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By Maria Elisa Gonzalez Manso

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I. Introduction

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

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

This rationality was definitely incorporated and taken as a standard for the professional health education from 1910 onwards, with the advent of the Flexner Report. This report brings a model of health organization focused on cure and treatment, based on diseases, centered on the hospital and on the figure of the doctor, with strong investment in technologies and hyperspecialization. Based on this report, professionals such as physiotherapists, nutritionists and doctors, among others, began to be trained to work, primarily and almost exclusively, in the hospital environment, a role strengthened, in Brazil, by the National Higher Education Guidelines and Framework Law of 1968[3].

Despite the undeniable improvements to people's quality of life, today, the Flexner model has been criticized for excessive medicalization, high costs and the abusive use of technologies, in a process that, over the years, has excluded considerable portions of the world's population from having access to health care. It is a model of power, where the health professional determines the rules and norms of conduct that must be passively followed by the people who seek them. In this way, the protagonism is removed from the person and the professional becomes the only holder of knowledge about the body, dictating all standards[4].

Such criticism highlights the professional inadequacy for the current epidemiological scenario dominated by health problems and non-communicable diseases, especially mental health problems and the high prevalence of disabilities related to them, which require a graduate profile different from that prioritized by the Flexner model. This new framework highlights the need to train health professionals with a more caring perspective, possessing skills that make them capable of innovating and qualifying the current mode of care, while being critical and having the capacity for reflection, management and producing more positive results in the professional-ailing relationship. In this new context, bonding, communicational relationships, empathy, compassion, teamwork and respect for users' diversity, rights and autonomy are fundamental[4].

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

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

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

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

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

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

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

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

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

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

II. Methodology

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

The population of this study is made up of 22 students enrolled in the Physiotherapy, Medicine and Nutrition courses at a University located in the city of São Paulo, selected according to the criteria contained in a public notice. Those approved signed a Free and Informed Consent Term, in which they became aware that their personal production (portfolios, participation in conversation circles and groups) would be analyzed and published.

After those steps, the project was initiated. The students collected illness narratives from people with chronic conditions in a health service also located in the city of São Paulo. For the collection of those narratives, we decided to use an instrument which deviates from the traditional model for collecting the stories of diseases used by professionals in the health areas, commonly referred to as anamnesis. The instrument chosen, adapted and cross-culturally validated for Brazil, called McGill MINInarrative of Illness, is a semi-structured, qualitative script that allows the apprehension of events or problems related to health, guiding the narrative of the subject's experience about health and disease, their explanations for their illness, the information and words they use to describe their experience, their relationships with the various health services and their professionals. This script was used so

that the undergraduates could have some guidelines, since they had never conducted open interviews, and because it is an instrument that has been used in medical courses in Brazil to facilitate the first contact of the undergraduates with narratives collected outside the traditional anamnesis scripts in the courses[16, 17].

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

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

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

IRaMuTeQ® generates descriptive statistics, such as the calculation of the number and frequency of words, and enables the performance of multivariate analyses, such as the Descending Hierarchical Classification (DHC). This classification works with clusters, allowing a classification in which the words are distributed in homogeneous lexical classes. In this step, the software performs chi-square tests (χ^2), seeking the associative strength between the terms and their respective class, analyzed when the test is greater than 3.84, representing $p<0.0001$. From the classes, a dendrogram is generated, a graphic representation of the different clusters, which translates social representations common to the studied group[18].

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

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

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

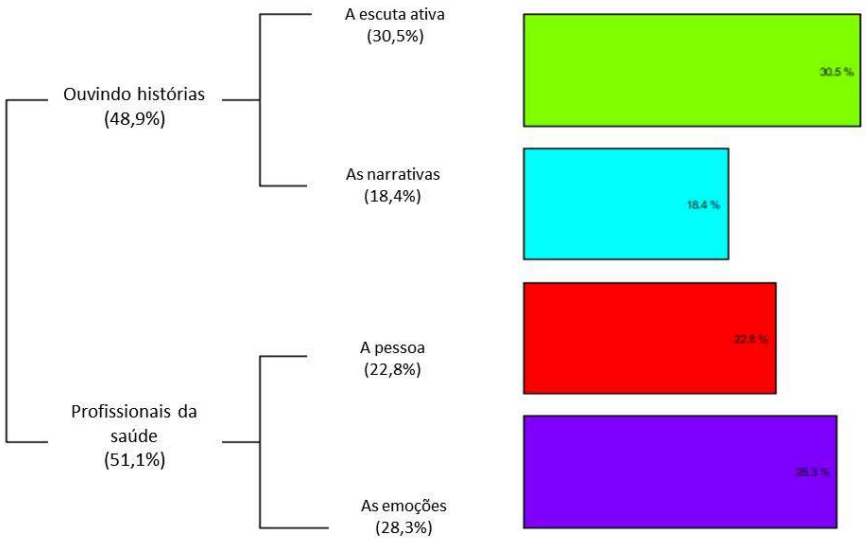
III. Results

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

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

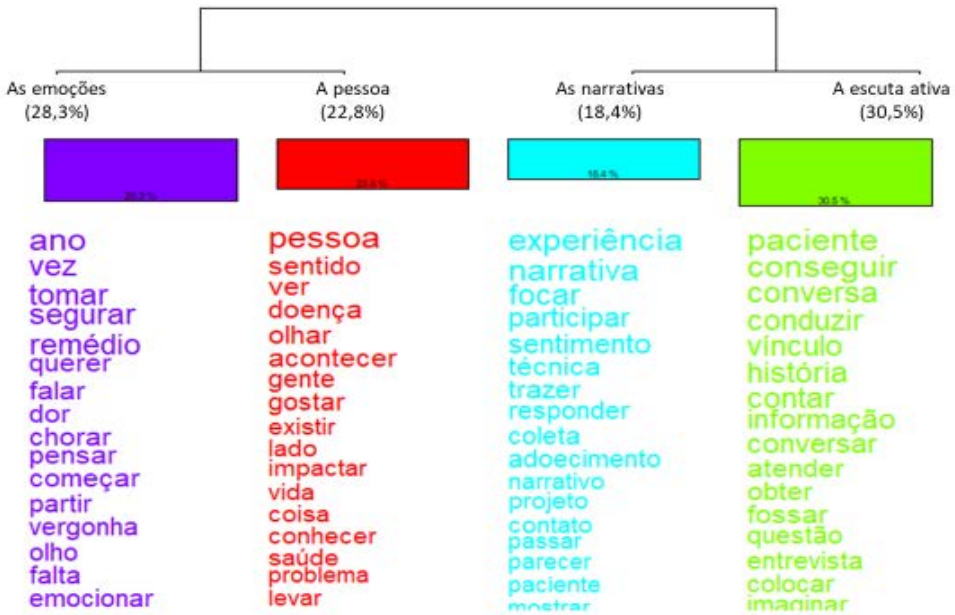
After the DHC was performed, two *subcorpora* called “Health Professionals” and “Listening to Stories” emerged, the former expressing 51.1% of the ECUs and the latter 48.9%. Each of these was composed of two classes, as shown in Figure 1, which shows the dendrogram obtained. Figure 2 displays the phylogram generated from the $\chi 2$ test for each of the classes. Only the textual elements that reached $p< 0.0001$ will be presented and only the excerpts with the highest score in each class will be transcribed, despite the entire *corpus* having been analyzed.

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.



Source: IRaMuTeQ®, research data.

Figure 1: Descending Hierarchical Classification, Narrative-Based Teaching Project, São Paulo, 2018-19



Source: IRaMuTeQ®, research data.

Figure 2: Phylogram according to analytical classes, Narrative-Based Teaching Project, São Paulo, 2018-19

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.

> *"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)

> "Well*, I think the anamnesis I did in Nutrition, at least in the first consultation, was very restricted like that, it had these questions and I directed it to be able to meet the time limit and finish all the questions".* (A17, Nutrition, score 81.63)

"The narratives" class, with the lowest percentage weight in this *subcorpora* (18.4%), has the textual elements *experience, narrative, strength, participate, feeling, technique and bring,* as statistically significant. It is a class closely related to the previous one, where students bring back the differences between traditional anamnesis in contrast to the narratives, but with an emphasis on the experiences, uniqueness and feelings of the people interviewed. It is clear that, for this group, the use of narratives complements the anamnesis, bringing psychosocial aspects to the table. Again, the feelings brought forward by the students are what stands out in the texts.

> *"[…,] when comparing to the common anamnesis, which does not go that far, does not entertain feelings, it is more technical, more objective, it focuses on the disease and not on the whole. The narrative collection is deep and goes beyond the technical, it goes beyond the body, it just listens."* (A20, Physiotherapy, score 112.27)

> *"[...], undoubtedly deeper, about the illness process, the patient's life process, this really impressed me with that narrative."* (A7, Medicine, score 100.80)

> *"The narrative brought an experience that we don't see so much in undergraduate courses, at least in Physiotherapy. We end up being very technical and the narratives are much more subjective. The illness process is never the same, everyone has their own, so respecting this illness process is*

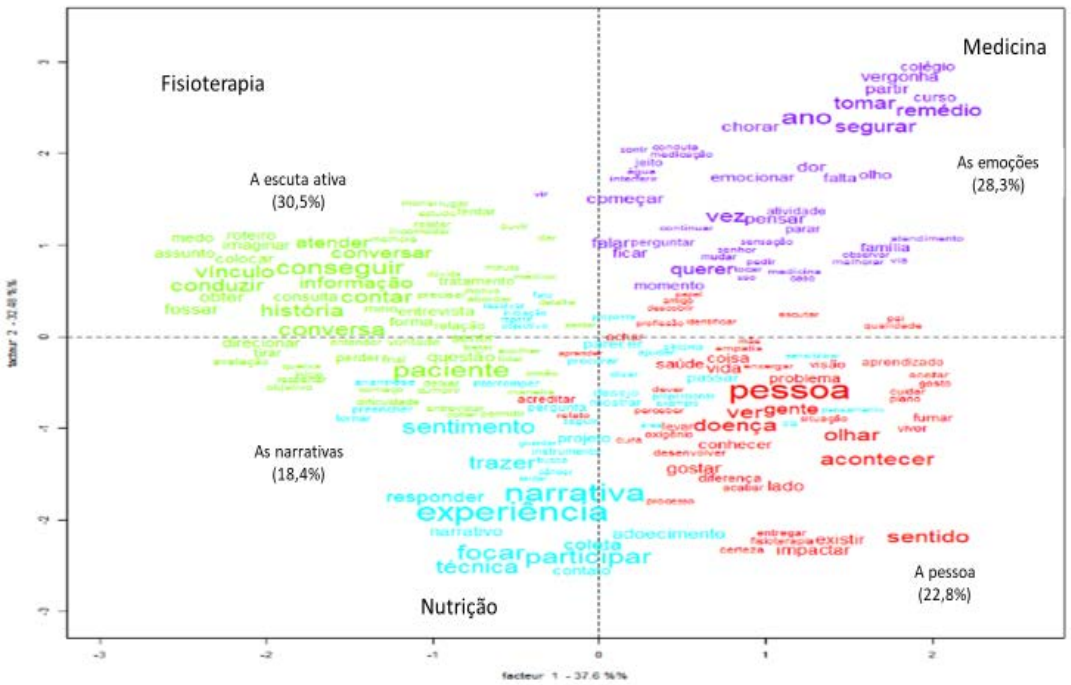
something that the narrative brought to me". (A22, Physiotherapy, 89.32)

"From this experience on, I think I will modify my approach. I think it would basically be about understanding that person's life story. I think I will try to understand not only the clinical or biochemical data, but also the personal, the human ones." (A13, Nutrition, 79.38)

When analyzing the CFA, it is noted, at the factorial level, that the classes that make up the "Listening to Stories" *subcorpora* are well interrelated with each other and with the "The person" class, while the "Emotions" class is somewhat more distant, with less interrelation with the others. It can be inferred, from the lexical analysis, that the collection of narratives allowed these participants to experience active listening, to understand that the patient is not just a disease to be treated and to value psychosocial and cultural aspects that otherwise would not be significantly considered. In turn, the collection brought forth affections and emotions, with causing students to sometimes be uncomfortable with such fact, despite the importance given to the experience.

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

The textual elements of the Nutrition course participants reveal the "Narratives" class as the most expressive, showing the importance given by these participants to aspects not brought up by the anamnesis of the area and to the emotions evidenced by the experience of collecting narratives.



Source: IRaMuTeQ®, research data.

Figure 3: CFA according to classes and participating courses, Narrative-Based Teaching Project, São Paulo, 2018-19

When the words classified according to the students' gender are analyzed, differences also appear. For male participating students, the main words refer to *area, process, patient*. As for the female participants, the words that appear are *tell, help, speak, stay*. The words highlighted by the male speeches, when analyzed in their contexts, show a concern of these students with their professional performance, while the words spoken by the women speeches refer more to care and the communication with the other.

IV. Discussion

Narratives are linguistic structures composed of a sequence of interrelated facts which are personified

through both mental and social processes and culturally and historically conditioned. During the narrative process, both the narrator and the listener are affected, through a process that allows for reflections, understanding and explanations related to the narrated events. When narrating the process of becoming ill, the patient justifies and provides meaning to their suffering, integrating representations, knowledge, practices, their own experiences and those of their families and social groups, reconstructing reality within a context. By transforming the fact into an experience, it is externalized through verbal and non-verbal language[14, 21].

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

The textual skills refer to identifying the structure of the story, perceiving its multiple perspectives and recognizing metaphors, creative skills stimulate the imagination and develop curiosity and, lastly, the affective skills include the respect for diversity, otherness and uncertainty. Together, these three contribute to the understanding of the story and its meanings, thus allowing a look beyond the biological mechanisms that produce diseases, focusing more on the language, representations, emotions and relationships that permeate daily practices in the health area[14, 21, 22].

In the medical field, the usage of illness narratives extends from the beginning of graduation[13, 23] all throughout the professional's education[22] and their professional life. Several ways of stimulating such narrative competence can be studied and implemented, such as the reading of classic works of literature or photographic essays and the analysis of cinematographic or artistic texts. This research made use of illness stories written by the students themselves and the collection of narratives from sick people[14, 24], examples where real people were interviewed by the undergraduates, without the need to resort to anamnesis scripts specific to each profession.

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

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

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

As has been already mentioned, the health professional is very early trained, primarily, to listen to people through a common script, called anamnesis. This script, permeated by a technical approach, completes, cleans and standardizes people's narrations in order to reach the ailment, however, in the process, it devalues the knowledge that the patients have about themselves. In this process of "selective deafness" [24: 54], the sick individual becomes an object, a vessel, with the highlight being on the disease. The health professionals think they are listening to the suffering person, but the social representations constructed and reproduced by the Flexner model prevent such an active listening.

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

These points appear in the subsequent reflections made by the students, who are surprised by the discovery of the subject beyond only diseases, an experience that permeates the entire *corpus* of the research and is highlighted in several of their speeches. It is a discovery that arouses a multiplicity of emotions in these undergraduates, who start to reflect on aspects not previously perceived by them. In the whole *corpus*, it is noted how much these students, from a more

thorough discovery of the other who was perceived, until then, solely as a patient, become more concerned regarding which professional they want to be, one that follows a more technical approach or more humanistic one. They realize, however, that it is possible to reconcile these two poles, which have never been antagonistic, but, rather, complementary.

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

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

The Flexner model had excellent success in controlling and reducing acute diseases, which can, above all, be considered biological processes, the main intention for which the model was designed. However, the current epidemiological picture, with a predominance of chronic diseases, needs to modify said standard, especially since the latter is characterized by being predominantly biographical, hence the need to listen to the broader history of the subject. In researches done with collections of illness narratives of people who have a chronic condition, it is observed that many interviewees, when reliving past moments, express feelings and experiences through verbal language, but, mainly, through non-verbal language. These readings are not always performed or taken into account when obtaining the traditional anamnesis[21, 24].

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

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

When working with narratives, the importance of perceptions and feelings that attentive listening provokes is also noted. The group of students was deeply affected by the listening, with researches emphasizing that undergraduates, despite admiring the patients, have difficulties in dealing with all the brought up emotions and suffering, possibly even resulting in emotional overload, hence the importance of the reception made by tutors to the students participating in the project soon after the collection[23, 25]. It is noted that undergraduates in Medicine and Nutrition are the ones most affected by these issues, as highlighted by the CFA.

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

The need for students who participated in the project to develop a habit of writing portfolios relating their experiences is also highlighted. The habit of writing about their experiences with others is not an activity normally encouraged in Brazilian's undergraduate health courses[30], however, research indicates that when the writing pertains to feelings, ideas and experiences, undergraduates tend to more comprehensively reflect on their own lives, making them more empathetic and approachable[13, 23, 25].

Finally, the differences in words found regarding the gender of the undergraduates are highlighted. As the software works with social representations and gender roles, as described and inscribed in our culture, are socially constructed, it is not surprising that a distinction is observed. The literature infers that women health professionals bring more evocations related to

humanization, teamwork and dedication, reproducing social representations that attribute the role of caregiver to women[31], something also observed in this study. On the other hand, the male students' words and texts show greater concern with their performance as future professionals.

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

V. Final Thought

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

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

However, limitations to this research are pointed out. The methodological design chosen does not allow generalizations. The absence in the literature, so far, of the application of narratives with Physiotherapy and Nutrition undergraduates does not allow comparisons of results; something also observed regarding the use of the IRaMuTeQ® software, used here as an aid in content analysis, which is a tool still rarely used in researches focused on health education.

References Références Referencias

1. Foucault M. The birth of the clinic. Rio de Janeiro, Brasil: Forense Universitária, 2001.
2. Good B. Medicine, Rationality and Experience: an anthropological perspective. New York, E.U.A: Cambridge Press, 1994.
3. Pagliosa FL, Da Ros MA. The Flexner report: for good and for bad. Rev. Brasil. Ensino Méd. 492–499, 2008.
4. Manso MEG. Saúde e doença: do controle sobre os corpos à perspectiva do adoecido. São Paulo: Max Limonad; 2015, p. 37-49.
5. National Board of Education. National Curriculum Guidelines for Undergraduate Courses in Medicine. Parecer CNE/CES Nº 116/2014. Brasília: CNES, 2014.
6. National Board of Education. National Curriculum Guidelines for Undergraduate Courses in Physiotherapy. Parecer CNE/CES Nº4/2002. Brasília: CNES, 2002.
7. National Board of Education. National Curriculum Guidelines for Undergraduate Courses in Nursing, Medicine, and Nutrition. Parecer CNE/CES Nº 1133/2001. Brasília: CNES, 2001a.
8. National Board of Education. National Curriculum Guidelines for Undergraduate Courses in Medicine. Parecer CNE/CES Nº 04/2001. Brasília: CNES, 2001b.
9. Starfield B. Primary Care: balance between health needs, services and technology. Brasília: UNESCO, 2002.
10. Teixeira RC, Muniz JWC, Nazaré DL. The Curriculum for the Academic Training of the Physical Therapist and Its Historic Construction. Cad. Educ. Saúde Fisioter. 4 (7): 27-27, 2017. DOI: https://doi.org/10.18310/2358-8306.v4n7.p27
11. Federal Nutrition Council. II National Meeting on Professional Training - Professional Training in Focus: National Curriculum Guidelines for the Undergraduate Course in Nutrition. Brasília: CFN, 2015.
12. Scheffer M. Medical demography in Brazil. São Paulo: Conselho Regional de Medicina do Estado de São Paulo, Conselho Federal de Medicina, 2020
13. Milota M et al. Narrative medicine as a medical education tool: A systematic review. Medical Teacher. 41 (7): 802-810, 2019. https://doi.org/10.1080/0142159X.2019.1584274
14. Charon R et al. Principles and Practice of Narrative Medicine. Nova York, E.U.A.: Oxford University Press, 2017.
15. Wiezel I et al. Is there a need for narrative medicine in medical students' education? A literature reviews. Medical education. 27: 559–565, 2017. https://doi.org/10.1007/s40670-017-0426-0
16. Manso M.E.G. "My Physician Doesn´t Listen to Me" Project: Students and Professors Perceptions. Manag Prim Health Care. 2020; 12: e19. https://doi.org/10.14295/jmphc.v12.975

17. Leal EM, Souza AN, Serpa Junior OD, Oliveira IC, Dahl CM, Figueiredo AC et al. McGill Entrevista Narrativa de Adoecimento - MINI: tradução e adaptação transcultural para o português. Cienc Saude Colet. 2016; 21(8): 2393-402. https://doi.org/10.1590/1413-81232015218.08612015.
18. Camargo BV, Justo AM. Tutorial para o uso do software de análise textual IRAMUTEQ. Laboratório de Psicologia Social da Comunicação e Cognição – LACCOS. 2013. Universidade Federal de Santa Catarina. http://www.iramuteq.org/documentation/fichiers/tutoriel-en-portugais.
19. Moscovici S. Social representations: Essays in social psychology. Petrópolis: Vozes, 2009.
20. Bardin L. Content analysis. São Paulo, Brasil: Edições 70, 2016:217-233.
21. Fernandes I. Leituras holísticas: de Tchékhov à Medicina Narrativa. Interface (Botucatu). 19 (52): 2015.
22. Gowda D. et al. Implementing an interprofessional narrative medicine program in academic clinics: Feasibility and program evaluation. Perspec. Med. Education. 8: 52–59, 2019. doi: 10.1007/s40037-019-0497-2.
23. Claro LBL, Mendes AAA. An experience of using narratives in medical students' education. Interface (Botucatu). 22(65): 621-30, 2018. https://doi.org/10.1590/1807-57622016.0850
24. Masana L. Entre médicos y antropólogos. La escucha atenta y comprometida de la experiencia narrada de la enfermedad crónica In Martinez-Hernaéz À, Masana L, Digiacomo S. Evidencias y narrativas en la atención sanitaria. Tarragona, Espanha: URV, 2015, p. 191-224.
25. De Benedetto MAC, Gallian DMC. The narratives of medicine and nursing students: the concealed curriculum and the dehumanization of health care. Interface (Botucatu). 22 (67): 1197- 1207, 2018.
26. Weiss T, Swede MJ. Transforming preprofessional health education through relationship-centered care and narrative medicine. Teach Learn Med. 31 (2): 222-233, 2016. DOI: 10.1080/10401334.2016.1159566
27. Brazilian Ministry of Health. National Humanization Policy. Brasília: Ministério da Saúde, 2013.
28. Mallet ALR et al. Narrative Medicine: Beyond the Single Story. Internat. Journ. Cardiovasc. Sciences. 29 (3): 233-235, 2016. DOI: 10.5935/2359-4802.20160037
29. Stewart M et al. Person-centered medicine: transforming the clinical method. Porto Alegre: Artmed, 2010.
30. Stelet BP et al. Portfólio reflexivo: subsídios filosóficos para uma práxis narrativa no ensino médico. Interface (Botucatu). 21 (60): 165-76, 2017.
31. Oba MV et al. Women under the social representations of health professionals. J. Health Sci Inst. 30 (4): 343-8, 2012
32. Gimeno Sacristán J. The curriculum: a reflection on practice. Porto Alegre: ARTMED, 2000.
33. Masetto MT. Desafios para a Docência Universitária na Contemporaneidade: Professor-Aluno em Inter-Ação Adulta. São Paulo: Avercamp, 2015, p.27.