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The Nature of Medicine

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The medical student during the curriculum is confronted with realities of different rank, without having differentiated training for each of them. Thus, starting from the basic sciences (physics, chemistry, physiology, physiopathology, etc.) and later in the clinic, students progressively learn, for example, about the glucose molecule, the clinical entity of diabetes, and the diabetic patient. It would be three different levels of reality: objects, areas and people, and to approach them different knowledge methods and different languages should be used [1,2].

However, although methods for dealing with objects are highly developed (the scientific-technical method), there is no training aimed at introducing the student to higher order realities such as the fields of experience and people. It is necessary to learn to treat higher order realities with adequate methods, since to do it with the useful methods to know objects is the essence of reductionism [3].

Thus, two paradigms can be differentiated: the biomedical and the biopsychosocial [4,5]. Both have their role in the training of doctors, since there is a part of medicine that works well precisely because it treats all individuals as if they were equal (statistical thinking), and another part of medicine that works well because it treats each individual as if it were different. But, modern medicine is running out of language to express categories such as existential pain, grief, despair, fear and moral pain, which often constitute the core of the disease experience. It is necessary that doctors expand their repertoire of knowledge methods of these realities.

In contrast to science, the humanities do not follow the linear discourse of cause and effect, but move from aspects or sectors of one reality to others, and explain each one of them by their insertion in the whole. The humanities are, classically, the disciplines related to philosophy and history (which study the being of man), linguistics and literature (which study the human being from the point of view of expression), and the theology (as the inquiry in the last sense of all things). If we define man as a person, we can see that this category shows historicity, freedom, the particular position in the cosmos and the sociability of man. These are all characteristics of the humanities, which focus on meaning, history and relationships.

Consequently, the precise elements to achieve a development of the humanistic capacities of physicians should be included in the curriculum [6-8]. The experiences in different countries are numerous, and include methods as different as:

1. Courses of art (literature, poetry, painting, music, cinema, etc.) and medicine. The aesthetic experience stands out for its ability to help us develop sensitivity to the mystery, and thus can help the future doctor to awaken or further develop their sensitivity to the mysterious dimension of each person.
2. Write (for example stories from the perspective of patients, or difficult events in our clinical practice).
3. Read. It allows through the imagination to reinforce the empathic capacity by going through the experience of others, training in entering other worlds and finding meaning within them, in order to see a light in the middle of chaotic, full lives, with losses or without sense; Reading increases tolerance for uncertainty, increases our resources and our value, and helps us listen to the stories until the end.
4. Training of empathy.
5. Groups of discussion on the emotional aspects of medical practice.
6. Discussion of the genogram and one's family and personal history, etc.
7. And, the reflection on one's own suffering.

All these methods are directed, finally, to an openness in our way of perceiving ourselves and the patients and "making our two hemispheres work together" in order to have an authentic encounter with the other.

The personal and professional values of physicians influence their clinical decisions [9]. Understanding these values can help improve patient-centered decision making by professionals. If we accept that healing is "to be again a whole", "re-connecting" or "unlocking" or integrating suffering into a meaningful story [10] -process that may or may not include physical healing- we understand the relevance to develop the humanistic capacities in the future doctors.

It is, then, among others strategies, to develop the "narrative competence" of future doctors, which allows them to penetrate the world of suffering of their patients, offer support and accompany patients in their experience of illness. But what is this "narrative competition"? Narrative knowledge, complementary to scientific knowledge, refers to the motivations and behaviors of people. It is always particular or contextualized, since it seeks to understand singular facts in its context, in its own time and space. The clinical histories, the clinical cases, are also narrations: they tell and interpret an event, in some form of chronology, and they preserve the seal of the author, who is not a neutral observer, but actively participates in constructing the story that is being told and listening [11-14].

Important questions about patients' health problems are usually too complex or imprecise for the conventional language of science [15]. Instead of this language, that of stories is used. Stories have a psychological impact that equations and graphics lack. Stories refer to meanings; they help explain why things happen in a certain way. They give order and meaning to events-a crucial aspect of medical understanding.

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