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Journal of Interprofessional Care

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ijic20

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To cite this article: Marvin So, Emma Sedarski, Megan Parries & Brian Sick (2023): "Many people know nothing about us": narrative medicine applications at a student-run free clinic, Journal of Interprofessional Care, DOI: 10.1080/13561820.2023.2218885

To link to this article: https://doi.org/10.1080/13561820.2023.2218885

Published online: 09 Jun 2023.

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JOURNAL OF INTERPROFESSIONAL CARE
https://doi.org/10.1080/13561820.2023.2218885

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"Many people know nothing about us": narrative medicine applications at a student-run free clinic

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ABSTRACT

Narrative medicine is an approach to healthcare that acknowledges the stories of patients' lives both within and beyond the clinical setting. Narrative medicine has been increasingly recognized as a promising tool to support modern educational needs in health professions training, such as interprofessional practice, while enhancing quality of care. Here, we describe the development, implementation, and application of a narrative medicine program at the University of Minnesota Phillips Neighborhood Clinic. First, in a qualitative analysis of patient stories ($n = 12$) we identified themes regarding the value of the storytelling experience; patients' personal journeys; and patients' experiences in healthcare and other systems. Second, an interprofessional educational activity for student volunteers ($n = 57$) leveraging a patient narrative was observed to be satisfactory, significantly improve attitudes toward the underserved, and enhance quality of care from the perspectives of trainees. Together, findings from the two studies imply the potential benefits of broader incorporation of narrative medicine into interprofessional service settings, for both learners and patients.

ARTICLE HISTORY
Received 3 October 2022
Revised 18 May 2023
Accepted 19 May 2023

KEYWORDS
health and social care; interprofessional practice; mixed methods; narrative medicine; student-run free clinic; underserved communities

Introduction

Health professions students are typically trained according to established pedagogical approaches such as by organ system (e.g., cardiovascular), basic science (e.g., genetics), or clinical discipline (e.g., pharmacology; Finnerty et al., 2010; Vlasses, 2010). However these categorizations may not reflect how patients understand illness and injury. Instead, social science evidence suggests most people recount their interactions with health and healthcare as narrative experiences (Bury, 2001; Maitra & Verghese, 2021; Pierret, 2003; Williams, 1984). Kleinman (1988) described the illness experience as "a story the patient tells . . . to give coherence to the distinctive events and long-term course of suffering" (p. 49). Patients' experiences often integrate into a longitudinal, iterative journey spanning symptom experiences, help-seeking processes, care utilization, health behaviors, and coping mechanisms, all situated within a unique sociocultural and emotional context (Bury, 2001; Charon, 2012; Egnew, 2005; Pierret, 2003; Williams, 1984).

Overall, this framing is encapsulated in *narrative medicine*, an approach to considering patients, providers, and healthcare systems through the lens of story (Charon, 2012). (Of note, we use the term "narrative medicine" as it is the most often used in the literature, but acknowledge that the framework is applicable to all health professions including but not limited to Medical Laboratory Sciences, Medicine, Nursing, Nutrition, Occupational Therapy, Pharmacy, Physical Therapy, Social Work, and other professions.) Increasingly, narrative medicine and humanities-based approaches have been emphasized as a possible means to address challenges in health professions education (Fioretti et al., 2016; Milota et al., 2019; Ousager & Johannessen, 2010; Sklar, 2017). Desirable skills for the 21st century workforce may be attainable through educational activities leveraging patient stories, including cultural humility (DasGupta, 2007), interprofessional communication (Arntfield et al., 2013), systems-based practice (Pearson et al., 2008), anti-racism (Peek et al., 2020), self-care (Small et al., 2017), and empathy (Chen et al., 2017).

Given these data, some have suggested that narrative medicine – applied as an intervention, framework, or assessment tool – could fill key gaps in existing curricula (Arntfield et al., 2013; Kalitzkus & Matthiessen, 2009). Multiple commentaries have articulated the conceptual promise of narrative medicine (Charon, 2001, 2012; Mehl-Madrona, 2007; Solomon, 2008) while other literature highlights the physiologic and psychosocial benefits of storytelling for care providers and recipients (Brockington et al., 2021; Pennebaker, 1985; Stephens et al., 2010). Such approaches may prove especially useful as systems continue to progress toward interprofessional, collaborative care models to deliver high-quality care. For example, Sands and colleagues' (Sands et al., 2008) study of interprofessional healthcare workers on a hospital pediatric oncology unit found that participation in narrative training seminars yielded improvements in perspective taking and bolstered teamwork. Similarly, Small et al. (2017) observed that an interprofessional narrative medicine program at an academic children's hospital appeared to mitigate isolation for health care workers and build community across traditionally hierarchical and siloed structures. These

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prior studies have provided valuable information, but less available are insights on how health sciences educators and trainees might practically apply narrative medicine in community-based outpatient settings, where the majority of healthcare is delivered (Fioretti et al., 2016; Milota et al., 2019).

Student-run free clinics (SRFCs) are increasingly expanding as a model for trainees to develop patient care competencies, while simultaneously caring for underserved communities (Buchanan & Witlen, 2006; Smith et al., 2014; Suen et al., 2020). Through convening interprofessional trainees, faculty, and patients into reciprocally beneficial settings, SRFCs may also be an opportune site for narrative medicine (Ng et al., 2021). Here, we describe our innovative approach for (a) embedding narrative medicine principles into a SRFC, and (b) applying gathered stories for therapeutic, strategic, and educational purposes.

Background

The University of Minnesota's Phillips Neighborhood Clinic (PNC) is an interprofessional SRFC described in-depth elsewhere (Sick et al., 2014; So et al., 2022). Phillips is an ethnically diverse neighborhood of Minneapolis with both cultural strengths and significant socioeconomic challenges. It has historically served as home for several immigrant communities, and nearly 80% of residents are Black, indigenous, or people of color (Hugill, 2016; Pennington et al., 2020). The clinic is managed by a student Administrative Board and medical school faculty member, and provides free acute, primary, and specialty services without requiring insurance. Students are recruited from the university's health professions degree programs to serve in varied roles, including clinical, quality improvement, community health worker, and other roles (So et al., 2022). Prior research has shown that volunteering at the PNC can potentially safeguard trainees from prospective declines in interprofessional skills (Sick et al., 2014) and attitudes toward underserved populations (Sick et al., 2017).

Methods

Informed by the experiences of a local partner clinic (Pallai & Tran, 2019), the PNC student Administrative Board formed the narrative medicine project to better understand the lives of patients beyond standard patient satisfaction surveys. The project was deemed not human subjects research by the University of Minnesota Institutional Review Board. Below, we describe our process for implementing and applying narrative medicine interviews at the PNC.

Narrative medicine interview protocol

PNC volunteers were invited to participate as interviewers to gather patient narratives. Students could elect to apply the time spent working on the project toward community outreach hours required for all clinic volunteers. Participating volunteers were first oriented to the project via a one-hour meeting with the student leader, who articulated the goals of the project and outlined processes and procedures. A guide was also available to volunteers with logistical guidance and reminders for future reference (So, 2022).

Student volunteers recruited patients from the PNC waiting room by explaining the purpose of the project and asking for their consent. Patients had the option to participate in a storytelling session prior to their clinic visit, afterward, or while waiting for medications to be dispensed. Given that PNC services are provided by students under faculty supervision, there were numerous periods in which patients were waiting. Students then brought patients to a private room to allow for confidential storytelling. Student volunteers reviewed the consent form with the patient, emphasizing voluntariness, confidentiality, and ability to withdraw their story at any point. Consent was obtained with a signature on the form, and the student volunteer recorded necessary contact information for those patients who wished to review their stories after sharing. Patients could elect to have their stories shared with the general public or with only student volunteers at the PNC.

Next, student volunteers provided patients with an open-ended prompt to share specific experiences in their lives, in healthcare, or anything else that they wanted to share. During the interview, the student volunteer actively listened, offered reactions and probing questions, and helped the patient process the experience afterward by asking them how it was to share their experience verbally. Interviews were audio recorded, and patient participants received a $10.00 gift card for participation.

Student volunteers transcribed patient stories verbatim from audio recordings. While transcribing, identifying information was removed. Stories from Spanish-speaking patients were transcribed and translated to English as needed by a bilingual author (M.S.). Transcribed narratives were shared back with those patients who had requested to review their stories via e-mail or telephone call. Patients were given the opportunity to modify, add to, or redact anything they had said, thereby promoting ownership of their own story and supporting its face validity. After obtaining patient approval for each story, the transcribed and de-identified narratives were uploaded to a secure storage environment (Box, Inc., Redwood City, CA).

Study 1: thematic analysis of stories

The first use of gathered narratives was to qualitatively analyze interview transcripts for overarching themes. The purpose of this effort was to holistically understand patient experiences through identification of key themes raised in patients' narratives, thereby informing potential administrative, operational, or outreach efforts to better support the local community. Two authors (E.S. and M.P.) conducted an inductive thematic analysis, employing an immersion-crystallization approach (Borkan, 1999) to cyclically read text from a set of transcripts ($n = 12$), taking memos throughout. Independently, they generated overarching themes emerging from the data and used a framework matrix (Bernard & Ryan, 2010) to capture salient codes constituting proposed themes. As done elsewhere, salience was defined as those codes which emerged with relatively greater frequency and representation across respondents (So et al., 2020). The two authors then met to reconcile areas of

disagreement, and themes and codes were reviewed and confirmed by a third author (M.S.). Finally, a constant comparative approach was applied to ensure agreed-upon themes reflected primary data (Bernard & Ryan, 2010).

Study 2: interprofessional educational activity

The second application involved leveraging patient stories to enhance the training experience of PNC's student volunteers. In 2020, all volunteers participated in a mandatory educational session based on one patient narrative during orientation. Students read the narrative and subsequently engaged in an interprofessional discussion covering their reactions to the story; the patient's personal needs and strengths; and how they might support the patient both through their PNC role and future profession. The discussion was facilitated by one of the student leaders serving on the PNC administrative board. Student volunteers were assigned sequential numbers at the onset of orientation to optimize dispersal across groups, without too many students from their own program in the same group. Activity facilitators elicited participant responses with a focus on implications across profession types. For example, when asked to reflect on the patient's primary needs expressed in the narrative, and what services they might be afforded, facilitators emphasized how identified needs could best be addressed through a range of services (e.g., mental health conditions can be targeted by psychotherapy, medications, and occupational therapy interventions). Facilitators employed techniques such as reflecting, probing, and engaging less talkative participants to elicit diverse perspectives and allow participants to appreciate the capabilities of other professions to achieve common goals. See So (2022) for further detail on how the exercise was carried out.

To evaluate the educational session, we asked students to complete an anonymous, voluntary survey (Qualtrics XM, Seattle, WA; $n = 57$). Respondents were predominantly female and in the 23- to 28-year-old age group. Trainees in clinical medicine (28%) were most represented, followed by nursing (21%) and pharmacy (14%); additional details are in Table 2. Students' perceptions of the session were assessed using a modified version of the Health Professions Attitudes Towards the Homeless Inventory (HPATHI-M), a validated index described previously (Buck et al., 2005; Sick et al., 2017). We assessed HPATHI-M overall and by its three subscales (personal advocacy, social advocacy, cynicism), asking students to indicate their perceptions from before to after the session. Close-ended items were quantitatively analyzed using descriptive statistics and non-parametric Wilcoxon signed-rank tests given skewed samples. Open-ended items were analyzed using an inductive thematic analysis, consistent with Study 1's approach. Finally, authors developed a diagram to conceptually map themes and salient codes gleaned from Study 2.

Results

Study 1: thematic analysis of stories

The qualitative analysis yielded three primary themes, described with relevant codes below and in Table 1. All direct quotations presented herein are from the subset of narratives of patients that agreed to be publicly shared in an aggregate, non-identifiable, and anonymous format.

Storytelling experience

Unanimously, respondents expressed the therapeutic benefit of sharing their story. Interviewees cited the positive aspects of having someone to listen to them, a sense of gratitude, and the value of processing their emotions through verbal storytelling. As Patient #3 shared, "It was nice to talk about it, cause I never really talk about it. And because it is still painful that it occurred. The pain doesn't just go away." In addition, many respondents shared goals of how patient stories could be used, including their potential to help students acquire key skills such as patient-centered care and cultural humility for diverse populations (e.g., "By understanding our story, they see that there are so many good immigrants"). Meanwhile, others shared that stories could benefit the quality of services at PNC and the healthcare system overall.

Personal journey

The majority of respondents shared their origin stories and how they came to their current situation. Whereas some talked about their upbringing, others discussed personal struggles they have had with health or raising children. Some interviewees disclosed immigration narratives, which captured their reflections surrounding their migration by choice or forced displacement. These experiences were often highly emotional and left lasting impressions years later, as Patient #2 expressed, "I crossed the border when my daughter was only 11 months old. We couldn't cross the border together . . . I didn't want to leave her there, so young. . .When I was finally reunited with her, I felt complete . . . since then, I have not been able to separate from her again." Mental health challenges were also a common focus in patients' journeys; several had specific stories about living with and managing mental illnesses such as substance use, personality, and trauma disorders via psychotherapy and medications. In spite of their challenges, multiple respondents demonstrated resilience through adversity, continuously moving forward despite stressors related to poverty, violence, isolation, and illness. Resilience was fostered through "looking to [other local families] to build a community," joyful activities like art and dancing (e.g., "salsa, merengue, bachata"), and religion. Relatedly, a few individuals possessed a future orientation/motivation, such as a desire to realize economic stability for their family or derive meaning from struggles, as Patient #5 described, "I always saw myself doing something with my hands, making something or fixing something . . . maybe this is what I was called to do. Maybe I'm meant to fix people. To mentor people and help them get off drugs".

Experiences in healthcare and other systems

Interviewees discussed a range of experiences within varied institutions, particularly healthcare. Their experiences with the PNC were primarily positive, specifically the opportunity to access free healthcare and avoid lapses in needed therapies, such as when uninsured. Other positive attributes included health education received (e.g., "One girl here told me about

Table 1. Themes and exemplar quotations from narrative medicine interviews conducted with 12 patients receiving care at a student-run free clinic – Minneapolis, Minnesota, 2020.

Theme	Code	Example Quotations
Storytelling experience	Therapeutic benefit of sharing story	• "So I appreciate it when people listen and are just open to hearing what I have to say. Thanks for listening." – Patient #17 • "Making connections helps me feel more positive, because many people know nothing about us. And I liked it because I can say what I feel. I am saying many reasons why we feel trapped. The things that prevent us from advancing forward. But this way of speaking, of expressing myself. . .I feel like I'm flying." – Patient #2
	Goals of how stories can be used	• "I hope this helps them understand that not all of us are criminals or unemployed people. There are many people like us who are here because in our country, there is not an opportunity to live a better life. We see this country as an opportunity." – Patient #2 • "But it would be nice if there could just be an improvement in the overall medical system in the country. But I don't see that changing." – Patient #12
Personal journey	Origin stories	• "I grew up and was raised in Ecuador. There were no studies back then to help you with the ADD or any kind of traumas or personal problems. So if you didn't know how to cope with things, there was nobody to help you or offer you help. You learn to rely on yourself. When you grow up like that, you don't trust people that much, especially the people that are supposed to help you." – Patient #17 • "So I did my time, and I'm finally back in line with the law now. If that hadn't happened, I would probably be dead by now from overdose or some other result. But since this all happened, I realized that I didn't want this kind of life." – Patient #5
	Immigration narratives	• "The culture there is different there. As a woman, once you have married, you no longer have the opportunity to go out, speak with your friends. . . It's like you are isolated from everything. You have to work in the house, care for the children and your husband, cook, and sleep, nothing more. It's always the same and I didn't want this for my life. I wanted to be able to visit my sisters. . .In the US, at least I can work and contribute." – Patient #2 • "I teach my children the importance of our roots, because they don't know their grandparents. We can't return to visit them. So, I tell them all about my town, our family, and explain how life there is so different from here." – Patient #7
	Mental health challenges	• "When I am doing something it's a problem when I am trying to concentrate because of the ADD, it's hard. Plus the schizoid personality sometimes contradict each other, sometimes I'm a little bothered in my head. You know, when you are younger nobody tells you anything and you try to figure out things on your own and then when things get messed up because you haven't experienced them. Then, when you try to talk to people, the words don't come out the way they are supposed to and people misunderstand you." – Patient #10 • "It's just interesting, life – what it gives you, what it doesn't give you. I have alcoholism in my family too, so I went to Al Anon for a number of years and I have learned to accept what is and make the best of it. I have learned in therapy over the years to love myself." – Patient #15
	Resilience through adversity	• "There is a large mural on [1st Street name] and [2nd Street name] that the church helped with. Before it was a wall that was always covered with graffiti, but since we have made it into art, they never cover it with graffiti. Before, people would put graffiti on all of the garages in the area. But the church started painting some garages, and now they don't put graffiti on them anymore. There is something good in art. People see it as beautiful and don't want to destroy it. – Patient #2 • "I actually thought of that beautiful room in the basement (of PNC) that has that wood floor, where all the healthcare workers are tonight. The big spacious room with the beautiful wood floor. I thought of trying to find a dance partner and asking if we can go in there for an hour. Just put on some music on the phone and dance in a huge mini ballroom by ourselves." – Patient #15
	Future orientation/ motivation	• "[My son] tells me, 'I don't like to live here because a lot of bad things happen here.' I respond by saying that in life there are many bad things, but we have to choose a good path for ourselves." – Patient #7 • "When my daughter graduated, I was so proud. We have lived through so many difficulties, but we always try to see the good in everything. Because we know that this isn't our country. We are here for a better opportunity for our children." – Patient #2
Experiences in healthcare and other systems	Experiences with the PNC	• "I am so thankful to be able to have medical care because I do not have insurance at this time. I am working but I cannot afford health insurance. Without it I am unable to get medical care." – Patient #8 • "I think the wait here is way too long, but so what. To get services, especially to pick up meds takes a while." – Patient #3
	Discrimination based on race/ethnicity	• "He unfortunately was treated by the nurses, being that he was a man of color, he was a Black man . . . .it does cause you to feel nervous as a person of color to go into the hospital." – Patient #16 • "I have always been attentive to my daughter, but have always found barriers put up to prevent us from advancing. I find that they put us to the side. . .It seems like they have an expectation that Latinos don't graduate." – Patient #2
	Discrimination based on class	• "They tend to not treat uninsured patients all that well, either. You'd think if they knew you were paying out of pocket, they would treat you the same. I had to go see a specialist the other day and it was like $500 for the visit. And the guy shuffled me in and out the door in like 15 minutes and I was like 'I paid $500 for that?'" – Patient #12 • "People get so snotty, and so middle-or-upper class. They treat others terribly while they are living the life of luxury. . .I don't have any more respect for the government." – Patient #3
	Distrust or fear of institutions	• "We know that getting into a small problem with the police can become a huge problem since we are immigrants. Because of that, we feel safer if the police are not around. Simply walking through the street makes us nervous." – Patient #5 • "They took my house, and then they fined me and fined me and fined me, so that I am now up to $40,000 in debt. How could the city get away with stealing my building? If a kid on the street steals my wallet, he is a criminal, but if the government takes my house and my livelihood, how are they not a criminal?" – Patient #3

(*Continued*)

Table 1. (Continued).

Theme	Code	Example Quotations
	Systemic healthcare challenges	• "My other doctor, she listens but because they have more patients, they cannot give you all the time. Plus, you have to wait for appointments and everything and everyone is saturated. Over here, people are more trying to listen." – Patient #17 • "They shuffle you around from one doctor to another, from one specialist to another, and it's hard to find someone to quarterback your whole medical situation . . . That's the thing – there's a lot of gaps in care. Wherever you go, they don't have your back story. They can't just look it up and have your medical history right at the tips of their fingers." – Patient #15

Table 2. Volunteer attitudes toward underserved populations from before to after participating in a patient narrative medicine educational session within a student-run free clinic, by demographic characteristics – Minneapolis, Minnesota, 2020.

			HPATHI-M Score				
			Pre-Intervention		Post-Intervention		
Characteristic	*n*	%	Mean	SD	Mean	SD	*p*-value
Gender[a]							
Female	47	83.93	4.38	0.30	4.52	0.26	<0.01
Male	8	14.29	4.36	0.32	4.52	0.26	0.04
Age[a]							
18–22	20	35.71	4.37	0.32	4.54	0.26	<0.01
23–28	29	51.79	4.38	0.30	4.52	0.26	<0.01
29+	7	12.50	4.38	0.30	4.54	0.27	<0.01
Degree program [b]							
Medical Laboratory Sciences	2	3.51	4.54	0.23	4.70	0.13	†
Medicine	16	28.07	4.39	0.30	4.53	0.26	<0.01
Nursing (bachelors and masters)	12	21.05	4.36	0.30	4.50	0.27	<0.01
Occupational Therapy	4	7.02	4.40	0.31	4.54	0.23	0.11
Pharmacy	8	14.04	4.37	0.29	4.50	0.26	0.04
Physical Therapy	7	12.28	4.40	0.29	4.52	0.26	0.07
Public Health: Healthcare Administration	3	5.26	4.41	0.30	4.52	0.26	0.29
Public Health: Nutrition	2	3.51	4.39	0.32	4.51	0.30	†
Public Health: Other	3	5.26	4.39	0.30	4.51	0.27	0.26
Overall	57	100.00	4.36	0.32	4.52	0.26	<0.01

Notes..
HPATHI-M: Health Professions Attitudes Towards the Homeless Inventory – Modified.
[a]Total does not sum to 57 as some respondents had missing data for this item.
[b]Although PNC does have social work volunteers, there were no survey responses from this profession available to analyze.
*Significant pre-post difference for this group ($p < .05$).
†Insufficient sample size available to calculate Wilcoxon signed-rank test.

[white rice]"), effective interpreters, "convenience", and empathetic care. A few patients cited the clinic's wait times as an aspect for improvement, though this was balanced with a recognition that "It is free. As a patient, you have to be patient." Additionally, some interviewees endorsed experiences with discrimination based on race/ethnicity and class in multiple institutions, which left them feeling misunderstood or undervalued. Racially or ethnically discriminatory experiences were cited in education, such as lower expectations for students of color, and healthcare, such as dismissive interpreters (e.g., "They make us feel like we are uneducated and have accents"). Others noted feeling judged or receiving lower quality of services based on their class identities, such as educational, insurance, or immigration status. Such experiences left several interviewees with views on systemic healthcare challenges, including a lack of coordinated care and the system's innate contradictions, such as disincentives to purchase medical insurance when otherwise healthy. Other people spoke to their distrust or fear of institutions, particularly government bodies such as police, housing, immigration enforcement, and public health authorities.

Study 2: interprofessional educational activity

Quantitative responses

Ninety-three percent of volunteers reported the exercise was of good/very good quality. Eighty-nine percent agreed or strongly agreed that the clinic should incorporate more narrative medicine activities into PNC's educational offerings. Students' average HPATHI-M score significantly improved from before to after the session (Table 2); improvements persisted regardless of gender or age group. All student groups demonstrated absolute pre-post increases in HPATHI-M, although the increase was only significant for Medicine, Nursing, and Pharmacy students. Item-specific analyses significantly improved for 13 of 19 items, although all 19 changed in the expected direction (see Online Supplement). 5 of 6 social advocacy, 4 of 9 personal advocacy, and 4 of 4 cynicism items significantly improved from pre- to post-exercise.

Qualitative responses

Participants' open-ended responses coalesced in three overarching themes, depicted in Table 3. Specifically, students

Table 3. Themes and exemplar quotes of health professions students' perspectives after participating in a patient narrative medicine educational session within a student-run free clinic – Minneapolis, Minnesota, 2020.

Theme	Code	Example Quotes
Background	No previous experience	"I don't have prior experiences"
	General, domestic exposure through work experiences	"I previously worked in a pharmacy that served quite a few people on Medicaid and patients who were immigrants from Somalia. I do not have a lot of experience with language barriers but am willing to learn."
	Working/volunteering in outpatient clinic	"Resource Navigator for [Name] Health Clinic in Minneapolis for 1 year. I helped connect patients who were facing barriers to achieving good health and quality of life to resources in the community and checked up on them weekly."
	International healthcare experiences	"I have volunteered at a malnutrition center in Guatemala for a week in [year]. I also shadowed in various clinics in Ecuador for two weeks in [year]."
	Working/volunteering in an emergency department	"I have worked at [Name] Hospital for over a year and I encounter underserved and underinsured patients every day. It is quite common for us to encounter these populations of people because they need care."
Influence on students	Helpful to hear and work with interprofessional perspectives	"It was a great reminder for me of the importance of working interprofessionally. Students with other medical backgrounds from me approached it very differently, and it was a relief to see that other people knew how to address problems I did not – as a team, we could meet the various needs of the patient."
	Value of listening to patient story	"It was amazing to hear the story the patient told and it reminded me that it's so easy to judge people but if you get to know them and build a relationship you can better understand where they are coming from."
	Considering patient beyond diagnosis or chief complaint	"What impacted me the most after participating in the narrative discussion was seeing how the underserved community has so much going on outside of just not having adequate access to healthcare. As healthcare professionals, it's often easy to see your patient as just their diagnosis, but it's extremely important to take a step back and understand that your patients are so much more complex than that."
	Challenging preconceptions	"It really opened my eyes to the type of people we could potentially interact with. I've only heard stories of what its like to work with underserved people, but reading the story and learning it was a real patient is something completely different from what we hear about."
	Preparation for clinic expectations/ encounters	"It really opened my eyes to the type of people we could potentially interact with. I've only heard stories of what its [sic] like to work with underserved people, but reading the story and learning it was a real patient is something completely different from what we hear about."
	Inspiring/moving/touching	"I was touched by the story and I was surprised with how honest the patient was about their situation. I am not sure how I would react in the actual situation and being prepared for difficult conversations like this will help me better serve my patients."
	Considering community resources that could be offered	"When I first read the case on my own I didn't think there was much the clinic could do for this patient, he wanted to tell a story, we could listen but other than that I didn't know what I would have done. Hearing my group dive into some of the more underlying issues that this patient was dealing with and requesting ways to help them or at least refer them to somewhere else was very eye opening and honestly pretty inspiring. This allowed me to see more and make suggestions as well on the fly that I didn't know I had before working together."
Influence on care	Greater consideration and desire to learn about patients' lives	"I think this will really help me respect every patient I encounter and take them as they are. All of their experiences – from housing, poverty, to violence – contribute to their health story and it is important for me to take into consideration each of these experiences."
	Improved quality of care (generally)	"I think that it will enhance PNC's ability to work with all patient populations."
	Empathetic, non-judgmental, respectful care	"I think this case provided a very vivid image of some of the struggles underserved patients face mentally and physically. It will remind me to be compassionate and empathetic toward patients' experiences in the PNC. I also learned that some patients might be in really tough places in their personal lives and I should never make any assumptions or judgment about their lives."
	Will remember this story in providing care	"This will be at the top of my mind whenever I'm interacting with a patient at PNC. Especially being a receptionist, I am going to be the first person they interact with, and I want to be as open and inviting as I can be to ensure the patient feels welcome and taken care of while they are at the PNC."

reported a range of work and volunteer experiences; notably, many had no prior experience with underserved populations. Volunteers reported that the educational session affected them personally, particularly the value of listening to patients' stories, and hearing from interprofessional perspectives. Finally, respondents described how care at the PNC would be influenced following the exercise, including that: they would personally provide more empathetic, non-judgmental, and respectful care; organizational care quality would improve; and clinic staff would be more willing to learn about patients' lives, including social determinants of health, and incorporate such information into care plans (Figure 1).

Discussion

In the context of growing interest in narrative medicine within health professions education (Fioretti et al., 2016; Milota et al., 2019; Ousager & Johannessen, 2010), this paper presents two tangible applications from an urban SRFC. Thematic analysis offered valuable information regarding patients' experiences and needs in a manner distinct from clinical history-taking. These insights have and continue to inform adjustments to clinic strategic and operational planning. For example, thematic findings were used to spur initial ideas for quality improvement initiatives, such as better addressing mental

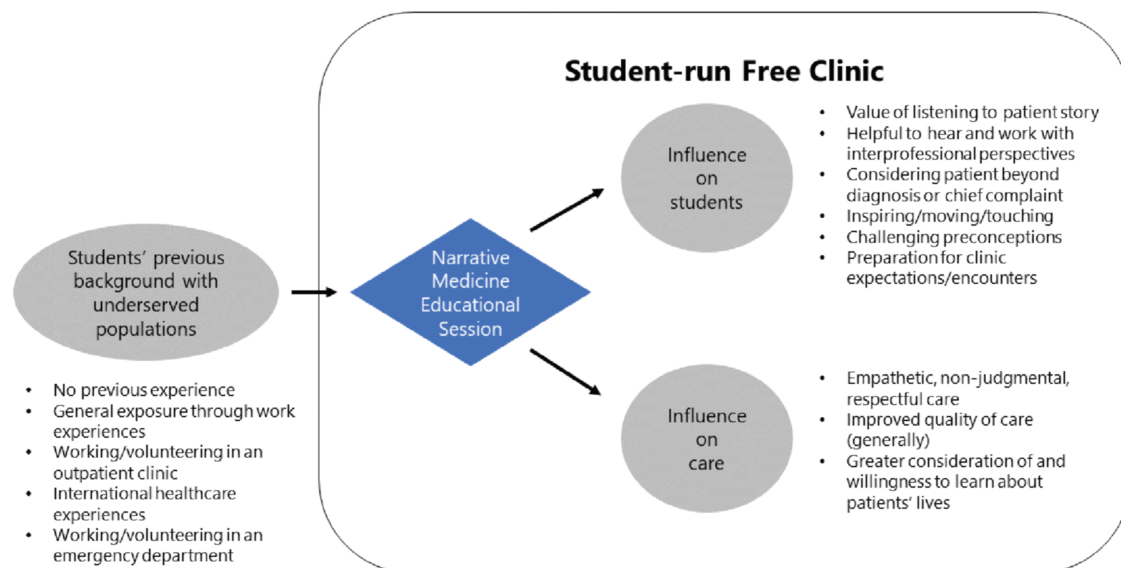

Figure 1. Conceptual diagram depicting primary themes and sub-themes of health professions students' perspectives after participating in a patient narrative medicine educational session within a student-run free clinic – Minneapolis, Minnesota, 2020. Primary themes are depicted in ovals. Bullet points associated with each circle reflect codes that emerged with high salience (i.e., relatively high frequency and representation across respondents with convergence across independent coders) from survey respondents ($n = 57$). Codes are presented in order of relative salience. One code each from the "Influence on students" and "Influence on care" themes were not highly salient and are therefore not represented in this diagram (see Table 3).

health issues and enhancing the clinic's referral protocols (Murphy & Millares, 2020). Stories were employed to emotionally and strategically ground the intentions of the PNC's Community Advisory Board before periodic meetings (see So et al., 2022 for more information). Finally, student leaders have incorporated patient stories into cultural humility trainings for volunteers, particularly considering the theme of discrimination that surfaced in interviews.

Further, by centering patient stories within volunteer's initial training, we observed their potential to facilitate acquisition of desirable outcomes for future healthcare workers, including attitudes toward the underserved and holistic consideration of patients' lived experiences. Of note, although we observed this significant relationship at the aggregate level in Study 2, it generally did not persist across profession types. The non-significant findings for certain health professions categories may be due to small subsamples precluding our ability to detect effects. Although several researchers have suggested the possible benefits for varied health professions (Gang & Gang, 2023; Small et al., 2017) – including our own salient theme that participants appreciated the opportunity to hear from viewpoints and expertise across others' disciplines – additional study is warranted to explore how narrative medicine educational activities may best serve all learners.

Overall, these insights merge bodies of research characterizing SRFCs as "transformative learning" spaces whereby key attitudinal and practice shifts are realized through authentic patient interactions (Huang et al., 2021; Ng et al., 2021) alongside literature demonstrating stories' ability to foster empathy for people unlike oneself (Bal et al., 2013; Charon, 2001). Because SRFCs often maintain dual missions to both patient populations and students, findings suggest SRFCs and other academic-community partnerships can benefit from integrating narrative medicine into training and service offerings.

Limitations

Despite this report's novel contribution, its limitations should be considered. First, our findings reflect only a small sample of trainees and patients, and additional work is needed to further clarify the value of narrative medicine interviews within SRFCs. Second, both trainees and patients may have been influenced by possible social desirability bias, given that both groups stand to gain from positive interactions at the SRFCs. Additional, more rigorous study designs can help ascertain whether narrative medicine-mediated changes translate to patient and community health improvements or trainee practice outcomes (Fioretti et al., 2016; Milota et al., 2019). Finally, we note that the HPATHI-M instrument has not been empirically tested as a valid adaptation of the original HPATHI, which focused on learners' attitudes toward individuals experiencing homelessness (Buck et al., 2005). Although the only modification made for the HPATHI-M was to replace the word "homeless" with "underserved" in each item, we cannot truly understand the implications of this change for the instrument's construct validity without further assessment (Sick et al., 2017).

Conclusion

This report offers an initial window into how SRFCs can practically leverage narrative medicine and promising evidence for student and patient benefits. Interprofessional service settings such as SRFCs are uniquely positioned to uplift the voices of an often underrecognized member of care teams – the patient themselves. As healthcare contends with complex issues such as provider shortages (Casapulla, 2021; Ng et al., 2021), burnout (Olson et al., 2019; Small et al., 2017) and health disparities (Burgess et al., 2019; Peek et al., 2020), narrative medicine is well positioned to play a growing role.

Acknowledgments

First and foremost, we thank the patients who honestly and bravely shared their stories. We also thank Riley Swenson, Zelda Blair, Emily Fjeldstad, Krystal Heinen, and Mary (Ellie) Krienke for gathering stories; and Nancy Baker and David Power for early guidance in shaping the project. We acknowledge the support of the University of Minnesota Medical School's Center for the Art of Medicine and Paulson Community Enrichment Program, and Association for Prevention Teaching and Research's Paul Ambrose Scholars Program.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

The work was supported by the Association of Prevention Teaching and Research; the University of Minnesota

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