

Challenges of Introducing Narrative Medicine To South Korea: A Grounded Theory Approach

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Abstract:

Using skills obtained from analyzing literature, Narrative Medicine (NM) is a novel medical approach that values the need for doctors to listen and understand the patients whole-heartedly. This is a growing field in America with multiple universities and doctors practicing its skills. However, in Korea, NM is virtually unheard of. Considering the need to employ narrative medicine skills to health care clinics, it is essential to determine what the challenges of introducing NM are. Using a Grounded Theory (GT) methodology, this research collects data to determine what the obstacles are. This study determines that the main challenges are: the discrepancy between time and medical fee, the lack of information of NM, the Korean medical culture of consultation, and the age gap of doctors. Despite the obviousness of these results, the specific medical consultation culture plays a unique role in Korean doctor's views. This paper also suggests specific recommendations such as hosting more NM workshops in Korea and regulating consultation fee through governmental means.

Introduction: An Emerging Field

Medicine has been advancing substantially in technological use. With our leading innovations, doctors today can cure fatal diseases, illness, and attacks to a patient's health. However, as our technology continuously advances, one crucial aspect of medicine lags behind: the human rapport between doctor and patient. As the focus of medicine is solely on curing illnesses, doctors lack the human component to empathize and listen to the patient's stories while joining them in recovering from their plights. Rather than individualizing their interaction with patients, the majority of the doctors preclude opportunities to connect with their patients, often interrupting them or asking them general diagnostic questions. Yet, a "scientifically competent medicine alone cannot help a patient grapple with the loss of health and find meaning in illness and dying" (*Narrative Medicine: Honoring the Stories of Illness*, 3). In response to the flaws of today's medical practice, a group of scholars and professors at the University of Columbia collaborated to introduce a novel medical approach: Narrative Medicine.

An alternative to the conventional evidence-based medicine, Narrative Medicine (NM) was founded by Professor Rita Charon who defined it as medicine "practiced with the narrative skills of recognizing, absorbing, interpreting, and being moved by the stories of illness." Although the notion of embedding literature with medicine was mentioned in the early 20th century, it only came into discussion and practice in the 2000s. Professor Charon upheld the notion that a narrative

understanding and competence is imperative in enhancing the healthcare. She envisioned that NM will “help move an impersonal and increasingly revenue-hungry healthcare toward a care that recognizes, that attunes to the singular, and that flows from the interior resources of participants in encounters of care” (*The Principles and Practice of Narrative Medicine*,2).

Initiating multiple workshops since 2006, the founders received positive response from physicians and those related with medicine as over 2000 participants attended them (*The Principles and Practice of Narrative Medicine*). Because of its popularity, Columbia University opened the world’s first Narrative Medicine Master’s Program; here, clinicians, nurses, and those involved with the intersection of medicine and literature come together to conduct close readings and writings and share their experiences of meaningful caregiver-patient interactions in their clinics (Narrative Medicine Master of Science). By doing so, doctors gain an understanding of themselves and their relationships with patients, a transformative change that is key to NM.

With the benefits and surprising lack of NM in Korea, this research employs Grounded Theory methodology and aims to determine the challenges of introducing the field to the country. It was found that the main challenges were the discrepancy between time and medical fee, the lack of information of NM, the Korean medical culture of consultation, and the age gap of doctors. With the identified obstacles, some of which are unique to the cultural context, this research further elaborates on possible recommendations in expanding this field.

Literature Review: Benefits and Challenges of NM

It is crucial to understand the core skills in NM to comprehend the various point of views on its efficiency and feasibility. One essential skill that is at the crux of the field is close reading; specifically, doctors read or watch literary works, art, and film while employing analytical skills and recognizing their own reactions and thoughts to the work. Additionally, doctors write parallel charts wherein they write their personal feelings towards their patients in an effort to better understand and care for the patients. These skills which are based on narratology elements enable doctors to have a deeper understanding and relation with their patients.

The benefits of NM in the doctor-patient relationship have been shown in multiple studies. One obvious advantage of NM is the rapport and empathy that is built between the two parties. Syl Jones, a medical and creative writer who spent over a year at Hennepin County Medical Centre to learn NM, expounded during an interview with the Public Health Journal that the field enables doctors to make meaningful connections with patients. He explained how it can “open the door for [doctors] to be a human being rather than a godlike figure as a physician who many people feel inferior and cannot relate to” (APHJ). Research findings also fortify his claim as a group of doctors who were trained with NM skills such as close listening claimed that the information that patients were giving was crucial and worthy of listening (Langwitz). In fact, NM can even benefit by helping doctors better diagnose patients (Nunes).

Similarly, a grounded theory research conducted on fourth year medical students also revealed that they found NM as an integral part of medicine that is important and effective in developing both their social and personal lives (Arntfield). It is of note, however, that the aforementioned research was conducted on medical students, not doctors. Therefore, there may be some divergences when focusing on doctors.

Even though it is difficult to quantify the effectiveness of NM on the relationship, it can be concluded that it plays a critical role as evidenced by the benefits that both researchers and first-hand doctors who adopted NM found. Hence, evidence indicates NM not only fortifies the doctor-patient relationship but also significantly improves the doctor's personal lives.

There are also the skeptics who doubt NM's advantages, the majority of whom believe that the practice is too idealistic when considering the time constraint doctors face. According to David D. Morris, a PHD who wrote in the journal *Narrative Medicines: Challenge and Resistance*, there is "a sharp dissonance between the fantasy of medical consensus over narrative and the entrenched skepticism among doctors" as there is no clear agreement on its benefits. Morris questions the feasibility of adopting such ideas since most doctors that he has met have responded with "I have only seven minutes per patient" (Morris).

Another challenge is the ethical problem that surface from narrative telling between the patient and doctor. In a journal by Halil Tekiner at the University of Erciyes, he explains how, despite the aforementioned benefits such as better rapport and diagnosis, the practice is not immune to misconduct. Personal information disclosed by the patients could be used "for other purposes or personal benefits outside of the healthcare settings" rather than for treatment purposes (Tekiner). However, the drawbacks of NM practice, as indicated by critics, are not corroborated from data; they are merely inferred statements.

Expanding NM to Asian Medical Practice

When examining how widespread the field of NM has grown, the benefits become obvious. From its inception at Columbia University, the NM classes are held in multiple universities across America including the University of Arizona, Lewis Katz School of Medicine, and more. Even schools that do not have a NM program advocate the use of NM such as Stanford University ("What Can Doctors Learn from Narrative Medicine?"). NM has even expanded beyond America as it has now expanded through workshops in Roma, Eastern Europe and even Tokyo and Kyoto, in the far East (*The Principles and Practice of Narrative Medicine*). However, in South Korea, NM is virtually unknown, except for a few individuals who have heard of it from developments in America. The lack NM's expansion into Korea has prompted me to the question: *what are the challenges to introducing NM into Korea?* Specifically, I will be analyzing the reactions of doctors to determine what those challenges are. I hypothesize that the time restraints and the perceived lack of necessity.

There is no research on NM's status quo in Korea except several journal articles by Hwang Lim Kyung, a professor at Jeju National University (Hwang). Despite how he

wrote multiple articles on the field, his main intention of the paper was to synthesize and expound upon the constituents of NM rather than its prevalence in Korea.

Nevertheless, tangential research conducted in 2017 examines the different perspectives on Narrative Medicine between Western and Chinese medical students. The study determined, utilizing a Likert scale survey completed by medical students, that undertaking a course in Chinese medicine will compel students to the NM (Huang). However, this study does not account for doctor's perspective since the subjects were medical students. In the same vein, the conclusions are questionable since researchers applied an outdated theory on the relationship between Easterners and Westerners. Even if this theory may hold true, the limited and biased sampling size and regional biases necessitate further studies to confirm such results.

Considering NM's growing presence and benefits in the U.S., it is necessary to research whether such benefits can be applied to Korea. I will be employing the grounded theory method in which my data will aid me in coming up with a theory explaining why NM is not present in Korea because no previous data or research to employ for a hypothesis currently exists. Hence, my research will consist of collecting data, observing patterns, and creating a theory on the challenges of NM in Korea.

This research contributes to the existing literature in various levels. First, this study will be the first research that has reliable data from doctors since most literature merely points out at challenges without substantial evidence. Second, by determining the root problems of introducing NM to Korea, it will aid in rendering solutions to implementing this practice specific to Korea. Third, pioneers of this field will be better equipped to expand the field beyond America. Lastly, a deeper understanding of NM and its implications will improve the health care on a global level.

Grounded Theory Methodology

As demonstrated in the literature review, there exists a void of research regarding how doctors view NM and why it is not widespread specifically in Korea. The plethora of unsubstantiated claims in current literature and the void of research done in Korea necessitate a research method that satisfies both needs. Consequently, I have employed the Grounded Theory (GT) method, a novel approach for constructing a theory based on data. Since GT research is commonly used to extend "beyond conjecture and preconception to exactly the underlying processes of what is going on," this method is harmonious with how current literature merely contends rather than proves (*Doing Grounded Theory: Issues and Discussions*). Through this method, I will be forming a theory to determine what the challenges are in regard to introducing NM practice to Korea.

Founded by Glaser and Strauss, GT is defined as "a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (*Basics of Grounded Theory Analysis: Emergences vs Forcing*). In other words, GT is a research approach wherein one constructs a theory grounded in data; without preconceived notions, the researcher must collect data, code, categorize, and finally build a theory. Unlike conventional research methodologies, GT's final product is a hypothesis.

GT has several processes that must be taken as outlined below in fig 1.

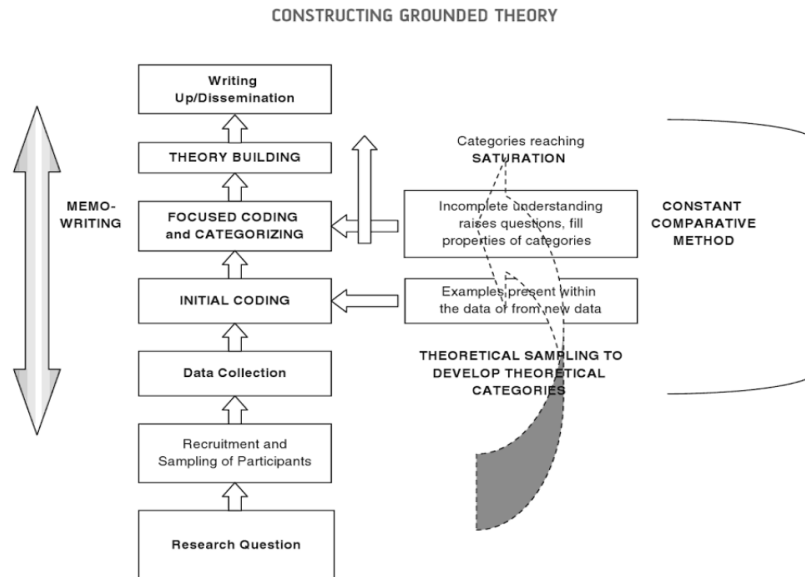
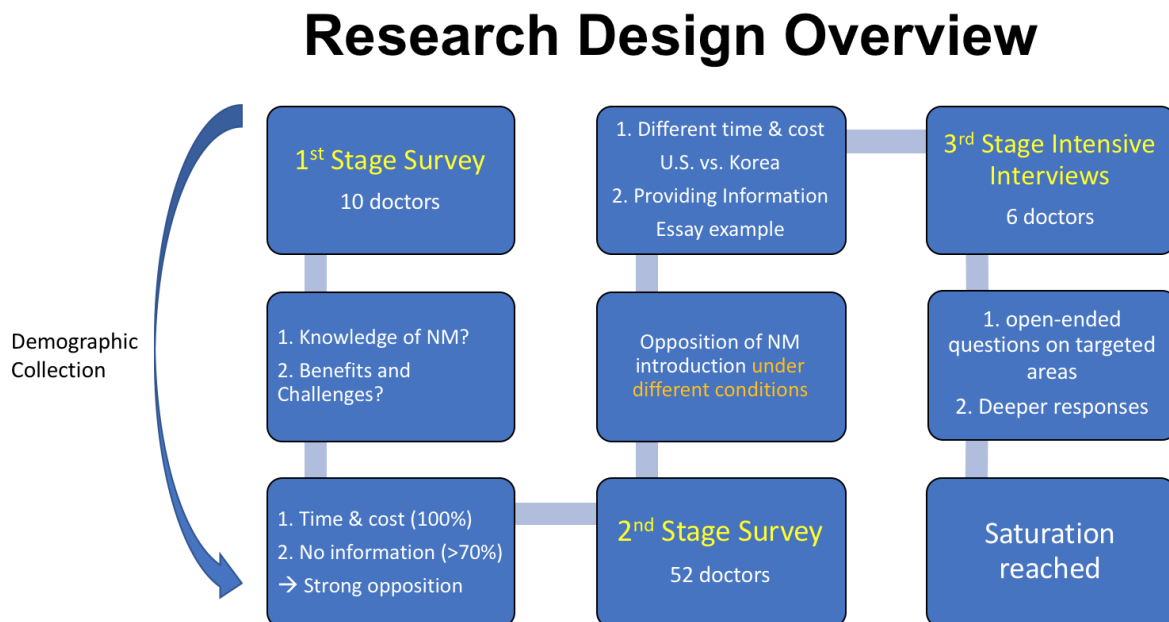


Fig 1. Outline of the GT method; Tweed, Alison, and Kathy Charmaz. "Grounded Theory Methods for Mental Health Practitioners." *Qualitative Research Methods in Mental Health and Psychotherapy*, 2011, pp. 131-146., doi:10.1002/9781119973249.ch10.

Fig 2. Research Design Overview



I. Data Collection

A total of 52 doctors were surveyed, six of whom were also interviewed. The data collection process was categorized into three stages: extensive survey, focused survey, and intensive interviews. Throughout each of the stages, an optional survey was attached to collect the demographics of the respondents. Specifically, the respondents were asked to give their gender, age, career, specialization, type of hospital working at (primary, secondary, or tertiary), and position in the hospital (director, substitute, resident). The purpose of collecting their demographic is to determine whether these characteristics influence the particular challenges that doctors have, aligning with the goal of GT method's first step to openly collect data.

1st Stage Survey:

An open, hand-written survey was given to ten doctors as part of a pilot study to verify the scarcity of NM in Korea and collect opinions from doctors. To obtain broader perspectives on the reactions of Korean doctors and align with the GT objective, a survey was used in the first stage. The doctors were asked two central questions: their awareness of NM and their reactions to the practice after an explanation about what it is. The pilot data, which is aligned with the GT method, helped inductively inform subsequent data collection.

2nd Stage Survey (Appendix B):

After determining the lack of awareness or understanding of NM among Korean doctors and the main factors for not introducing the practice, a second in-depth survey was distributed to 52 doctors to determine any other challenges. Since over 70% of the doctors in the first stage survey claim that time and fee is the primary barrier along with the issue with the lack of information, the void of other stated factors motivated me to refine my survey to draw out other factors. To accomplish this aim, I removed the barrier of time and fee and the lack of information as choices.

Since the medical fee in America for consulting doctors is 4.5 times higher per patient than in Korea, I asked the doctors to rate on a modified three-point Likert scale their stance of practicing NM under two environments: America medical environment and that of Korea (Kim Il Seoul; Fay). The doctors were then asked to justify their choice by focusing exclusively on what they thought were the barriers. By giving the doctors the question on two different situations (one with time and fee problem and the other without), the doctors were forced to give other reasons to why they would or would not practice NM.

To compensate for the second most common response of the lack of information on NM, I gave the doctors not only a more thorough explanation of NM but also a case study of a doctor who implements NM skills with his clinical practice and who finds benefits, such as more efficient diagnosis. After the doctors read the case, they were again asked whether their decision to use NM skills in their clinical practice would change from the previous response. By removing the factor of lacking information, I could better determine the existence of other factors that might prohibit NM's introduction or bolster the finding that the lack of information is a problem. Furthermore, a negative case analysis was conducted to account for the outliers (Willig).

3rd Stage Survey:

From the 52 surveyed who claimed that the primary hindering factor for introducing NM is one of the three main factors determined from the second survey, I selected six doctors. Although the surveys were structured to enable more open responses from the respondents, the lack of depth in the responses required me to construct semi-structured intensive interviews. Consequently, I followed Charmaz's GT intensive interview format by asking open-ended questions (Charmaz, 25-35). The purpose of the interviews was twofold: obtain more compelling data that could be used for coding and dissect the main factors determined in the second survey.

II. Coding and Categorizing

Coding is a crucial stage in GT research because it serves as the "bridge" between the data collected and the emerging theory that shows what the responses signify (Charmaz, 69). While analyzing the survey responses and interviews, I coded using Glaser and Charmaz's framework of three-stage coding: initial, focused, and theoretical coding (*Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*). In initial coding, all arising codes were noted while in focused coding, a select set of codes that were most pertinent to the inquiry received focus. This stage is crucial since it leads to the categorization of the codes. Then, theoretical coding was conducted to refine the categories and verify their correlation. All coding was used with gerunds at first and in vivo to ensure that the analysis adhered to the data while minimizing the researcher's own bias and perspective.

III. Theoretical Saturation

One issue that arises with GT is how the data collection and coding can go on infinitely. Hence, knowing when to transition from coding to refining one's theory is critical. Theoretical saturation is reached when no new categories are formed from the data (Charmaz, 96-123; Willig). Theoretical saturation was attained after the third stage of interviews since no new factors arose.

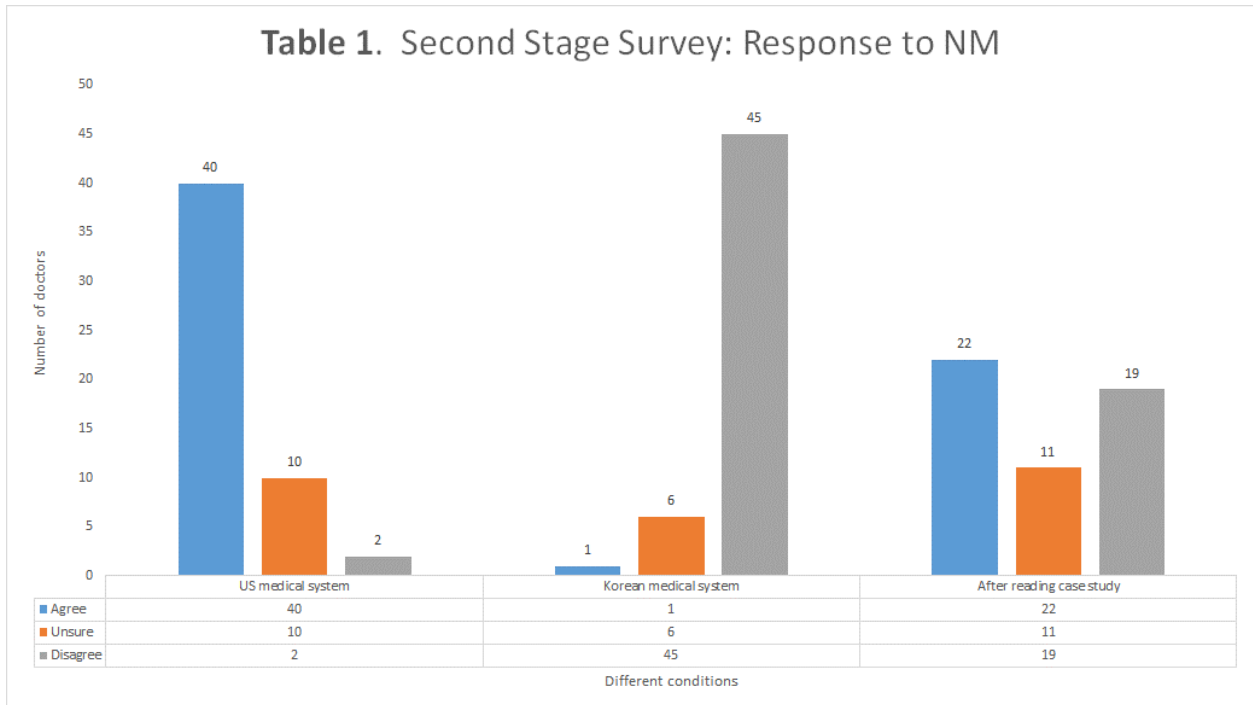
IV. Theory Building and Constant Comparative Method

Throughout the process of collecting and analyzing the data, I employed the constant comparative method of GT, an integral part of the theory building process. Constant comparative method transitions between the similarities and differences among categories to construct a theory. Transitioning from one stage to another, I ensured that the old and new categories arising from the second survey and interview were all juxtaposed to the initial stages.

Results

As aforementioned, first stage survey results showed that 10 out of 10 doctors opposed using NM in their clinical practice because of the discrepancy between the amount of time that they could spend with each patient and the profit that they could earn. The second most common response (70%) was that a lack of knowledge in the field prevented utilization; in other words, they could not apply NM to their clinical practice because they still did not fully understand NM.

The second survey results demonstrated the fact that a majority of the 52 doctors opposed the introduction of NM into the Korean medical system. However, when considering the U.S. medical system, less than 1% of the respondents disagreed with applying NM. Although the number of people who disagreed did still exist, this number significantly decreased upon reading the case study (shown in table 1). Furthermore, the number of people who were still unsure rose even after reading the case study.



Regarding the challenge factors in Korea that were claimed by the doctors, five identifiable categories emerged from the data as shown in table 2-1 and 2-2; 71% of the respondents claim that the challenge was the low medical fee, 13% the different medical culture, 8% the lack of information on NM, 4% the violation of privacy, and 2% ineffectiveness. On the contrary, the main challenge under the American system was the lack of information, which only 2 out of 52 doctors claimed. Even after reading a NM essay, 63% believed that the low medical fee was the problem, 16% the different medical culture, 11% the lack of information, and 5% the ineffectiveness. Table 2-3 shows the main factors that were told by the respondents on a macro level. The issue of the service fee and time, lack of information, and the different medical culture remained as the main under the Korean environment and the essay reading. It is of note that there were 5 outliers who claimed that they are using NM in their clinics currently.

Table 2-1. Second Stage Survey : Challenges of NM under Korean Medical System

	US medical system	Korean medical system	After reading case study
Low medical service fee & Limited time	0	32 (71.1%)	12 (63.1%)
Different medical culture	0	6 (13.3%)	3 (15.8%)
Lack of information on NM	2	4 (8.8%)	2 (10.5%)
Ineffectiveness	0	1 (2.2%)	1(5.3%)
Violation of patient privacy	0	2 (4.4%)	0
Already implemented	0	0	1(5.3%)
Total number	2	45 (100%)	19 (100%)

Table 2-2. Second Stage Survey: Challenges of NM Under Korean Medical Systems

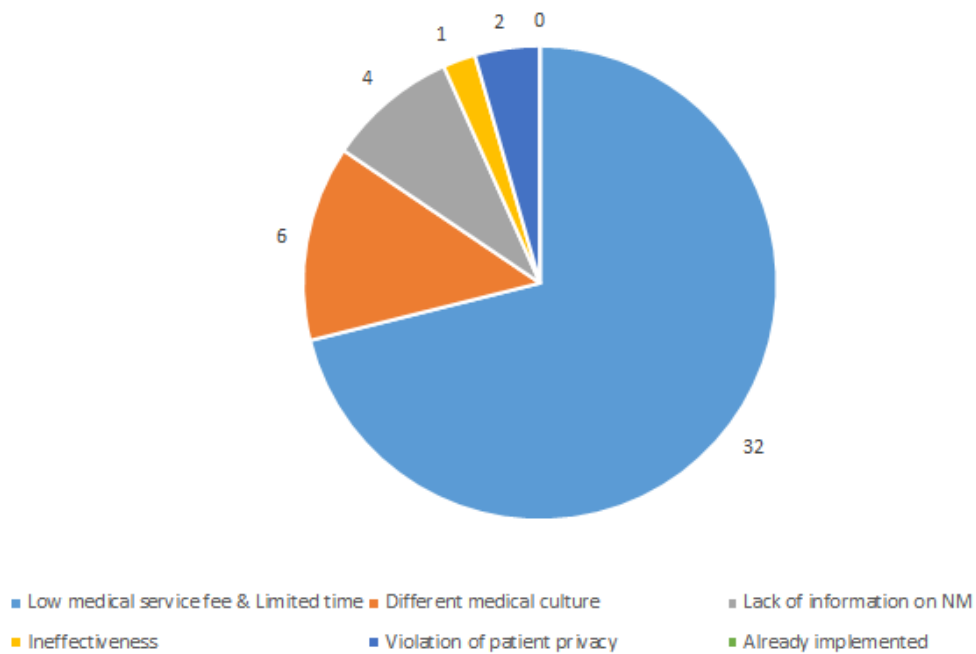
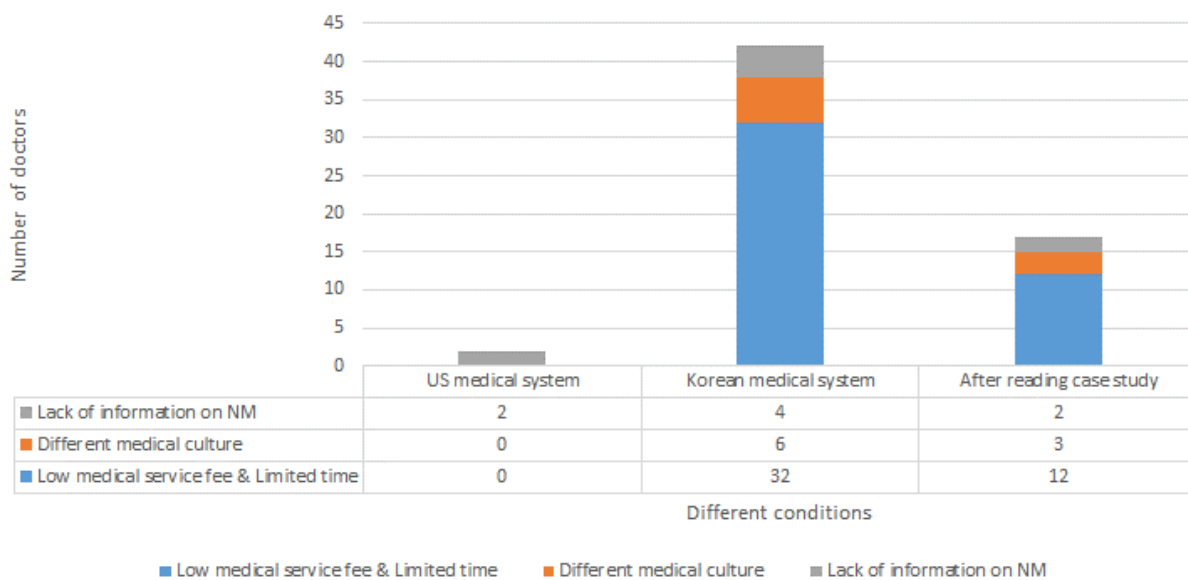
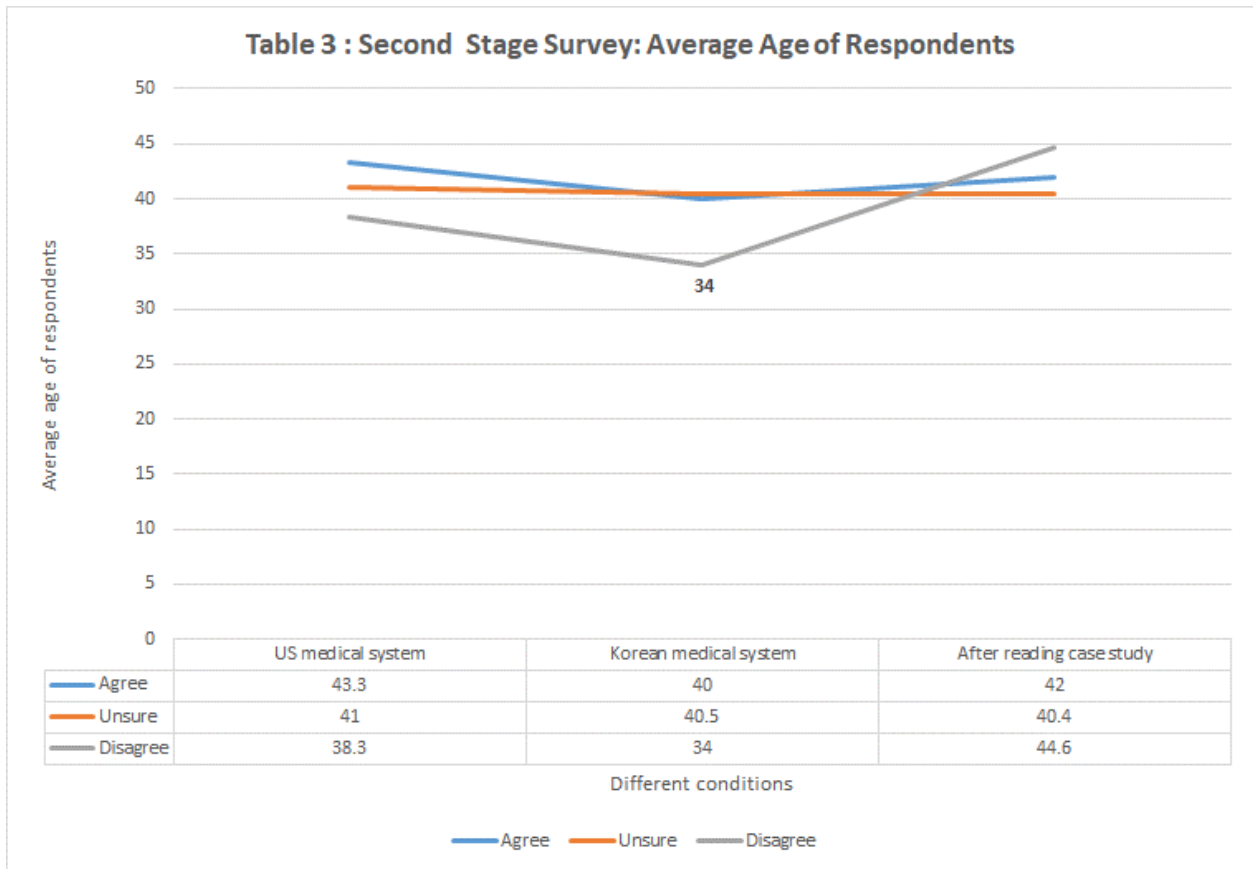


Table 2-3 . Second Stage Survey: Top Three Challenges of NM under Different Systems



Demographic characteristics such as gender, type of hospital, and more were excluded from the research since they did not show any significant patterns. However, age did show a pattern; table 3 shows the average age of doctors who agreed, disagreed, or were unsure about applying NM under different medical systems. While the average age of doctors who agreed practicing it under the Korean environment was 40, the age for those who disagree under the same setting was significantly lower (34). Other average ages under the American environment or after reading the essay range around 38 to 45.



In table 4, the coding for the 3 sample intensive interviews is shown. In each of the three factors, three different coding steps were conducted, the last of which are the finalized categories.

Table 4. Third Stage Intensive Interviews Sample

Selected Interviewee	Sample Response	Initial Coding	Focused Coding	Theoretical Coding
FOCUS: Lack of Time and medical fee Interviewee # 1 Age: 40	" Here, we get paid according to how many patients we see. So the longer I talk deeply with one, I lose the opportunity to earn another 10,000 or 20,000 (\$10-\$20)..."	<ul style="list-style-type: none"> - Needing to balance time and profit - Desiring wealth over patients 	<ul style="list-style-type: none"> - Lacking time - Low medical fee given to doctors 	-discrepancy between time and medical fee
FOCUS: Lack of information Interviewee # 4 Age: 41	" So... do you mean NM is just talking with patients deeply?..."	<ul style="list-style-type: none"> - Lacking knowledge of NM - Questioning the understanding - Defining NM 	- Lacking knowledge of NM	-Lack of Information on NM
FOCUS: Medical environment Interviewee # 5 Age:40	" The patients in Korea want quick consultation. I doubt they would want me to sit with them for over 10 minutes..."	<ul style="list-style-type: none"> - Differing point of view - Lacking harmony in what health care is 	<ul style="list-style-type: none"> -Diverging Perspectives between patient and doctor - Consulting meaning specific to Korea 	- Korean Medical Culture on consultation

In summary, table 1 shows the reactions of the doctors when asked about NM under different medical environments and after reading the case study essay. Table 2-1 depicts the overall data collected while table 2-2 shows the results specific to Korea. In table 2-3 the main challenge factors were collected, both under the aforementioned conditions. To account for the demographic patterns, the average age under different choices are shown in table 3. Lastly, table 4 shows the sample coding process of the intensive interviews. These responses, when synthesized and compared together, will help in identifying the critical challenges to introducing NM to Korea.

Data Analysis

The data collected from the third-stage research shows what the challenges are for introducing NM to Korea based on the perspective of the Korean doctors. The survey and interview responses were coded and then categorized into the factors that encompass the respondent's opinion. While the two surveys identified the main factors, the intensive interviews gave a more in-depth meaning behind these categories. This section will report on the findings of the survey and interviews and the conclusion of this paper. It is critical to understand that the most repeating categories throughout the stages show the main challenges to bringing NM to Korea. The semi-quantified results show that there are four main factors.

Repeating Category 1: Discrepancy between time and medical fee

In the first stage survey, it was established that the majority of the doctors opposed NM due to the lack of time. Furthermore, in the second survey, the problem with the medical fee and time repeated the most number of times among the participants, especially under Korea. This demonstrates that the issue of time and fee is specific to Korea. This is also shown throughout all three stages of the research as 100% doctors in first stage survey, 71% in the second stage, and all interviewees mentioned the time-fee concern.

When interviewing two doctors who claim that time and fee was the main factor, they both claimed that the need to earn money was key to their field. As interviewee 2 claims,

“We do not get paid as much as we consult with the patients...there must be some regulation that makes the medical fee proportional to the time we spend with the patients. We want increased profit.”

Interviewee 1 also shared similar sentiments as he wanted to get paid equivalent to the amount of time he spends with patients. Even with the three of the remaining four respondents mentioned that this was an issue. These Korean doctors hold the firm belief that the lengthened time they spend with each patient takes away the profits the doctors can obtain. In other words, they equate the number of patients they talk with the profit they earn, putting a greater emphasis on the material gain. The high percentage of doctors who claim that time and fee was the issue in stage one

and two surveys and the interview responses demonstrate that this fee factor is one of the leading challenges.

Repeating Category 2: Lacking information on NM

In the first stage survey, 70% of the doctors claimed that the lack of information on NM made it difficult for them to practice NM skills in their clinics. Likewise, even in the second stage survey, the lack of information was the second core factor after time and fee. In fact, when asked under the U.S. and Korean medical environment, the doctors indicated that the problem of not fully comprehending NM was a contributing factor. To be more specific, the few doctors who opposed using NM even under the U.S. medical system claim that the lack of information was the challenge while 8.8% claim the same under the Korean environment. Even more important is how this factor persists even after reading the case study that described a doctor's gain from using NM skills. Even though the percentage did decrease, the number of doctors who pointed out at this as a factor was still 11%. Furthermore, there were five outliers who claimed after reading the case that they were practicing NM currently. However, it was determined that these respondents misunderstood what NM skills are since they thought that NM is merely talking for a long time with each patient. The negative case analysis demonstrated that these outliers actually support this category of lack of information because they had misconceptions on what NM truly is.

The doctors interviewed for these factors asserted that they were still unsure about what NM indeed is. In all three stages, the doctors expressed hesitation when asked to decide whether to use NM in their clinics since they felt the explanation and the essay were both insufficient to fully understand NM. As interviewee 3 states,

“I could not choose ‘agree’ in the survey because I still don’t and didn’t understand what narrative medicine is.”

This category was shown multiple times from the first stage survey to the third stage interviews. In all three stages, doctors found it difficult to fully understand the scope of NM, limiting them from accepting the practice. The recurring category of the lack of information provides evidence that the difficulty of comprehending the depth of NM is a significant challenge.

Repeating Category 3: Korean Medical Culture of Consultation

As shown in graph 2-3, the second most common response from the doctors was the differences in the medical culture of consultation. Although much less than repeating category 1, this factor was prevalent in the second stage survey. Here, 13% of the respondents claimed that the medical culture of Korea limits the doctor's acceptance of NM. Even after understanding the benefits of it, 16% of the doctors still held the belief that this was an issue.

When examined at a closer level, the specific Korean medical culture of consultation is the way in which patients often view interactions with doctors. As evidenced throughout the surveys and the interviews, doctors find that patients do not believe that a mere discussion with the caregiver is true medical consultation; instead, the patients expect concrete actions, such as injections, medications, and therapy. Interviewee 6 maintained,

“Patients in Korea do not think that merely talking and listening to them are effective. They want tangible things from the doctors: medications, injections, and therapy. Sure- I can talk with a patient deeply and listen. However, what’s the point when the patient are dissatisfied with just talking? I would rather just give them medications.”

However, the Korean medical culture of consultation does not end here; according to interviewee 5 and several other survey respondents pointed out that the impatience of the patients prohibits them from integrating NM practice. Interviewee 5 maintained “the fast-paced, impatient patients in Korea” make doctors meet their needs by just summarizing the key points of their illness and moving onto the next patient. In this way, patients will not experience any delays.

Although the factor of the culture of Korean consultation did not appear in the first stage survey, it did surface in the subsequent stages. The medical consultation culture, in which patients believe that physical actions and fast-paced meetings are superior, does play a role in challenging the introduction of NM to Korea.

Identified factor: Age

When examining the demographic collection, I found that there were no pertinent patterns. However, the average age of the doctors who agreed or disagreed did show significance since younger doctors tend to disagree with NM practice more than the more experienced caregivers. Interviewee one and two pointed out at how their young ages influences their choice of lacking time and medical fee as the challenge. As interviewee one claims,

“As one of the youngest doctor in the hospital, it is important for me to get to as many patients as possible to earn the maximum money. It is a small environment with great competition; I do not get enough money if I just see four patients in an hour.”

The competitive nature in the medical field necessitate these younger doctors to value the profit they earn. This nature accounts for why the average age of those who disagreed was the youngest. Therefore, the data indicate that the main challenges of introducing NM are: lack of time and medical fee, lack of knowledge of NM, Korean medical culture of consultation, and the age gap of the doctors.

Limitations

Firstly, the most critical limitation is the definition of NM. The explanation I gave to the doctors was insufficient to embody the true weight the field holds. Because NM is not a concept but rather a set of skills that doctors must learn to use and feel a transformative change within themselves, a mere written and verbal explanation is not adequate. Having the doctors experience NM by teaching them the skills and practicing it in their clinics will have made the results more accurate with a better understanding of NM.

Secondly, the errors in translations could have affected the results. Because the surveys and interviews were translated into English before coding, the responses may not hold the same nuances that the doctors wanted to convey. For future research,

multiple translators should verify and agree on the subtle nuances that the responses hold. This way, the arising codes, and categories adhere to the data more precisely.

Lastly, the rise of new perspectives limits the theory. Although my theory holds the four challenge factors, this may not hold true always since it is a theory, not a definitive statement. In fact, from May 1, a new regulation in Korea was established wherein doctors must meaningfully consult with a patient for 15 minutes if the patient requests and pays for the in-depth consultation with an equitable amount (Lee Jin Han). Hence, if this research collected data today, the responses may have changed regarding the factor of time and fee. To suffice for these limitations, further theoretical sampling is suggested to construct a comprehensive theory.

Discussion

The results demonstrate that my initial hypothesis of how the time-restraint is a challenge was accurate as illustrated by the data. However, my second hypothesis that Korean doctors find NM practice unnecessary was inaccurate. Doctors acknowledge that NM is essential and beneficial; however, the external challenges prevent them from employing it in their practice. Returning to the original research question of “what are the challenges of introducing Narrative Medicine to South Korea?” my research concludes that the challenges are the discrepancy between time and medical fees, lack of information on NM, the medical culture of consultation, and the age gap of doctors.

These challenges have various implications for both Korean and global scales. Now that the root challenges are identified, these can be used to find the possible solutions to how we can introduce NM to Korean health care. For instance, the discrepancy between time and fee can be resolved by having governmental laws regulating the fee; creating more NM workshops or classes in Korea can eradicate the second barrier of the lack of information. Furthermore, this research is the first empirical study that shows the challenges of NM, providing reliable data from Korean doctors. Most importantly, this research is a crucial step in expanding this field in a broader global scale. Although these challenges may not apply to every country, these significant obstacles can be resolved to better equip the pioneers of this field to promulgate and implement NM. As Rita Charon claims, “unless we can attend to the interior life, the courage, if you will, of our developing doctors, we will end up with doctors who flinch when things don’t go well, who abandon patients when they’re dying (“Dr. Rita Charon”). Thus, to avoid a society with irresponsible, uncompassionate doctors, we must press to cultivate NM practice in Korea.

APPENDIX A.

Additional research on this issue is showing that another central challenge of introducing NM to Korea is the obscurity and lack of acceptance of the medical humanities in Korea. While medical humanities have existed for many decades in America, it has only been introduced to Korea in the early 2000, the time when NM was officially introduced. This may hint at how the growth and acceptance of medical humanities in Korea may be one of the first steps to take.

APPENDIX B

This is a combined survey for the second stage survey.

Survey for narrative medicine of doctors in Korea

(대한민국 의사를 대상으로한 대사의학에 대한 설문조사)

The purpose of the following questions is to evaluate the awareness, acceptance rate, oppositional factors, and preceding conditions for doctor to introduce **narrative medicine** in Korea and to evaluate the response after reading a case of applying narrative medicine into the clinic.

Your answerers are very important to the accuracy of this study and will help the gathering information to introduce narrative medicine in Korea. All answers will be used only for academic purposes. You can choose English or Korean version of survey.

Thank you for your time and help.

본 설문지의 목적은 미국에서 대두되고 있는 **대사의학**(Narrative medicine)에 대한 한국 의사들의 인지도, 한국으로 도입에 대한 수용율, 반대인자, 선행조건을 알아보기 위한 것입니다. 또한 대사의학을 실제 진료에 적용한 예를 본 후의 반응을 보기 위한 것입니다.

귀하의 설문지에 대한 답은 이 연구의 정확도를 위해 중요하며, 한국으로 대사의학의 도입에 관한 자료수집에 많은 도움이 될 것 입니다. 모든 설문 관련 자료는 연구적 목적에만 사용될 것입니다.

영어나 한국어 중 한가지 설문지를 택하여 작성해주시기 바랍니다.

귀중한 시간을 내주셔서 감사합니다.

English version

1. Have you ever heard about narrative medicine?

1) Yes

2) No

2. If you answered 'Yes' at question 1, please write down the details at the blank.

When and how did you get the information of it?

()

Please read the explanation for narrative medicine

Narrative medicine is a medical study that develops competence narratives in clinical practice, research, and education to promote healing. This program has been firstly performed in Columbia University Medical center by Dr. Rita Charon as a new medical approach.

It emphasize the relational and psychological dimensions that occur in tandem with physical illness, with the attempt to treat patients as humans with individual stories, rather than purely based on symptoms. In doing this, narrative medicine aims not only to validate the experience of the patient but also to encourage creativity and self-reflection in the physician.

3. If you apply narrative medicine into your clinic for patients, what are the advantages and disadvantages in your opinion?

Advantage	
Disadvantage	

-
4. If you work under the similar medical treatment condition (environment) of USA, to what extent do you agree or disagree with the statement? :

'Narrative medicine should be introduced in Korea'

Strongly disagree	Disagree	Unsure	Agree	Strongly agree

Please explain the reasons below..

5. If you **consider the present medical environment**, to what extent do you agree or disagree with the introduction of narrative medicine in Korea.

Strongly disagree	Disagree	Unsure	Agree	Strongly agree

Please explain the reasons below..

6. What do you think the preceding factors before introduction of narrative medicine in Korea?
-

Please answer the questions after reading the essay of a doctor who applied narrative medicine into actual practice.

- Essay by doctor -

A middle-aged woman came to the eye clinic. She felt like there was a foreign object stuck in her eye in spite of visiting other eye clinics. No foreign body was found in her eye, but her discomfort at night continued to get worse for two weeks. At her third visit, she was too distressed and suffered from insomnia. Both patient and doctor were under too much stress because there seemed to be no solution to the issue. The parallel chart program was applied to this case for the deeper understanding and relieving tension. Patient, nurse, and doctor gathered in a room and narrated illness with story after the

time extension. Medical team narrated each feeling and used everyday terms instead of medical terms. In a comfortable atmosphere, the patient described her pain, explaining even her personal life such as job, hobby, and social relationship.

What was unique about her narration was that she was a member of a mountain climbing club and got back from the mountain about 3-4weeks ago. She was troubled with many flies when she climbed down. When her persistent foreign body sensation over one month and history of contact with flies on the mountain were combined, parasite infection of eye was suspected. I observed her upper conjunctiva after eversion and waited a bit longer than routine examination. Surprisingly, long white parasites appeared from upper fornix of conjunctiva and disappear (referring to photograph). I removed over 10 parasites for few days and her symptom improved. It took about 4 weeks for the eggs to grow into adult worms in her conjunctiva. That was the reason that I had difficulty finding the parasite in her eye. The parasite (*Thelazia Callipaeda*) infection of the eye from flies are so rare that about 30 cases have been reported in Korea.



Photograph of parasite at conjunctiva

(Eye clinic and patient approved all contents as a purpose of research.)

I regarded her foreign body sensation of eye as an unimportant one because that symptom was very common at eye clinic. The process of comprehending a patient based

on not a symptom but a whole- person provided a clue, which helped to make an accurate diagnosis of a rare disease. This also gave an emotional stability to patient and the physician while fortifying confidence between them.

-Translated from Korean

7. As a given essay, if narrative medicine is helpful to strengthen the confidence between patient-physician, to make diagnosis and proper treatment, and to relieve emotional stress of physician and patient, to what extent do you agree or disagree with the introducing narrative medicine in your clinic **under the present medical environment of Korea?**

Strongly disagree	Disagree	Unsure	Agree	Strongly agree

Please explain the reasons below..

8. OPTIONAL: Please fill out the blanks. You are entitled to keep your response as anonymous if you would like.

Gender / age	M or F /()years
Major	
Clinical carrier	Years
Working condition	Pay doctor()/ the director of hospital()
Forms of hospital	Primary ()/ Secondary ()/ Tertiary ()
Average time to care a patient at OPD *	Minutes
Expected time to care a patient to apply narrative medicine at OPD	Minutes
Expected % increase of medical care cost to introduce narrative medicine	%

* Severe or life threatening cases are excluded in average time to care a patient in the clinic.

Address of Hospital/Phone Number _____ / + 82- - -

Works Cited

- "APHJ - Narrative Medicine with Syl Jones." *A Public Health Journal*, 11 May 2016, www.youtube.com/watch?v=O7xnkTu2Ngs.
- Arntfield, Shannon L., et al. "Narrative Medicine as a Means of Training Medical Students toward Residency Competencies." *Patient Education and Counseling*, vol. 91, no. 3, 2013, pp. 280–286. ScienceDirect, doi:10.1016/j.pec.2013.01.014.
- Charmaz, Kathy. "Gathering Rich Data." *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*, SAGE Publications, 2006, pp. 25–35.
- Charon, Rita. "Dr. Rita Charon." *U.S. National Library of Medicine*, National Institutes of Health, cfmedicine.nlm.nih.gov/video/58_1_trans.html.
- Charon, Rita. *Narrative Medicine: Honoring the Stories of Illness*. Oxford University Press, 2008.
- Charon, Rita. *The Principles and Practice of Narrative Medicine*. Oxford University Press, 2017.
- Fay, Bill. "How Much A Doctor Visit Will Costs You - Blue Book Prices." *Debt.org*, America's Debt Help Organization, 10 Aug. 2017, www.debt.org/medical/doctor-visit-costs/.
- Glaser, Barney G. *Basics of Grounded Theory Analysis: Emergences vs Forcing*. Sociology Press, 1992.
- Glaser, Barney G. *Doing Grounded Theory: Issues and Discussions*. Sociology Press, 1998.
- Glaser, Barney G. *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. The Sociology Press, 1978.
- Huang, Chien-Da, et al. "Different Perceptions of Narrative Medicine between Western and Chinese Medicine Students." *BMC Medical Education*, vol. 17, no. 1, Oct. 2017, doi:10.1186/s12909-017-0925-0.
- Hwang, Im-Kyung. "Medicine and Narrative." *Seoul National University Library*, 2002.
- Kim Yi Sheul. "'Elderly Outpatient Treatment Fee' Will Be given in January next Year." 2 Nov. 2017, www.kmpnews.co.kr/news/articleView.html?idxno=29326.
- Langewitz, W. "Spontaneous Talking Time at Start of Consultation in Outpatient Clinic: Cohort Study." *Bmj*, vol. 325, no. 7366, 2002, pp. 682–683. US National Library of Medicine, doi:10.1136/bmj.325.7366.682.
- Lee Jin Han. "Local Lawmakers Also Have a '15-Minute Medical Examination.'" *동아일보*, 18 Apr. 2018.
- Marvel, M. Kim, et al. "Soliciting the Patient's Agenda." *Jama*, vol. 281, no. 3, 1999, p. 283., doi:10.1001/jama.281.3.283.

- Morris, David. "Narrative Medicines: Challenge and Resistance." *The Permanente Journal*, vol. 12, no. 1, Jan. 2008, doi:10.7812/tpp/07-088.
- "Narrative Medicine Master of Science." *Narrative Medicine*, Columbia University, sps.columbia.edu/narrative-medicine.
- Nunes, Ana, et al. *When Narrative Medicine Helps in the Diagnosis of Conjunctival Melanoma – an Exceptional Case Report*. US National Library of Medicine National Institutes of Health, 17 July 2012.
- Rosti, Giovanni. "Role of Narrative-Based Medicine in Proper Patient Assessment." *Supportive Care in Cancer*, vol. 25, no. S1, 2017, pp. 3–6., doi:10.1007/s00520-017-3637-4.
- Tekiner, Halil. "Ethical Considerations Related to Narrative Medicine." *Patient Centered Medicine*, Dec. 2017, doi:10.5772/66167.
- "What Can Doctors Learn from Narrative Medicine?" *What Can Doctors Learn from Narrative Medicine? | Stanford Medicine 25 | Stanford Medicine*, Stanford University, stanfordmedicine25.stanford.edu/blog/archive/2014/What-Can-Doctors-Learn-from-Narrative-Medicine.html.
- Willig, Carla. "Chapter 7: Grounded Theory Methodology." *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*, Open University Press, 2014, pp. 69–82.

Sarah Se-Jung Oh is a high school senior at Korea International School. Originally from Australia, she moved to South Korea about 4 years ago. As an avid bibliophile and journalist, Oh was drawn to Narrative Medicine because it encompasses her values: literature, medicine, and most importantly empathy. She decided to embark on this research topic as her AP Capstone Research project, a college level research course. This paper is her first step in her pursuit in this field. After contacting Professor Rita Charon, she had the privilege to meet her in person in June 2018 to discuss her research and path. Her number one dream today is to cultivate more experience and knowledge to construct a Narrative Medicine model for Korea.