stood out the most in the experience of these participants.
256 As for the participants of the Physiotherapy course, "Active listening" was the most highlighted class.

257 The textual elements of the Nutrition course participants reveal the "Narratives" class as the most expressive,
258 showing the importance given by these participants to aspects not brought up by the anamnesis of the area
259 and to the emotions evidenced by the experience of collecting narratives. When the words classified according
260 to the students' gender are analyzed, differences also appear. For male participating students, the main words
261 refer to area, process, patient. As for the female participants, the words that appear are tell, help, speak, stay.
262 The words highlighted by the male speeches, when analyzed in their contexts, show a concern of these students
263 with their professional performance, while the words spoken by the women speeches refer more to care and the
264 communication with the other.

265 **8 IV.**

266 **9 Discussion**

267 Narratives are linguistic structures composed of a sequence of interrelated facts which are personified Volume XXII
268 Issue VII Version I 6 () through both mental and social processes and culturally and historically conditioned.
269 During the narrative process, both the narrator and the listener are affected, through a process that allows
270 for reflections, understanding and explanations related to the narrated events. When narrating the process of
271 becoming ill, the patient justifies and provides meaning to their suffering, integrating representations, knowledge,
272 practices, their own experiences and those of their families and social groups, reconstructing reality within a
273 context. By transforming the fact into an experience, it is externalized through verbal and non-verbal language
274 14,21 .

275 From the mid-twentieth century, illness narratives start being applied in the teaching of health professionals as
276 a tool that encourages active listening, empathy, bonding, and the humanization of the health professional-patient
277 relationship. Unlike the anamnesis (standardized interview scripts used by different health professionals), the
278 narratives seek to stimulate the students' narrative competence, working on skills such as recognizing, absorbing,
279 interpreting and being moved by the story of the other, combining textual, creative and affective skills 14,22 .

280 The textual skills refer to identifying the structure of the story, perceiving its multiple perspectives and
281 recognizing metaphors, creative skills stimulate the imagination and develop curiosity and, lastly, the affective
282 skills include the respect for diversity, otherness and uncertainty. Together, these three contribute to the

9 DISCUSSION

284 diseases, focusing more on the language, representations, emotions and relationships that permeate daily practices
285 in the health area 14,21,22 .

286 In the medical field, the usage of illness narratives extends from the beginning of graduation 13, ??3 all
287 throughout the professional's education 22 and their professional life. Several ways of stimulating such narrative
288 competence can be studied and implemented, such as the reading of classic works of literature or photographic
289 essays and the analysis of cinematographic or artistic texts. This research made use of illness stories written by
290 the students themselves and the collection of narratives from sick people 14,24 , examples where real people were
291 interviewed by the undergraduates, without the need to resort to anamnesis scripts specific to each profession.

292 Regardless of the form, narratives are considered as transforming care practices, promoting empathy,
293 approximating the student to the ailing person and forming a bond. By encouraging active listening, they
294 favor the expansion of the view regarding the entire process of becoming ill 21 . In Brazil, there are reports
295 of its use in the training of doctors, nurses and psychologists, both at undergraduate and graduate levels 25
296 . As already mentioned, in the literature, there are no prior mentions concerning the use of narratives in the
297 graduation of physiotherapists and nutritionists in the country, which was done in this research.

298 The narratives would break with the technicity of the curriculum, incorporating popular knowledge and
299 allowing a look beyond the biological, while contextualizing the illness as a complex, multifaceted, non-reducible
300 phenomenon carried out by those who suffer. Health professionals enter people's lives at moments of significant
301 fragility, with the narratives bringing out the subjectivity and uniqueness of such moments. Due to these
302 characteristics, they are able to provide the necessary life experiences and reflections that allow the shifting
303 of the standards of health education from the traditional hospital setting to a more humanized primary care 26 .

304 When working with narratives, listening is a priority. Being recognized as one of the foundations for the
305 effectiveness of the care proposed by the Expanded and Shared Clinic, a strategy included in the Humanize SUS
306 policy, which prioritizes the expanded understanding of the health-disease process, the shared construction of
307 diagnoses and therapies, the expansion of the work object, the transformation of means and work instruments
308 and the support for health professionals 25,27 .

309 As has been already mentioned, the health professional is very early trained, primarily, to listen to people
310 through a common script, called anamnesis. This script, permeated by a technical approach, completes, cleans
311 and standardizes people's narrations in order to reach the ailment, however, in the process, it devalues the
312 knowledge that the patients have about themselves. In this process of "selective deafness" ??4: 54 , the sick
313 individual becomes an object, a vessel, with the highlight being on the disease. The health professionals think
314 they are listening to the suffering person, but the social representations constructed and reproduced by the
315 Flexner model prevent such an active listening.

316 During this process, the disease is treated as a universality, equally applicable to everyone, due to the removal
317 of the psychic, cultural and social issues related particularly to the person seeking treatment. This creates a
318 distance that prevents the formation of bonds. The Flexner model, by prioritizing only traditional scientific
319 knowledge and technical skills, removes compassion, empathy, attitudes and relationships 28 .

320 These points appear in the subsequent reflections made by the students, who are surprised by the discovery of
321 the subject beyond only diseases, an experience that permeates the entire corpus of the research and is highlighted
322 in several of their speeches. It is a discovery that arouses a multiplicity of emotions in these undergraduates,
323 who start to reflect on aspects not previously perceived by them. In the whole corpus, it is noted how much
324 these students, from a more thorough discovery of the other who was perceived, until then, solely as a patient,
325 become more concerned regarding which professional they want to be, one that follows a more technical approach
326 or more humanistic one. They realize, however, that it is possible to reconcile these two poles, which have never
327 been antagonistic, but, rather, complementary.

328 The undergraduates participating in the project highlighted how much the anamnesis does not allow them to
329 apprehend aspects such as feelings, worldviews nor the experiences resulted from living with an illness. They also
330 emphasized that the diagnosis process is focused on interruptions and directions that lead them to the disease,
331 but distancing them from the speaker. In this process, the person becomes solely the patient, no longer leading
332 his own story.

333 When practicing active listening, the group emphasizes how important it was for the understanding of the illness
334 experience of the people they interviewed, while highlighting points not commonly observed in the anamnesis
335 collection, such as the importance of the psychosocial aspects. The existence of a restriction on the subject that
336 occurs when only talking about the disease was evident, as well as the discovery of emotions, both in the people
337 from whom the narratives were collected and in the students themselves. As said, these are aspects that permeate
338 all the speeches, but stand out the most from Physiotherapy and Nutrition students, as is also observed in the
339 CFA.

340 The Flexner model had excellent success in controlling and reducing acute diseases, which can, above all,
341 be considered biological processes, the main intention for which the model was designed. However, the current
342 epidemiological picture, with a predominance of chronic diseases, needs to modify said standard, especially since
343 the latter is characterized by being predominantly biographical, hence the need to listen to the broader history
344 of the subject. In researches done with collections of illness narratives of people who have a chronic condition, it
345 is observed that many interviewees, when reliving past moments, express feelings and experiences through verbal

346 language, but, mainly, through non-verbal language. These readings are not always performed or taken into
347 account when obtaining the traditional anamnesis 21,24 .

348 The narrative representation of the disease, specifically the reconstruction of the experience of illness and
349 suffering, allows the person to re-elaborate what they lived and how they felt in such a way that the entire
350 experience becomes more clearly defined, not only for others, but, above all, for themselves. Thus, it provides
351 cultural meanings and reintegration of social relationships altered by the disease. For a subject with a chronic
352 illness, it is an open process, because the illness has not ended, which leads them to be continually alternating
353 the present and the past, weaving a plot that makes their suffering understandable 2,24 .

354 Regarding the collections of narratives of illness from people who have a chronic condition, it is observed
355 that many interviewees suffer when reliving past moments of hardship, which can be noticed by these students.
356 These emotions are not always valued when obtaining the traditional anamnesis, thus preventing the creation of
357 a deeper and more trusting bond 2,25 .

358 When working with narratives, the importance of perceptions and feelings that attentive listening provokes
359 is also noted. The group of students was deeply affected by the listening, with researches emphasizing that
360 undergraduates, despite admiring the patients, have difficulties in dealing with all the brought up emotions and
361 suffering, possibly even resulting in emotional overload, hence the importance of the reception made by tutors
362 to the students participating in the project soon after the collection ??3,25 . It is noted that undergraduates in
363 Medicine and Nutrition are the ones most affected by these issues, as highlighted by the CFA.

364 During the activity, countertransference movements were observed. This occurs in the health professional-
365 person relationship positively (feelings of affection and admiration) or negatively (aggressiveness and resistance).
366 Aspects that were too painful for the health professional, especially in the family environment, are usually the
367 triggers of countertransference, blocking the relationship. In the case of countertransference, some of its possible
368 consequences can be: lack of carefulness and attention to the listening of the narrative, early interruptions,
369 judgment and self-identification. These factors were observed in the speeches of one of the undergraduates, which
370 made it impossible for her to continue listening attentively to the person from whom she collected the narrative,
371 resulting in a phenomenon rarely discussed during undergraduate training, which is the erosion of the health
372 professional-person relationship by bringing irrational, unconscious, unrealistic issues to it 29 .

373 The need for students who participated in the project to develop a habit of writing portfolios relating their
374 experiences is also highlighted. The habit of writing about their experiences with others is not an activity
375 normally encouraged in Brazilian's undergraduate health courses 30 , however, research indicates that when the
376 writing pertains to feelings, ideas and experiences, undergraduates tend to more comprehensively reflect on their
377 own lives, making them more empathetic and approachable 13, ??3,25 .

378 Finally, the differences in words found regarding the gender of the undergraduates are highlighted. As the
379 software works with social representations and gender roles, as described and inscribed in our culture, are
380 socially constructed, it is not surprising that a distinction is observed. The literature infers that women health
381 professionals bring more evocations related to Volume XXII Issue VII Version I 8 () humanization, teamwork
382 and dedication, reproducing social representations that attribute the role of caregiver to women 31 , something
383 also observed in this study. On the other hand, the male students' words and texts show greater concern with
384 their performance as future professionals.

385 The reconstruction of knowledge by students has long been discussed, as they need to find their own personal
386 meaning in what they learn. In addition to said meaning, they must relate new information with what they already
387 have, alongside new demands posed by professional practice and, mainly, with the needs of the population with
388 whom they are going to work with 32 . Learning is a process of personal growth and development in its entirety,
389 requiring not only theoretical knowledge, but also affective-emotional knowledge, human skills, attitudes and
390 values 33 . It is believed that these objectives were achieved with this project, as can be seen in several speeches
391 by the undergraduates.

392 V.

393 10 Final Thought

394 It is believed that the project "Innovate-SUS-Narrative-Based Teaching" has achieved its objectives. Discussions
395 on changes in the profile of graduates of courses in the health area are now a reality, with emphasis on the need
396 to balance technical and humanistic skills.

397 Through the collection of illness narratives, it can be seen that the experience provided reflections to this group
398 of undergraduates about their professional future and the need for active listening. Being able to see the person
399 beyond the disease and reflect on the multidimensionality of becoming ill, the receptiveness and approachability in
400 the professional-patient relationship, the comprehensiveness of care, the need to incorporate psychosocial aspects
401 to better understand the person, how much emotions are present in the experience of illness and on the need
402 to expand the look at this process constituted important points highlighted by the group. Thus, this activity
403 brought important reflections for these students in the sense of achieving the profile expressed in the current
404 NCG for these undergraduate courses.

405 However, limitations to this research are pointed out. The methodological design chosen does not allow
406 generalizations. The absence in the literature, so far, of the application of narratives with Physiotherapy and

10 FINAL THOUGHT

408 the IRaMuTeQ® software, used here as an aid in content analysis, which is a tool still rarely used in researches focused on health education. ¹ ²

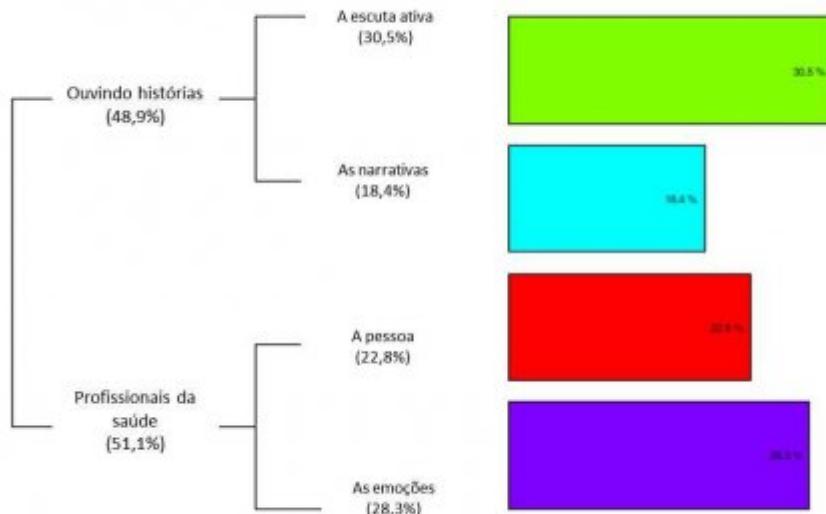
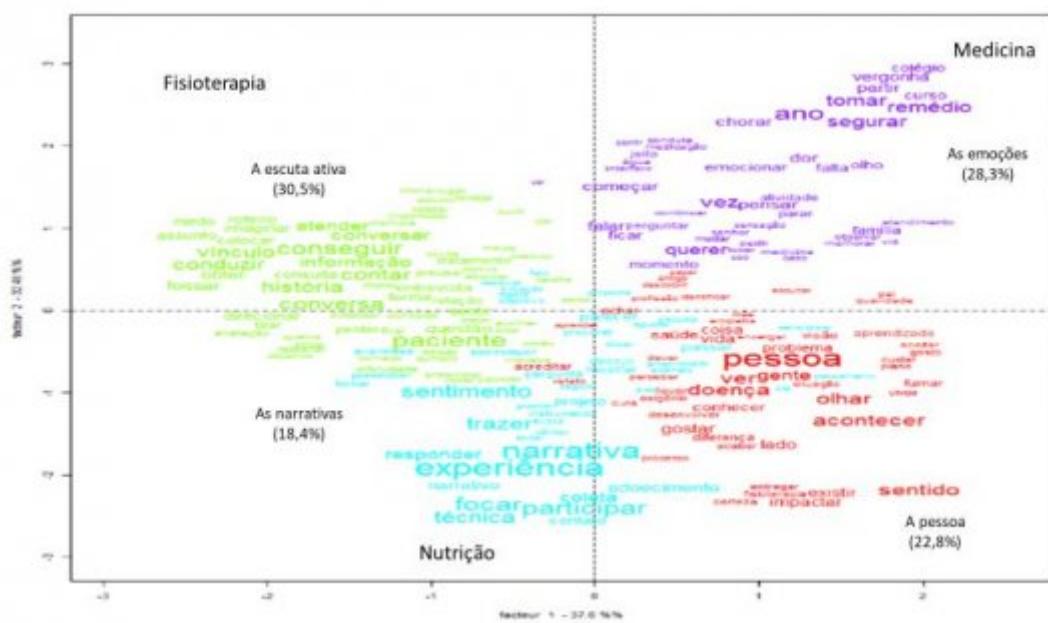


Figure 1:



1

Figure 2: Figure 1 :



2

Figure 3: Figure 2 :

10 FINAL THOUGHT

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