

‘Narrative Competence’ in Help and Care. The Contribution of Narrative Medicine¹

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Abstract

The paper aims at deepening the meaning of narrative competence in the field of care and help work. A fuller awareness of narrative competence allows both professionals and carers to better understand, interpret and respond to the stories of illness and difficulties told by the assisted person and define the best path to adopt. Explaining what the narrative competence are allows to pave the way to create paths of continuing medical education for doctors, educators, health and social workers.

Keywords: Continuing medical education; narrative medicine; narrative competence.

Introduction

Especially in the last decade, narrative medicine has become part of the studies on the relationship of care and help, both in the medical field and in other areas.² Charon's well-known contribution outlines the meaning and areas of application of narrative medicine. Within the relationship with the assisted person, narrative medicine requires something that the author defines as ‘narrative competence’. The latest, that can be translated with narrative ‘competence’ (Ragazzini, 1984, p. 177) reminds namely a set of knowledge, skills and abilities articulated in a dimension of ‘theory and practice’ (Nosari, 2013, p. 162). This competence represents the doctor's operative and meaningful response to the concrete situation in which they operate,³ not only for the purpose of resolving or improving a contingent issue, but mainly in order to act in the pursuit a meaningful objective. In fact, when competence is declined in the narrative field, it is focused not so much on performance, but rather on the preceding planning and on the dimensions that define its meaning and areas of expression.

So far, there have only been few targeted studies aimed at defining the specific meanings and characteristics of narrative competence within narrative medicine: the topic has rather emerged transversely in much of the specialised literature (Colombini, 2017), in a way that is not fully organic.⁴ Therefore the present paper intends to investigate the possible dimensions underlying narrative competence, with the goal of understanding some of its main characteristics and of laying the foundations for a training project to promote its structuring and consolidation in the professionals who intend to work in the area of narrative medicine.

1. This contribution is part of the research path of the Narravita Study Group (Degree in Nursing / AslTo4 - Ivrea).

2. Narrative medicine, after a first appearance in Britain, emerged in the United States following the studies of Rita Charon (2001, 2006, 2007, 2008) and Rachel Remen (1996, 2001, 2010). Narrative Based Medicine was developed at the Harvard Medicine School and was characterised by a hermeneutic and phenomenological approach. Its original reference authors include Arthur Kleinman (1980, 1988) and Byron Good (1994), both working in the field of Medical Anthropology (Guarcello 2017). Narrative medicine finds application in the context of the relationship with the assisted person in places of treatment, mainly in relation to chronic-degenerative diseases: ‘challenges a central tenet of biomedicine - that objective knowledge of the human body and of disease are possible apart from subjective experience’ (Good, 1994, p. 117).

3. ‘By competence we mean the full ability to analyse, understand and evaluate specific problems, taking advantage of available personal resources and situational conditions in order to make choices and act accordingly, together with the ability to set in motion and coordinate one's internal resources and the external ones available to positively face a number of challenging situations’ (Cortassa et al., 2014, pp. 9-16). For more information, see: Pellerey, M. (2004). *Le competenze individuali ed il portfolio*. Roma: La Nuova Scuola.

4. Charon (2006) herself, in fact, considers narrative competence the consequence of a professional action based on narrativity: working through narrative medicine, the professional can implement some useful aspects to improve their relationship with the patient: ‘by developing narrative competence, we have argued, health care professionals can become more attentive to patients, more attuned to patients’ experiences, more reflective in their own practice, and more accurate in interpreting the stories patients telling of illness’ (p. 107).

1. 'Narrative' Listening: aspects of an oxymoron

In order to analyse one first aspect of narrative competence, it is necessary to reflect on the phases through which narration is developed in narrative medicine (and not only). The first stage is called 'mimesis 1' (5) and refers to the first phase of narration, that is, to prefiguration, which has the function of imitating or representing actions, facts, or events connected to the concrete experience narrated. Mimesis 1 expresses a pre-figured lifetime (what we already know, what has happened up to now, the known facts of the story), told with reference to its 'sequentiality' (Nanni, 1996), to the diachronic order and to its semantics (meaning): language and story give a configuration to what, in human action, is already figured (Ricœur, 1991, p. 108).

From this point of view, the first phase of narration is the one in which the assisted person talks about their health / illness as they have experienced it up to now, in relation to its known aspects and the events that have already occurred. In order to be possible, the care professional needs a basic narrative competence that Charon (2006) defines *diastolic attention*. The author associates narrative medicine with cardiac functioning, characterised by a systolic (contraction) and a diastolic (relaxation) movement. In narrative medicine, the diastolic movement consists in the ability to wait, accept, pay attention; the systolic movement, instead, is the ability to guide and propose (which are both necessary). Attention, therefore, appears as a propensity to 'listen in silence' (Vittori, 1996, p. 23), 'to attend gravely and silently, absorbing diastolically that what the other says, connotes, displays, performs, and means requires of effective diagnostic and therapeutic work. By emptying the self and by accepting the patient's perspectives and stance, the clinician can allow himself or herself to be filled with the patient's own particular suffering, thereby getting to glimpse the sufferer's needs and desires, as it was, from the inside' (Charon, 2006, p. 134).

The care professional's attention, absorbing and diastolic, certainly has the function of truly grasping what the other is narrating about himself and is fundamental because 'there is no narration without the possibility of being heard' (Garrino, 2012, p. 88). The action of self 'emptying', welcoming the words and suffering of the other, implies something that is defined 'Generative Empathy'⁶, understood as the professional's capability of 'sharing in and comprehending the momentary psychological state of another person' (Charon, 2006, p. 133), experiencing and understanding the other's feelings within them. This 'To matter for the patient' (p. 127) and so to give importance to the assisted person, can represent a form of professional 'generosity': 'It is not enough to behave as if we cared about the other; we need to really care about them' (Garrino, 2015, p. 20). An authentic relational attitude allows the operator to decentralise itself both cognitively and emotionally, endowing them with the ability to 'Imagine the other's situation, understand their point of view, truly accept one's own and others' hesitations [...]. Skills related to empathic communication and the ability to deduce, interpret and translate the history of the patient's illness' (p. 26, p. 32).

So, listening is configured as diastolic and empathic, and therefore also 'emotional' (Iori, 2009; Musi, 2011): it is the ability to grasp and give meaning to the emotions that accompany the person's life story and which reverberate in the care professional's experience. 'What matters is to go beyond the indispensable act of understanding, so as to begin to feel oneself and others' (Zannini, 2008, p. 246). Welcoming a narrative involves seeing oneself in the mirror (Formenti, 1998), with a reflective gaze from above, since 'care for the other is self-consciousness' (Del Vecchio, 2010, p. 85). Listening to a narrative, in fact, always implies the operator's self-emptying to accommodate the story of the other's facts and emotions, but at the same time it is also a 're-comprehension' through which the professional, while listening to the other, also gets a better understanding of themselves, their point of view and emotions: 'he observes himself from the other side' (Buber, 1993, p. 180). In this way, both subjects come to change and the listener enters the generational cycle of the narrator (Atkinson, 1998).

Becoming part of a person's narrative requires attentive, empathetic, emotional and even 'active' listening - something more than 'simply hearing out' (Garrino, 2015, p. 20). The point, in fact, is to promote the narrative of the person (Cnmr, 2015), orienting and finalizing their story in relation to the therapeutic path.

5. The concept is mentioned in much of the specialised literature (Charon, 2006; Bert, 2007; Garrino, 2010) and refers to the Greek word *μίμησις*, 'imitation' (Rocci, 1990, p. 1240), with which Ricœur describes the different phases of narration.

6 The construct of generativity (Guarcello, 2015), representing the desire to take care, originated with Erikson's studies (1999). According to McAdams and de St. Aubin (1992), expresses two motivational drives that accompany human life (not only professionally) and that cannot be separated: communion and agency. The first motivational drive (communion) refers to the desire to be useful to others, by relating to them in an intimate and loving way (need for intimacy). The second recalls the desire for immortality, making what surrounds us last in order to leave something behind that will live after our death (need of power).

Hence the 'necessity of an education to listening' (Formenti, 1998, p. 27) to allow the professional to 'absorb' the narration and, at the same time, to facilitate it (Knowles, 2010; Mezirow, 2003; Schon, 1983). Keeping this in mind, considerable attention is paid to the art of asking (Spinsanti, 2016),⁷ through questions 'about 'what', 'why', 'who', 'how', 'with whom', or 'against whom' in regard to any action. But the decisive fact is that to employ any one of these terms in a significant fashion, within a situation of questions and answers, is to be capable of linking that term to every other term of the same set' (Ricoeur, 1990, p. 55). What is needed, thus, is respectful listening, not asking 'Intrusive questions nor searching for information that is not strictly useful, thereby forcing the person's narrative' (Garrino, 2010, p. 11). This recalls one of the five elements that Charon (2006) places at the basis of narration in medicine: the 'ethical' attitude (Liberati, 2005), ensuring that it is not 'humiliated in the name of 'bios' (CNMR, 2015).

Narrative competence implies, therefore, attention and respect in terms of both reception and facilitation of the person's narrative, in order to preserve and promote a spontaneous and authentic expression that, at the same time, can aim at treatment, so as to result effective within the limited time available.⁸ Therefore, the first phase of the narration requires a competence in terms of listening that, due to its internal dimensions (diastolic attention, generative empathy, emotional and active character), confronts us with the semantic oxymoron of a kind of listening that is deeply *communicative*.⁹ On the one hand, the oxymoron expresses the juxtaposition of two apparently antithetical concepts (listening and communication); on the other, it contains two aspects, *ὀξύς*, 'acute' and *μωρός*, 'obtuse' from the Greek root *ὀξύμωρον* ('oxymoron: witty union of discordant things') (Rocci, 1990, p. 1342). These dimensions are related to the complexity of narrative listening, because the professional sometimes creates an 'acute angle' (directed towards the other in a proactive and active way, and therefore communicative) within the dialogical construction of a story. So, surely, 'Many efforts must be made to improve the communication skills of health workers, especially those who consider themselves interested in narration' (Cnmr, 2015). On the other hand, the operator also creates an 'obtuse angle', welcoming the words of the other, through the emphatically communicative listening endowed with 'respect for what the patient brings: no matter how extravagant or irrational it may seem to us, all this makes sense to him'; we are therefore called to 'take a stand with [...] respect and curiosity, with suspension of judgment' (Garrino, 2015, p. 20, 26).

Indeed, the fundamental ingredient of every 'narrative' listening is 'empathic curiosity' (Bert, 2007, p. 66)¹⁰. The care professional must also be able to consciously deal with their inevitable prejudice (Husserl, 2005; Iori, 2009) ¹¹, previous ideas that may lead them to instinctively attribute a positive or negative value to what they are told, the emotions that resonate in them while listening, associations with their own previous experiences, fears, anxieties, resistance... 'There is no action that does not give rise to approbation or reprobation, to however small a degree, as a function of a hierarchy of values for which goodness and wickedness are the poles'.

7. The point is to proceed by 'dialogue and not by alternating or accumulating monologues' (Garrino, 2015, p. 20), so as to build interaction and narration. The communicative practice and, in particular, counselling (Bert, 2007, pp. 253 – 260; Spinsanti, 2016) offers the opportunity to reflect on the use of various types of questions: closed / open, semi-structured / suspended, multiple choice, linked multiple choice, linear, in-depth, or analytic. Moreover, it can be effective for one to communicate and help communicate through deconstructive questions (get to the origin of the problem) and perspectival ones (helping the person understand their problem) (Cnmr, 2015), which are circular, profound and generative. In fact, knowing how to ask questions in a reflective form can solicit the person's narration (Bert & Quadrino, 2002; Garrino, 2012).

8. 'The narrative is not necessarily long: a narration can also be a short message like the one that an 82-year-old lady left on her doctor's answering machine on a Friday evening: *Good evening, Doctor, it's me, Maria, it's Friday night, it's half past nine, I'm not sick, I do not need medicine, but I'm here alone and I'm so scared...* In these few words there is a whole story that speaks of loneliness, old age, eternal weekends that are not holiday weekends if days are all the same, with no expectations, no trips to the countryside or to the sea with the children. It speaks of the indifference between illness in the biological sense ('I do not need medicine') and illness as an existential problem ('I'm alone ... I'm so scared ...'); finally, it speaks of the conviction that the doctor, precisely because he is her doctor, can understand, help, do something even without prescribing medicines (Bert, 2007, p. 21).

9. For a discussion of the communicative aspects of narrative medicine (often related to ideas derived from counselling practices), see, among others: Bert, G. & Quadrino, S. (2002). *Parole di medici, parole di pazienti. Councelling e narrativa in medicina*. Roma: Il Pensiero Scientifico.

10. Ability to cultivate ingenuity of eye, ear and thought (Dewey, 1973).

11. Any ambition to 'neutrality' must therefore be left aside. In fact, the clinician is not a 'machine' that can, in any case, cure the patient's ills. The clinician is a very concrete man or woman, with external signs that allow the patient to see what the matter is and which must correspond to those of the patient's representation "as it is" - and not to the latter's description of their symptoms, their account of why they came to the health centre, but how they live, what they like and do not like...'

(Benasayag, 2016, p. 131).

A 'possible ethical neutrality has to be conquered by force in an encounter with one previous and inherent feature of action: precisely that it can never be ethically neutral. One reason for thinking that this neutrality is neither possible nor desirable is that the actual order of action does not just offer the artist conventions and convictions to dissolve, but also ambiguities and perplexities to resolve in a hypothetical mode' (Ricoeur, 1990, p. 59).

An authentic listening makes it possible to grasp not only the 'technical', logical, datum, which can be predicted from a given narrative,¹² but above all the ambiguities, the perplexities, the uncertainties that make it unique and specific of a certain person and of the only therapeutic path possible for them.

2. Signification: welcoming and configuring 'narrative' meaning

The successful outcome of the narrative listening phase is what brings us to the heart of what we might call 'second stage' of the narrative process. In this phase, often the ambiguities, perplexities, suspensions, uncertainties, or 'referential opacities'¹³ (Nanni, 1996, p. 49) of the story represent opportunities to search for meaning with respect to the life story that the professional and the person are sharing. And the search for sense, the struggle for meaning, is an 'Omnipresent, general and human process [...it is] the origin and background of the adult's educational choices and their biographical turns, much more than the rational calculation of the cost/benefit ratio' (Formenti, 1998, p. 70). Narrative medicine recalls, in this sense, 'mimesis II' characterised by con-figuration: this is the sphere of the 'as if', namely the plot that 'draws a meaningful story from a diversity of events or incidents (...) or that it transforms the events or incidents into a story', creating a 'synthesis of the heterogeneous' (Ricoeur, 1990, pp. 64 - 66). In fact, individual events lead to a life story, configured according to a meaning that is suddenly or painstakingly outlined and accomplished in a conclusion (final overall vision / meaning).

This second narrative step leads the professional from a known time, consisting of actions and situations that have already happened, to a time to con-figure (the time of the soul), to which to attribute an image that goes beyond the facts. This image opens up to possible interpretations and to implications with respect to the individual's experiences, expectations, projects and context of life. This is necessary in order to lay the foundations for a subsequent re-elaboration process: 'In reality, I have always thought that, behind what we call our 'personal' stories, there is always the same challenge, in one form or another: to make life (and not survival) possible in *this* concrete situation' (Benasayag, 2016, p. 9).

This is the narrative competence defined as '*representation*' (Charon, 2006, pp. 136-140), which expresses the systolic movement of 'guiding', 'proposing', seeking together the meaning of what is narrated.¹⁴ This is a 'hermeneutic combination' (Nanni, 1996, p. 49), carried out according to an interpretative methodology aimed at giving a meaning to the person's experience (Zannini, 2008), in harmony with one of the five aspects that constitute the narrative elements typical of narrative medicine (Charon, 2006), i.e. *uniqueness*. It is aimed at co-constructing a unique and original therapeutic relationship based on a shared reflection on the meaning of the patient's story of illness. The ability to read and critically to analyse this life story also recalls the narrative element of 'causality' (Charon, 2006): the latter 'implies the fact that [...] the doctor investigates the *multiple causal relationships* between the symptoms and the complex situations that the patient presents with a creative, open and courageous mind' (Garrino, 2010, p. 11). In this logic, it is not only the professional who improves and deepens his/her own understanding of the person's life story, but the latter also has the opportunity to 'know' better himself/herself and his/her situation 'through the causes' (Benasayag, 2016, p. 113) and the links of sense that support and intertwine the events he/she is facing.¹⁵

The narrative competence connected to the attribution of meaning does not only involve the dimensions of uniqueness

12. An "extended" traditional anamnesis is not narrative medicine' (Bert, 2007, p. 104).

13. Lack of univocity between meaning and reference within the narration (Nanni, 1996).

14. 'To let the patient narrate is not enough to make narrative medicine; [...] The ability to arouse narratives can never go without the ability to guide them: this competence makes it possible for the patient to find at least some order in the chaos. A spontaneous narration, in fact, tends to be chaotic; if one allows the patient to unfold it in all possible directions, one will get excessive, uncoordinated, redundant material that will largely be unusable by the doctor' (Bert, 2007, pp. 100-101).

15. Numerous insights in this regard are offered by interpretative pedagogy (Bertolini & Caronia, 1993; Zannini, 2003). Further reflections come from the studies of 'narrative pedagogy' (Mantegazza, 1996) whose traits are outlined, according to Nanni (1996), in some works such as: the trilogy *Time and Narrative* (Ricoeur, 1987, 1988, 1991); Bruner's writings (1993, 2002), including *Acts of Meaning* (1992); the theory of multiple intelligences (Gardner, 1994); Demetrio's works (1995); *La clinica della formazione* (Massa, 1992), *I bambini che si perdono nel bosco* (Canevaro, 1993), *Il pensiero narrativo* (Smorti, 1994), *L'ospite bambino* (Lorenzoni, 1994) and Dolci's works (1974, 1985).

and causality, but also consists of *reception*¹⁶ (of the story and of meaning): a different professional condition from what is commonly defined as understanding. In fact, in a context of unconditional acceptance of the other (Mariani, 2006, 2012) and of temporary suspension of judgments and pre-concepts, understanding can leave us open to the risk of excessive intrusion and interpretive violence with respect to the world that the person portrays through his/her story. In this sense, for Levinas (1969) *com-prehension* (to take with oneself, to understand in reference to one's own patterns of meaning) recalls the idea of incorporating the other, assimilating them to one's own thoughts, values, references of meaning. In this case, therefore, we have the opposite end of what was indicated by two seminal authors in the field of narrative reflection (not only in medicine): on the one hand, there is Charon's 'emptying', on the other, there is Ricœur's 'ipseity' in relation to a non-centralizing subject, one that does not assimilate otherness (Nanni, 1996, p. 44). Surrendering to the temptation to draw to us what we have before us and make them similar to us, we abdicate our responsibility to respond authentically, with a 'free' and 'light' gaze (Iori, 2009), to the 'face' of the other. This is the only possibility to give rise to 'what Levinas calls the 'conversation' (Charon, 2006, p. 135).

Conversation, the dialogic narration sought by narrative medicine, necessarily places me in the condition to 'encounter the indiscreet face of the Other that calls me into question' (Levinas, 1969, p. 171) and urges me to constantly review patterns and models of how I interpret the world. They remain present in the professional's mind, but from time to time they are suspended, questioned, investigated in the tension aimed at getting '*syntonically closer* to the patient' (Bertolini, 1994, p. 19). This gives one greater chance both to grasp the person in their entirety (Dasgupta, 2004), and to exercise greater sensitivity and acceptance even with respect to oneself (errors, distraction, frustrations, fears, anger...), recognizing the irreducibility of the self and the other with respect to any form of simplification.

The willingness of the practitioner to accept, with no reductionism, the meaning that the person attributes to their narration must come with the possibility of outlining a hypothesis of meaning with them: 'The key word is not healing but meaning'. The clinician's competence cannot be purely technical-scientific but must also be 'human'. In other words, they must be able not only to understand, but also to 'work' on, the meaning that the illness and the prospect of healing have for the patient (Bertolini, 1994, p. 19).

This capacity for acceptance and signification can bear its fruit within the practice of anamnestic and diagnostic construction: 'the nursing needs theory which is built as a constructivist theory, able to interpret the needs of the other in the particular situationality of each case, re-interpreting, or better, re-constructing its own scientific categories (pre-comprehensions) *ex-novo* through the relationship with the other' (Manara, 2000, p. 50). Narrative medicine, therefore, promotes an anamnesis based on the need to understand and systematise the patient's life story through both scientific and narrative categories of meaning (including the patient's). Therefore, 'it is a narration by nature' (Garrino, 2010, p. 12). The anamnesis, in fact, is discursive and collective, acting as a prerequisite for a diagnosis understood as 'an effort to depict the source of disease, to localise and objectify cause. It is also, however, an effort to 'invoke' an effective response. Narrativization is a process of locating suffering in history, of placing events in a meaningful order in time. It also has the object of opening the future to a positive ending, of enabling the sufferer to imagine a means of overcoming adversity and the kinds of activities that would allow life experience to mirror the projected story' (Good, 1994, p. 128).

Thanks to the narrative competence of reception and signification, 'narrative medicine becomes a fundamental element of the diagnostic act' (Garrino, 2012, p. 87), which is an independent and alternative means compared to its use in non-narrative situations. This, in fact, is a *Narrative Based Diagnosis*, based on listening, welcoming and configuring plots and meanings underlying the health situation, which is co-constructed and co-written (Charon, 2006) together with the assisted person.¹⁷

3. *Promoting transformations of oneself and of others*

The third major area in which the professional's narrative competences can be expressed recalls what Ricœur (1991) termed 'mimesis III', namely the intertwining of the text world (the patient's narration) and the reader's world (the professional's). After the patient has recounted the data and characteristics of the illness experience (pre-figuration), which are received and signified based on the meaning they are given by the assisted person (con-figuration), the time for re-figuration comes.

16. The term *welcome* comes etymologically from *excipere*, meaning to take, receive, collect, but also listen, intend, write, hold and support, receive and host, interpret, speak after listening (and therefore respond). (Castiglioni & Mariotti, 1966, p. 367, p. 1272).

17. While Evidence Based Diagnosis finds ample evidence in the literature (Newman & Kohn, 2009; Leeflang et al., 2009), the 'Narrative Based Diagnosis' has emerged to date only in the psychiatric field (Vanheule, 2017), as opposed to the 'checklist - based diagnosis'.

At this stage, starting from the reflection on experience, professional and patient imagine together new repercussions in terms of action and change. The relationship created through listening, receiving and signifying the story, is now called to promote a '*transformative contact*' (Charon, 2006, p. 140): a new re-reading of the self, following the comparison with the other. The narration is, therefore, understood as 'the force generating a covenant for change' (Garrino, 2010, p. 125) and is aimed at transforming the assisted person and the health professional who has implemented the process of emptying and receiving made up of ('lucid') immersion and ('professional') contamination with the story of illness.

This third phase makes it clear that 'narrative has its full meaning when it is restored to the time of action and of suffering' (Ricoeur, 1990, p. 70). The point is therefore to recover what emerged in the first two narrative phases, so as to begin to outline and better define possible paths and actions that are plausible for the person and appropriate for the professional, in order to co-construct an adequate therapeutic plan for the given story of illness.

Refiguring, together with the person, new or viable trajectories of concrete commitment in the present and in the near future imply, on the part of the professional, the narrative competence not only to promote transformations, but also to accept the '*shadows*' (Iori & Bruzzone, 2016) of change. In fact, there are areas, spheres, and connections that sometimes one cannot and should not question or force to change, because they would arouse resistance, denial, opposition, negation, removal, and escape in the assisted person. In fact, change does take place through destabilization, but in continuity, which allows the person to maintain a sense of integrity and self-recognition. This is even more important in a phase of identity deconstruction and reconstruction, as the one of illness¹⁸: 'In order for someone or something to change, something must stay unchanged. [...]. 'Healing' requires the conflicting assumption of this tension between the constitutive invariant and the production of changes' (Benasayag, 2016, p. 138). The third narrative phase therefore implies the availability of the professional and the assisted person to progress backward (Kierkegaard, 1983), to go towards change while returning to one's history, to the experiences, fears, conceptions that have guided and still guide one's life and health choices, without eradicating them but using them as bases for new leaps forward or possible partial attempts to act.

This narrative moment therefore implies, besides the awareness that 'nobody can save anyone' by imposing changes, also the firm conviction that 'nobody can be saved on their own' (Freire, 2002). In fact, it is necessary that the narration of narrative medicine can be promoted while trying to *integrate the different points of view* of the people involved, in order to build together the knowledge (Wenger, 2006) necessary to face the condition of illness: 'Thought is not consciousness: it is a process, a work that is always shared' (Benasayag, 2016, p. 144). Precisely in this sense, the narrative paradigm and constructivism are closely connected: 'We must not forget the social context that generates and sustains every narrative. The act of self-narrating through a life story 'is not produced in a situation of epistemological solitude. In every articulation, be it described as contingency, critical incident or turning point, other actors enter the drama. Therefore, every self-narrative is necessarily a collaborative, negotiated enterprise' (Sarbin, 1994, p. 9). The narration is not, therefore, only an individual experience, but it is often shared, analysed and re-read in the group (Garrino, 2010). Narrative medicine, in fact, makes it necessary to use self-narration as an opportunity to relate and to share with all the actors of the reference context, in order to integrate the point of view of professionals, patients, and family members so as to co-construct a framework that is as wide and deep as possible compared to the meaning of the experience of illness (Bruner, 1991, 1992).

In this perspective, it is worth mentioning one of the five aspects that make up the narrative elements in the relationship with the assisted person: 'intersubjectivity' (Charon, 2006). According to it, a story is constructed (at least) by two people and is 'born from the encounter between a narrator and a listener through a text, a plot understood as a structure that connects events to each other according to meaningful causal links' (Garrino, 2010, p. 11). This bond, which grows stronger through the narrative exchange, has the positive result of the possible *affiliation* with colleagues and patients, understood as 'intersubjective communion' both between patient and operator (working out the specific forms of care suitable for that patient) and between professionals ('affiliate into cohesive professional collectives with colleagues mentoring with colleagues and community network with members of the lay public') (Charon, 2006, pp. 150-151).

18. Good claims that 'narrative, the imaginative linking of experiences and events into a meaningful story or plot, is one of the primary reciprocal processes of both personal and social efforts to counter this dissolution and to reconstitute the world', which is typical of illness (Good, 1994, p. 118).

Therefore, the operator must be able to promote fruitful relationships both with the people affected by the disease and with other professionals, even within their own working group.¹⁹ This initiates a process of transformation that, while accompanying the patient and their relatives towards actions of care, deeply involves the operators themselves. In contact with the patient's life story, they achieve their own professional identity in a prospective and introspective sense, as well as the ability to deconstruct and reconstruct therapeutic projects of intervention tailored to the narrating person. The narrative path, which emerges through the three mentioned stages, creates immediate and deep connections between narrative medicine and the educational dimension of the relationship, which is always dialogic (based on words) and involves unconditional acceptance of the person and the promotion of a further transformation of the other and of oneself.²⁰

A suitable affiliation between patients, family members and professionals, allows one to exploit a further 'narrative competence' of the operator dealing with narrative medicine: the co-construction of the effective and shared care path (participated, personalised), through a *project of Narrative Based Therapeutic Education* (NBP),²¹ expressing the decision-making capacity (Spinsanti, 2016) of all the actors involved. The project dimension recalls another one of the five aspects that constitute the narrative elements in the relationship with the assisted person, i.e. 'temporality' (Charon, 2006), understood as 'development over time of the patient's narration and recognition of the subjectivity attributed to time' (Garrino, 2010, p. 10). Therefore, it is a matter of collecting the data and meaning of what is narrated to make it the background of a personalised vision of the care path, one that clarifies and verifies *in itinere* objectives and actions consistent with one's needs/options. This opportunity allows the patient to co-construct a subjectively and scientifically valid life project, starting from the question: 'what can be done? As we have seen, regardless of the characteristics of the 'deck of cards' the patient happens to have, the only thing that matters are *the hand they have been dealt*' (Benasayag, 2016, p. 141).

The hand that one, patient or professional, has been dealt with is an interesting first opportunity to understand the therapeutic objectives, with a focus on the potential of the person (empowerment), the shared and agreed definition of strategies and the self-determined and conscious choice of the care path. In this way, the patient is supported in deciding to undertake a treatment and in implementing it, since promoting new attitudes towards oneself (change) is one of the main goals of narrative medicine: 'the narratives are aimed not only at describing the origins of suffering, but at imagining its location and source and imagining a solution to the predicament' (Good, 1994, p. 121).

Each of the three narrative moments analysed is intertwined and completed with the use of specific terms of narrative medicine. In fact, each phase (listening, signification, transformation) can resort to narrative competence related to knowledge, mastery and implementation of tools (reading, writing, music, art, image...) that can facilitate and enrich the listening, signification and transformation phases to promote the dynamics and the necessary dimensions of each narrative moment.²²

4. Conclusion. Bringing out the unpredictable from the unexpected

In the face of what we have seen about the different narrative stages analysed, promoting narrative competence in medicine implies, therefore, co-planning with the patient an unpredictable treatment path starting from an unexpected context (which is particular, not canonical). This requires the professional's personal willingness to accept uncertainty (De Mennato et al., 2011): 'For example, helping a student grasp the complexity of the experience of cancer, through paths of medical humanities [...] in all likelihood will not produce solid evidence, but rather will raise doubts, questions and, therefore, will probably produce uncertainty' (Zannini, 2008, p. 241). The latter, indeed, should be sought and promoted (if accompanied by solid methodological and procedural assurances) since it is one of the central aspects of narrative based projects.

Being able to accept the unexpected, to manage it, to grasp unpredictable data and meanings (not codified in protocols, procedures, scientific analyses) does not imply the absence of reference points made up of solid methodological and strategic acquisitions, to support the complexity resulting from uncertainty.

¹⁹ 'Team quality is essential to work long-term with narrative medicine in the chronic area' (CNMR, 2015). The very tools of narrative medicine can provide interesting occasions to work with professional teams on the issues of cohesion, affiliation and how to face critical phases related to the work organization.

²⁰ The reflection on the connections between pedagogy and medicine is not recent. For more information see, among others: Bertolini, G. (1994). *I problemi della conoscenza in medicina e nella formazione del medico*. Milano: Guerini. Di Giorgio, A.M. (1981). *Pedagogia e medicina*. Bologna: Cappelli.

²¹ Recent literature does not yet report specific studies or experiences in this regard.

²² For more, see Guarcello, 2017; CNRM, 2015.

Also for this reason, I have insisted on the clarification of some relational and methodological nodes, trying not to fall into excessive reductionism and simplification with respect to a complex phenomenon that is difficult to describe through detailed descriptive and definitive checklists. However, the attempt at a systematization, at a photographic snapshot of the present, may be a necessary step to clarify and strengthen the skills necessary for a medicine based also on uncertainty and unpredictability, irreducible to any attempt at complete schematization and constantly changing according to the transformations of what humans experience and feel (personally, socially, culturally...).

All this outlines the profile of a 'humble' professional, for whom 'there are no certainties, nor dogmas nor absolute truths' (Garrino, 2015, p. 20) because they know 'that the clinical work is something too serious for the clinician to take themselves seriously' (Benasayag, 2016, p. 130). In this sense, a metaphor of the health worker can be found in the figure of the father as described by Recalcati (2016), taken as an example of a professional who no longer reflects the 'need for ideal models, dogmas, legendary and invincible heroes, unmodifiable hierarchies, for a merely repressive and disciplinary authority, but for acts, choices, passions capable of bearing witness, precisely, to how to exist in this world with desire and, at the same time, with responsibility'. The operator cannot be the one who 'has the last word on life and death, on the meaning of good and evil'. Rather, the professional is 'radically humanised, vulnerable, unable to say what the ultimate meaning of life is but able to show, *through the testimony of their own life, that life can have a meaning*' (p. 14).

And the search for the meaning of life and of one's particular experience is the core of any process based on words. Words remind us that the home of man is language - the possibility of humanizing life and the engine of desire for what we do not have and therefore seek. In this sense, promoting words, narrating and letting others narrate, can build a 'nest' created together, with an infinite number of elements found both intentionally and fortuitously; a nest that is precarious, fragile but fruitfully aimed at containing and generating the new. A nest that is a 'good' womb in which to rest and grow stronger; a safe, familiar place where to return to seek and rediscover meaning when we feel the pressure of what does not work, of what is missing, of a wound still open and throbbing, but already in search of new opportunities for healing.

Finally, the nest of words is the basis *par excellence* of every flight, the starting and finishing point for any research, exploration, travel and migration with and without return, a point of take off and landing for our transformations. This is because the word, and its paths of care, education and training, aspire 'to joy and to action. Sadness, Deleuze explained, is what unites oppressed and oppressors. The tyrants need sad men to enact their oppression and sad men need the tyrant to justify their sadness. That millions of men and women suffer without finding either the means or the strength to rebel is a sad reality; the only news worthy of note is that a minority of them do rebel. Love, revolt, thought, artistic creation: this is what is to be sought' (Benasayag, 2016, p. 141).

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