



FROM CURE TO CARE: REIMAGINING MEDICAL ETHICS THROUGH NARRATIVE MEDICINE AND EMPATHY

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Abstract

Medical ethics in the modern era has long been defined through the lenses of principlism, based on such principles as autonomy, beneficence, non-maleficence, and justice. Although highly analytical, principlist medical ethics is subject to criticism, primarily because it puts emphasis on the applicability of general rules rather than the contextual and personal aspects of the clinical interaction. This paper provides a conceptual and critical review of the ideas of narrative medicine and empathy as two frameworks complementing each other in an attempt to rethink medical ethics as a care-focused rather than purely curative practice. Using the fundamental works of Rita Charon on narrative medicine, Arthur Kleinman and Arthur Frank on illness narratives, as well as Mohammadreza Hojat et al. on the research of physician empathy, the paper discusses the "narrative turn" in medical ethics and shows the potential of narrative medicine and empathy to augment rather than replace the principlist approach. The paper reviews the literature thematically, proposes a conceptual model linking narrative medicine practices to its ethical consequences, and discusses the practical challenges of incorporating the ideas of narrative medicine and empathy into today's healthcare environment.

Keywords: *narrative medicine; medical ethics; empathy; illness narratives; patient-centred care; narrative humility; principlism; medical humanities*

1. Introduction

Interpretation is at the very heart of medicine. Even prior to the formulation of a set of bioethics principles, doctors used to hear complaints from patients, analyze their bodies, and interpret their pains in order to diagnose and treat them. However, throughout the twentieth century, as biomedicine gained incredible progress in the biochemical and technical understanding of diseases, the moral discourse about clinical practice shifted towards abstract and generalizable moral principles rather than stories of individual patients. This paradigmatic change was most widely recognized by Beauchamp and Childress in their famous book *Principles of Biomedical Ethics* (1979), which outlined four fundamental principles of moral reasoning in the clinic: respect for autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2001). However, principlism has shown itself to be resilient and quite effective in helping clinicians and ethicists develop a common language with which to discuss ethical issues, from informed consent to end-of-life decision making. However, precisely because of its very broad nature, principlism has also been heavily criticized throughout its history. Some scholars suggest that the use of only

principles can deprive the whole process of ethical reflection of the moral complexity and reduce it to mere calculations that fail to take into account particular details and nuances of an individual experience, his or her personal values, fears, life experience etc. It is under this circumstance that the notions of narrative medicine and medical humanities have appeared in the last decades of the twentieth century – in opposition to the principlist approach or as a necessary supplement to it.

The notion of “from cure to care” encapsulates the core conceptual journey that this paper attempts to elucidate. In this case, “cure” refers to the biomedical paradigm’s typical approach to viewing disease as an identifiable biological phenomenon that is to be detected and eradicated, along with the principlist framework of bioethics that has traditionally been associated with such an approach. On the other hand, “care” refers to a more holistic perspective on the sick individual in question, his/her story, relationships, and the context within which illness emerges – a perspective that cannot be approached either through the prism of biomedical science or through principlism alone. It is important to emphasize that this dichotomy, although useful for analytic purposes, is not to be construed as an opposition; as this paper aims to show, a truly effective contemporary framework of medical ethics synthesizes rather than abandons principlism. Physician-literary scholar Rita Charon’s work is central to this rethinking, and she developed the term “narrative medicine” for medicine practiced with the narrative competence to “recognize, absorb, interpret, and be moved by the stories of illness” (Charon, 2006). Charon’s framework describes three related narrative capacities – attention, representation, and affiliation – through which clinicians listen carefully to a patient’s story, represent or reflect on what they have heard (often through structured reflective writing), and thus come to an affiliative bond with the patient. The framework explicitly draws on literary theory and the practice of close reading, conceptualizing the clinical encounter as an interpretive act akin to the reading of a literary text, and arguing that such narrative competence is not merely a communication skill but an ethical capacity in its own right.

Arthur Kleinman’s *The Illness Narratives* (1988) and sociologist Arthur Frank’s *The Wounded Storyteller* (1995) complemented Charon’s explicitly pedagogical and clinical framework with influential theoretical accounts of how patients make meaning out of illness through storytelling, and how the act of narration itself can be understood as ethically and existentially significant—what Frank calls the transformation of “fate into experience.” In the meantime, a large empirical literature, most notably the programme of research started by Mohammadreza Hojat et al. using the Jefferson Scale of Empathy, has attempted to measure, and controversially found evidence of decline in, physician and medical-student empathy over the course of medical training. This finding has led to extensive debate about the causes, generalisability and educational implications of empathy erosion in contemporary medical education.

In this paper I critically engage these several strands of scholarship—principlist bioethics, narrative medicine theory, illness-narrative scholarship, and empirical empathy research—to formulate an integrated conceptual account of how narrative medicine and empathy might reimagine rather than simply supplement contemporary medical ethics. The remainder of the paper is organized as follows. The particular objectives of the review are described in Section 2. The relevant literature supporting the analysis in this research is reviewed in Section 3. Section 4 discusses the adopted conceptual methodology.

Section 5 offers a thematic synthesis of the studied material together with a summary table and a graphic of a conceptual framework. Section 6 lays out the main tensions and consequences that follow from this synthesis, and Section 7 concludes.

2. Objectives of the Study

1. To critically examine, through a synthesis of existing interdisciplinary literature, how narrative medicine and empathy research complicate, complement, and potentially reimagine the dominant principlist paradigm in contemporary medical ethics.
2. To develop an integrated conceptual framework linking narrative medicine practice (attention, representation, and affiliation), illness-narrative scholarship, and empirical empathy research to ethically responsive, care-oriented clinical practice, and to identify the key tensions involved in operationalising this framework within contemporary healthcare systems.

3. Review of Literature

The literature reviewed below has been selected for its foundational or empirically significant contribution to the intersection of narrative medicine, illness-narrative theory, and empathy research within medical ethics, and is presented in approximate chronological order.

Beauchamp and Childress (2001), in the influential and repeatedly revised *Principles of Biomedical Ethics*, established the four-principle framework — respect for autonomy, beneficence, non-maleficence, and justice — that has since become the dominant paradigm for clinical ethical reasoning in Western biomedicine. While not itself a narrative or empathy-focused text, this work is essential background for the present review, since much of the subsequent narrative-medicine literature explicitly positions itself in critical dialogue with, rather than simple rejection of, this principlist paradigm.

Kleinman (1988), in *The Illness Narratives: Suffering, Healing, and the Human Condition*, introduced a highly influential distinction between “disease” (the biomedical, pathophysiological process) and “illness” (the patient's lived, meaning-laden experience of being unwell), arguing that the illness narrative — the story a patient constructs and retells to give coherence to their suffering — constitutes an essential and frequently neglected object of clinical attention. Kleinman's framework of illness as “biographical disruption” has become foundational to subsequent medical humanities scholarship.

Frank (1995), in *The Wounded Storyteller: Body, Illness, and Ethics*, extended this line of inquiry through a sociological and ethical analysis of illness storytelling, characterising ill persons as “wounded storytellers” who, through the act of narration, transform the isolating fate of illness into a shareable experience that connects them to others in “their shared vulnerability.” Frank's typology of restitution, chaos, and quest narratives has been widely applied in subsequent scholarship on how patients construct meaning from illness, and his work explicitly frames storytelling itself as an ethical practice.

Hojat, Mangione, Nasca, and colleagues (2004), in “An empirical study of decline in empathy in medical school,” developed and applied the Jefferson Scale of Physician Empathy (JSPE) to a cohort of 125 medical students at the beginning and end of the clinically intensive third year, reporting a statistically significant decline in measured empathy over this period. This study, and the measurement instrument it introduced, established an empirical research programme that has since been replicated, contested, and extended across dozens of subsequent studies internationally.

Charon (2006), in *Narrative Medicine: Honoring the Stories of Illness*, provided the field's most comprehensive theoretical and practical synthesis, formally defining narrative medicine as medicine practised with the competence to recognise, absorb, interpret, and be moved by the stories of illness, and introducing the interlinked narrative capacities of attention, representation, and affiliation as the core competencies to be cultivated in clinical training. Charon explicitly argues that narrative competence is not merely instrumental to good communication but is itself constitutive of ethical, humane clinical practice, and the book has become the foundational text of the narrative medicine movement centred at Columbia University's Program in Narrative Medicine, which Charon founded.

Hojat, Vergare, Maxwell, and colleagues (2009), in “The devil is in the third year: A longitudinal study of erosion of empathy in medical school,” extended the 2004 findings using a larger longitudinal cohort, again identifying a significant decline in empathy specifically associated with the transition into clinical clerkships, and proposing that increased workload, diminished role-modelling of humanistic care, and exposure to the depersonalising aspects of clinical training may each contribute to this erosion. This study remains among the most frequently cited in the empathy-decline literature, though its methodology and generalisability have subsequently been contested by other researchers.

Neumann, Edelhäuser, Tauschel, and colleagues (2011), in a systematic review of studies examining empathy decline among medical students and residents, synthesised the by-then substantial empirical literature on this phenomenon, concluding that empathy decline was a broadly consistent finding across studies but that its underlying causes — variously attributed to curricular structure, clinical workload, exposure to patient suffering without adequate support, and the hidden curriculum of clinical training — remained incompletely understood, and calling for renewed attention to humanistic and reflective practice within medical education.

DasGupta (2008), in the short but highly influential *Lancet* commentary “Narrative humility,” proposed an important corrective and extension to Charon's narrative competence framework, arguing that patients' stories should be approached not as texts that clinicians can fully “master” or comprehend, but as dynamic, ambiguous, and partially resistant to interpretation — requiring an attitude of humility, openness, and ongoing engagement rather than confident interpretive closure. DasGupta's concept of narrative humility has since become a widely cited corrective within the narrative medicine literature, particularly in relation to cross-cultural clinical encounters.

A more recent contribution (PMC, “Narrative medicine in ethics education: from theory to practice”) has explicitly sought to integrate narrative approaches with the casuistic (case-based) methodology traditional

to clinical ethics consultation, proposing what the authors term “narrative casuistry” — a hybrid approach in which moral reasoning proceeds through careful, thickly described analysis of paradigmatic clinical cases enriched by narrative context, explicitly addressing what Beauchamp and Childress themselves acknowledged as the “specification problem” inherent in translating abstract bioethical principles into concrete clinical guidance.

Most recently, a systematic review examining the integration of digital technologies and narrative medicine within healthcare education (PMC, “Integrating digital and narrative medicine in modern healthcare”) found that narrative medicine training reliably nurtures empathy, communication skill, and professional identity formation among healthcare trainees, and that digital tools — including virtual reality simulations, mobile health applications, and reflective e-portfolios — can reinforce these outcomes by providing immersive and interactive opportunities for narrative reflection, suggesting a promising avenue for scaling narrative medicine pedagogy within resource-constrained or geographically dispersed training programmes.

4. Methodology

Consistent with its aim of critically synthesising and interpreting an existing body of interdisciplinary scholarship rather than generating new primary empirical data, this paper adopts a conceptual, literature-based methodology, specifically a critical, theoretically framed narrative review. The relationship between principlist bioethics (as articulated by Beauchamp and Childress) and narrative/empathy-based approaches to medical ethics serves as the paper's central interpretive lens, with the reviewed literature read, organised, and synthesised in relation to this central conceptual tension. The literature underpinning this review was identified through a targeted search of academic databases and publisher platforms (including PubMed/MEDLINE, Oxford Academic, The Lancet, and relevant institutional repositories) using search terms combining “narrative medicine,” “medical ethics,” “empathy,” “illness narrative,” “narrative humility,” and “principlism.” Priority was given to foundational theoretical and clinical texts within the narrative medicine and medical humanities tradition (Kleinman, 1988; Frank, 1995; Charon, 2006; DasGupta, 2008), to the empirical empathy-research programme initiated by Hojat and colleagues, and to recent (post-2020) scholarship examining the practical integration of narrative approaches into ethics education and clinical training.

The analytical procedure followed in preparing this review involved three stages: first, close reading and summarisation of each selected source with attention to its central argument regarding the relationship between narrative, empathy, and ethical clinical practice; second, thematic coding of the reviewed literature according to the specific conceptual contribution each source primarily makes (critique of principlism, narrative competence, illness-narrative theory, empirical empathy measurement, or narrative humility/integration); and third, synthesis of these themes into an integrated conceptual framework, presented in Section 5, intended to represent the process by which narrative attention to the clinical encounter can inform and enrich ethically responsive care. As a conceptual review, this paper does not report statistical results, sample sizes, or effect sizes of its own; the “results” presented in the following

section constitute a thematic and conceptual synthesis of the reviewed literature rather than findings derived from original empirical data collection.

5. Results

The reviewed literature converges on five recurring, interrelated themes concerning the relationship between narrative medicine, empathy, and medical ethics. These themes are presented individually below and are then integrated into a single conceptual framework (Figure 1) and summarised comparatively in Table 1.

5.1 The Limits of Principlism: From Rules to Relationships

The reviewed literature consistently identifies a shared starting point: dissatisfaction with the sufficiency of the four-principle framework (Beauchamp & Childress, 2001) as a complete account of clinical moral reasoning. Critics within the narrative medicine tradition do not typically reject the four principles outright but argue that their application requires precisely the kind of contextual, particular, and relational understanding that narrative attention to the patient's story provides — a concern most explicitly addressed by the “narrative casuistry” proposal, which frames narrative engagement as a solution to the “specification problem” inherent in principle-based reasoning.

5.2 Narrative Medicine as Ethical Practice

Charon's (2006) tripartite framework of attention, representation, and affiliation reframes narrative competence itself as an ethical capacity rather than a mere communication technique. Close, disciplined attention to a patient's account; reflective representation of what has been absorbed (often through structured written reflection); and the affiliative bond this process cultivates between clinician and patient together constitute, in this framework, a mode of ethical practice grounded not in the application of external rules but in the cultivation of a particular kind of clinical relationship and attentiveness.

5.3 Illness Narratives and the Recovery of Patient Voice

Kleinman's (1988) distinction between disease and illness, and Frank's (1995) account of the ill person as a “wounded storyteller,” together establish the theoretical case that patients' own accounts of their suffering — rather than only the clinician's biomedical account of their disease — constitute an essential object of ethical attention. Both authors argue that the act of storytelling is itself therapeutically and ethically significant, allowing patients to reclaim a sense of coherence, agency, and connection to others that severe illness frequently disrupts.

5.4 Empathy as a Measurable and Contested Clinical Competency

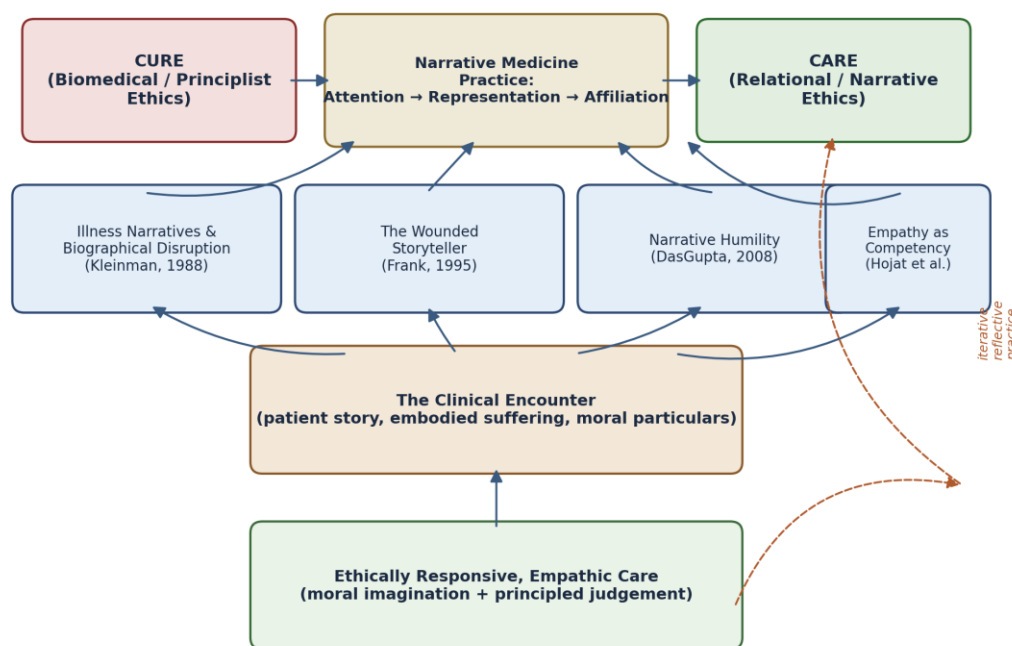
The empirical research programme initiated by Hojat and colleagues (2004, 2009) and subsequently synthesised by Neumann and colleagues (2011) establishes empathy as an object of rigorous, if contested, empirical measurement within medical education research. This body of work demonstrates that empathy

is not a fixed trait but a clinical competency that fluctuates — and, on the balance of the reviewed evidence, frequently declines — across the course of medical training, with important implications for how narrative medicine and humanistic pedagogy might be deployed as a corrective intervention.

5.5 Narrative Humility and the Integration of Perspectives

DasGupta's (2008) concept of narrative humility provides an important corrective to any overly confident reading of narrative medicine as a technique for fully “knowing” the patient's story, insisting instead on an orientation of ongoing openness, self-reflexivity, and acknowledgement of the clinician's own interpretive limitations — a stance of particular importance in cross-cultural and socially unequal clinical encounters. Recent work on the integration of digital tools with narrative medicine pedagogy further suggests that this combination of narrative competence and humility can be cultivated and reinforced through structured, technologically supported reflective practice, offering a scalable pathway for embedding these capacities within contemporary medical education.

Figure 1: Conceptual framework linking narrative medicine practice to ethically responsive, care-oriented clinical practice



Source: Author's conceptual synthesis, developed from the literature reviewed in Section 3.

As Figure 1 illustrates, the clinical encounter — the site of embodied suffering and moral particularity — is the shared point of departure for both cure-oriented, principlist reasoning and care-oriented, narrative reasoning. Narrative medicine practice, understood through Charon's triad of attention, representation, and affiliation, draws on and is informed by illness-narrative theory (Kleinman, Frank), narrative humility

(DasGupta), and empirical empathy research (Hojat and colleagues), and functions as the interpretive bridge between the two orientations, producing ethically responsive care that integrates moral imagination with principled judgement. The dashed feedback loop indicates that this is conceived as an iterative, reflective process rather than a one-directional pipeline: each clinical encounter, and the narrative and empathic engagement it calls for, in turn refines the clinician's capacity for future ethical attentiveness.

Table 1: Comparative summary of key contributions reviewed

Theme / Contribution	Key Source(s)	Core Argument	Relation to Principlist Ethics
Principlist foundation	Beauchamp & Childress (2001)	Four principles — autonomy, beneficence, non-maleficence, justice — as core moral framework	Baseline paradigm that narrative approaches engage critically, not wholesale rejection
Illness narrative theory	Kleinman (1988); Frank (1995)	Disease/illness distinction; storytelling as meaning-making and ethically significant act	Supplies the particular, biographical content principles alone cannot capture
Narrative medicine practice	Charon (2006)	Attention, representation, affiliation as core narrative competencies	Reframes narrative skill itself as an ethical, not merely communicative, capacity
Empirical empathy research	Hojat et al. (2004, 2009); Neumann et al. (2011)	Empathy is measurable and shown to decline across medical training	Identifies an empirical gap that narrative/humanistic pedagogy may help address
Narrative humility & integration	DasGupta (2008); recent narrative casuistry and digital-integration studies	Interpretive openness; hybrid narrative–principlist and technology-supported models	Proposes practical mechanisms for reconciling narrative and principle-based reasoning

Taken together, the thematic synthesis presented in this section indicates that narrative medicine and empathy research do not offer a wholesale replacement for principle-based medical ethics, but rather supply the interpretive, relational, and empirically grounded resources necessary to apply such principles with genuine attentiveness to the particular patient — a convergence that supports the paper's central

contention that medical ethics is best reimagined as an integration, rather than a simple substitution, of cure-oriented and care-oriented modes of reasoning.

6. Discussion

The thematic synthesis presented above points to a productive, if unresolved, tension running through the literature on narrative medicine and medical ethics. On one hand, the narrative medicine tradition offers a compelling corrective to the perceived abstraction and impersonality of principlist bioethics, insisting that ethical clinical practice requires genuine attention to the particular patient's story, embodied experience, and cultural context (Charon, 2006; Kleinman, 1988; Frank, 1995). On the other hand, an exclusive or uncritical embrace of narrative approaches risks its own difficulties: the particularity and interpretive openness that narrative humility (DasGupta, 2008) rightly demands can sit uneasily with the need for consistent, generalisable, and defensible ethical decision-making, particularly in high-stakes or resource-constrained clinical contexts where principlist reasoning continues to provide indispensable structure and accountability. A further significant tension concerns the teachability and measurability of empathy itself. The empirical research programme initiated by Hojat and colleagues has been valuable in demonstrating that empathy is not simply an innate trait but a competency responsive to educational and institutional conditions — and one that, troublingly, appears to decline rather than develop over the course of conventional medical training (Hojat et al., 2004, 2009). Yet this same body of research has also been contested on methodological grounds, with subsequent scholars questioning whether observed declines reflect genuine loss of empathic capacity or artefacts of self-report measurement, response bias, or the specific instruments used (Neumann et al., 2011). This methodological uncertainty has direct implications for how confidently narrative medicine interventions can be presented as an empirically validated remedy for empathy decline, as opposed to a plausible but not yet definitively proven pedagogical response.

A third implication concerns the practical integration of narrative approaches into contemporary healthcare systems characterised by significant time pressure, productivity metrics, and increasing reliance on electronic documentation. The narrative competencies Charon (2006) describes — sustained attention, reflective representation, affiliative engagement — require time and institutional support that many contemporary clinical environments do not readily afford. Recent scholarship examining the integration of digital tools with narrative medicine pedagogy suggests one promising avenue for addressing this constraint, using structured digital reflection and simulation to cultivate narrative competence more efficiently within existing training structures, though questions remain regarding whether digitally mediated narrative engagement can fully replicate the relational depth of unmediated clinical attention. Finally, this synthesis suggests that the most defensible path forward for medical ethics lies not in choosing between cure-oriented principlism and care-oriented narrative ethics, but in their disciplined integration — an approach exemplified by the “narrative casuistry” model, which explicitly uses narrative, contextually rich case analysis to inform, rather than replace, principle-based ethical reasoning. Such integration requires sustained institutional investment in narrative medicine training, careful further empirical study of its educational and clinical outcomes, and continued critical attention to

the practical constraints that contemporary healthcare delivery places on the time and relational depth that genuine narrative and empathic engagement demand.

7. Conclusion

This paper has offered a conceptual and critical review of how narrative medicine and empathy research invite a reimagining of contemporary medical ethics, from an orientation centred primarily on cure and abstract principle toward one that integrates care, narrative attentiveness, and empathic engagement with the patient's particular, embodied story. Drawing on the foundational contributions of Kleinman, Frank, Charon, DasGupta, and the empirical empathy-research programme of Hojat and colleagues, the paper has argued that narrative medicine does not seek to displace principlist bioethics but to supply the interpretive and relational resources through which its principles can be applied with genuine ethical attentiveness to the individual patient. As medical education and healthcare delivery continue to grapple with documented declines in trainee empathy and the depersonalising pressures of modern clinical practice, sustained attention to narrative competence, narrative humility, and their disciplined integration with principle-based reasoning will remain essential to the project of reimagining medicine as a practice of care, and not of cure alone.

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