

Elaborating, sharing, narrating: a narrative analysis of three approaches to health communication

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Elaborar, compartir, narrar: un análisis narrativo de tres abordajes de comunicación en salud (resumen: p. 16)

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Abstract

Communication, despite being considered a key aspect in medical practice, has not received the corresponding attention both on literature and medical training as has the technological and biomedical aspects. As a reaction to this context emerged fields of knowledge proposing to reflect and strengthen aspects of communication between the physician and the patient. In this article, we perform a narrative analysis of the literature of three of such approaches to communication in health: the Balint Groups, the Patient Centered Care and Narrative-Based Medicine. The study highlights the approximations and distances between these approaches, along with the recognition of the potency of each of them in the different contexts of medical practice.

Keyword: Communication. Patient centered care. Balint groups. Narrative medicine.



Introduction

The communication skill has been considered a key clinical competence. The medical-therapeutic encounter starts from an asymmetric relationship in which someone, who is in a professional position, is sought out to offer care to someone else who, many times, is in a fragile condition. Before this meeting actually takes place, there is already a setting conditioned by cultural and social expectations operating unconsciously over the characters.

The professional may use different conversation techniques as able tools to influence the doctor-patient relationship, changing the pragmatic dimension of the encounter. According to Teixeira¹, the substance of health work - as “live work in act” - is conversation:

The great advantage we see in admitting that conversation is the very substance of health work is the recognition that one acts on an object, from the beginning, shared, worked on together, in a more or less symmetrical way. It is only as matter necessarily worked on by all the actors present in the conversation that it takes shape¹. (p. 98)

Contemporary medicine has undergone significant scientific-technological advances in recent decades, with a growing valorization and improvement of techniques, while the problems associated with communication in the doctor-patient relationship have not gained as much prominence, having been, to a certain degree, marginalized, especially with regard to the insertion of this theme in the doctor’s training^{2,3}. Even so, in response to these problems, we have seen the emergence of new approaches that seek to rethink, expand and strengthen aspects of communication between the physician and the patient, and that have become part, albeit in a limited way, of the pedagogical processes of medical education.

In the present article, we carry out a narrative analysis, presenting and comparing three important communicational approaches to the doctor-patient relationship, selected for fulfilling the following attributes: significant international expression; considerable degree of formalization, and the constitution of training schools and groups.

Development

Balint groups

Michel Balint (1896-1970), a Hungarian physician and psychoanalyst, practiced at the Tavistock Clinic in London and, in collaboration with his wife, Enid Balint (1903-1994), an English economist, developed groups composed of General Practitioners (GPs) - from the then newly launched NHS, the English National Health System - so that they could broaden their understanding of the doctor-patient relationship as a tool to provide better care⁴. He synthesized his observations in a book released in 1957: “The Doctor, His Patient, and Illness”⁵.



For Balint, the groups should be directed to general practitioners, not to specialists. In addition, he gave preference to more experienced physicians, and not to students, because he valued the fact that the former had already gone through challenging times⁵.

Balint pointed out that a large part of the daily life of a general practitioner involves cases in which the psychological dimension is very present. Even in clinical cases where this dimension is not evident, it operates in the doctor-patient relationship. Balint calls the ability to manage this dimension “psychotherapeutic ability”. And, for him, medical training is very theoretical in relation to this issue, which does not do without direct experience, practice, and the acquisition of this ability consists in the transformation of the physician’s personality, of his subjective perspective of the world⁵. This view shows how current and relevant Balint’s ideas continue to be, since this gap in the approach of the psychological dimension in medical education, even after so many decades, is still perpetuated^{2,3}.

Although Balint officially graduated in psychoanalysis in Berlin, the cradle of his psychoanalytic training was Budapest, where he founded a psychoanalytic clinic, the Mészáros u. 12, the site for frequent meetings and conferences among experienced analysts, stressing the debates regarding counter-transference. Thus, Balint based his practice on the Hungarian supervision method, in which there is no separation between the personal analysis of the professional and the psychoanalytic supervision of the cases he attends. Therefore, the handling of the transference and countertransference phenomena is carried out by the same professional who accompanies the patient in his psychotherapeutic process, unlike the Berlin psychoanalytic system - which constitutes the most consecrated form - in which personal analysis and supervision of the cases attended to are conducted by different professionals⁶.

Enid and Michel Balint’s first training scheme was at the Centre for Family Studies in London with social workers who were dealing with their clients’ marital problems. Balint created strategies so that all the countertransference of these professionals could emerge as freely as possible. Therefore, no written material was admitted to the meetings⁵.

The social worker had to report freely about his experience with the client, something very similar to the “free association” (psychoanalytic technique that had some influence in the groups), allowing all kinds of subjective distortions, omissions and reflections. Then this report was interpreted in a similar way to the content manifested in the dream, and from there we tried to infer the dynamic factors that shaped it. Both the reflections of the reporter and the comments of the listener group were taken as a kind of free association⁵.

This dynamic also began to be developed among general practitioners: the patient was described without an effort to edit or censor any of the content. Thus, thoughts and ideas that could potentially be suppressed could emerge. The most important material to be examined was the doctor’s countertransference, that is, the effect produced in the relationship by his personality, his scientific convictions and his automatic reaction patterns⁵.

The backbone of Balint’s plan is the weekly conference in which cases are discussed with approximately eight people and a leader. The role of the trained group leaders is to: facilitate the process; maintain a respectful environment, guaranteeing



confidentiality; avoid judgments, thus allowing the presenter to express feelings of any nature; guide the discussion, ensuring that both patient and caregiver receive the proper attention⁴.

As already explained, the purpose of the meetings is to help physicians acquire greater sensitivity to the process that takes place, consciously or unconsciously, in the mind of the patient and the physician, when the physician and the patient are together. There has been great difficulty in getting physicians to adopt this type of approach, since the collection of clinical history revolves almost exclusively around objective facts, when those that matter in this process are of a subjective nature. For the author, these facts are only partly intelligent adaptations to the ever-changing milieu. For the most part, they are governed by quasi-automatic guidelines, originating mainly in childhood and influenced by the emotional experiences of later life. Balint's goal was to make doctors aware of these automatic patterns and their influence on the patients, their relationships with other people, and especially with their doctors⁵.

The author points out that there are also automatic patterns that have an influence on the physician's behavior in his relationship with the patient. The interaction of these two sets of patterns determines, to a great extent, the effectiveness of any treatment, especially in chronic diseases. Thus, the physician must become aware of his own automatic patterns and gradually acquire greater freedom in relation to them⁵.

Some categories of analysis that underlie his theory have been proposed, "physician as medicine" being the best known. According to Balint, the most frequently used medicine in general practice is the doctor himself, and there is still no study about this important substance. There is no handbook indicating what dosage the doctor should prescribe of her/himself, in what presentation and posology. Above all, there would be no reference to the possible risks of this type of medication and undesirable side effects of the substance⁵.

The "medication" function is related to the transference and counter-transference that occurs between the professional and the person being treated. According to the transference theory, we bring to each of our interpersonal encounters our hidden history of desires, fears, and psychic traumas. For Freud, the unconscious has the power to influence our perceptions of each other and our reactions to each other both in therapy and in life. He also draws attention to the possibility for the analyst to handle the patient's transference as a tool for the development of his or her own healing⁷.

A study called "Balint training makes GPs perform better at work"⁸ indicated greater work-related satisfaction and better patient-physician relationships among clinicians who had participated in Balint groups. They reported feeling less uncomfortable with patients presenting with psychosomatic symptoms, less likely to refer patients or order tests unnecessarily to end the consultation earlier.

Michael Balint passed away in 1970; however, his practice has not been extinguished, it is still current and timely, and his legacy has gained global proportions, which can be proven by the International Balint Federation^(c), with more than 40 years of existence and at least 23 national societies in several countries. Its groups, pioneered in the Tavistok Clinic 60 years ago, have been used in undergraduate, graduate, PHC units and several other settings where the doctor-patient relationship is present. There

^(c) Available in: <https://www.balintinternational.com>



are also some experiences of online Balint Groups, to make possible the participation of people who live in cities where there are no face-to-face groups. Thus, they constitute the most durable supervision model for family physicians.

Patient-Centered Clinical Method

The patient-centered clinical method (PCCM) emerged in the Department of Family Medicine at the University of Western Ontario, founded in 1968. Ian R. McWhinney, the first head of this department, began to study the real reason why a person goes to the doctor, which triggered investigations into the range of physical, social, and psychological problems of individuals. His supervisor, epidemiologist Moira Stewart, decided to follow a similarly focused path, basing her doctoral research on the relationship between the person seeking care and the physician⁹.

Although this model was developed in the context of family medicine, it can be applied by professionals from all medical disciplines and other health areas such as nursing, social work, physical therapy, and occupational therapy.

The term “patient-centered medicine” was created by Balint to contrast with “disease-centered medicine”, a fact that evidences the strong ascendancy that the author represented for the method. Among the influences that the PCCM suffered, besides Balint, are the works of Karl Rogers¹⁰ on client-centered counseling, very present in some counseling materials on STI/AIDS from the Ministry of Health, which is an active and client-centered listening process - and not patient, a term that, for the author, denotes passivity - which presupposes “the rescue of the inner resources of the person assisted so that he/she has the possibility of recognizing him/herself as the subject of his/her own transformation”¹⁰ (p. 79).

Rogers’ theory is characterized by two aspects: unconditional positive regard (the physician will have to accept patients the way they are, even if he doesn’t agree with their behavior, opinions, and feelings, which implies respect and otherness in relation to patients) and empathy, described by the author as follows

Experiencing the client’s private world as if it were your own, but without ever losing the quality of “as if” - this is empathy and seems essential to therapy. To feel the client’s anger, fear, or confusion as if they were your own, yet without allowing your anger, fear, or confusion to clash with them, is the condition we are trying to describe¹¹. (p. 49)

Also influential on PCCM were the studies by Newman and Young¹² on the whole person approach - in which the authors set out the view that nursing should consider all dimensions of the person, facilitating the achievement of a maximum level of well-being.

The authors believe that⁹:

This proposal for care presupposes several changes in the mindset of the physician. First, the hierarchical notion that the professional is in charge and that the person seeking care is passive is not supported in this approach. To



be patient-centered, the physician needs to be able to empower the person, to share the power in the relationship, which means relinquishing the control that traditionally lies in his or her hands. This is the moral imperative of patient-centered practice. In realizing this shift in values, the physician will experience the new directions that the relationship can take when power is shared. Second, maintaining an always objective position toward people produces an insensitivity to human suffering that is unacceptable. Being patient-centered requires a balance between the subjective and the objective, in an encounter between mind and body⁹. (p. 4)

According to Stewart¹³:

Having observed a practice that considers the individual as a whole, I have thought about the various elements it requires. One is the physician's openness to learning about all dimensions of a patient's problems. Another is a willingness to meet the patient on an emotional level, not only to understand their problems, but also to facilitate the healing of the whole person. I have learned, therefore, that this way of being a doctor requires involvement on both the cognitive level (the doctor will learn more about the patient) and the emotional level (the doctor will feel the patient's pain and suffering), but also exploring the doctor's intuition, the creative side, which brings together complex webs of different types of information (cognitive, emotional, and intuitive) into a new and deep insight, not in isolation, but in communion with the patient. The team of GPs I work with believe that practicing healing medicine involves a change of heart as well as a change of mindset¹³. (p. 793)

The four components of PCCM are described in the following frame:

Frame 1. The four interactive components of the patient-centered clinical method.

1. Exploring Health, Illness, and the Experience of Illness:
 - Personal and unique health perceptions and experience (meaning and aspirations)
 - History, physical examination, complementary tests
 - Dimensions of the illness experience (feelings, ideas, effects on functioning, and expectations)
2. Understanding the person as a Whole:
 - The person (e.g., life history, personal and developmental issues)
 - The immediate context (e.g., family, work, social support)
 - The broader context (e.g., culture, community, ecosystem)
3. Developing a Joint Problem Management Plan:
 - Problems and priorities
 - Treatment and/or management goals
 - Roles of the person and the clinician
4. Intensifying the Relationship between the Person and the Physician:
 - Compassion and empathy
 - Power
 - Healing and hope
 - Self-knowledge and practical wisdom
 - Transference and countertransference

Source: Stewart M, et al.⁹ (p. 7).

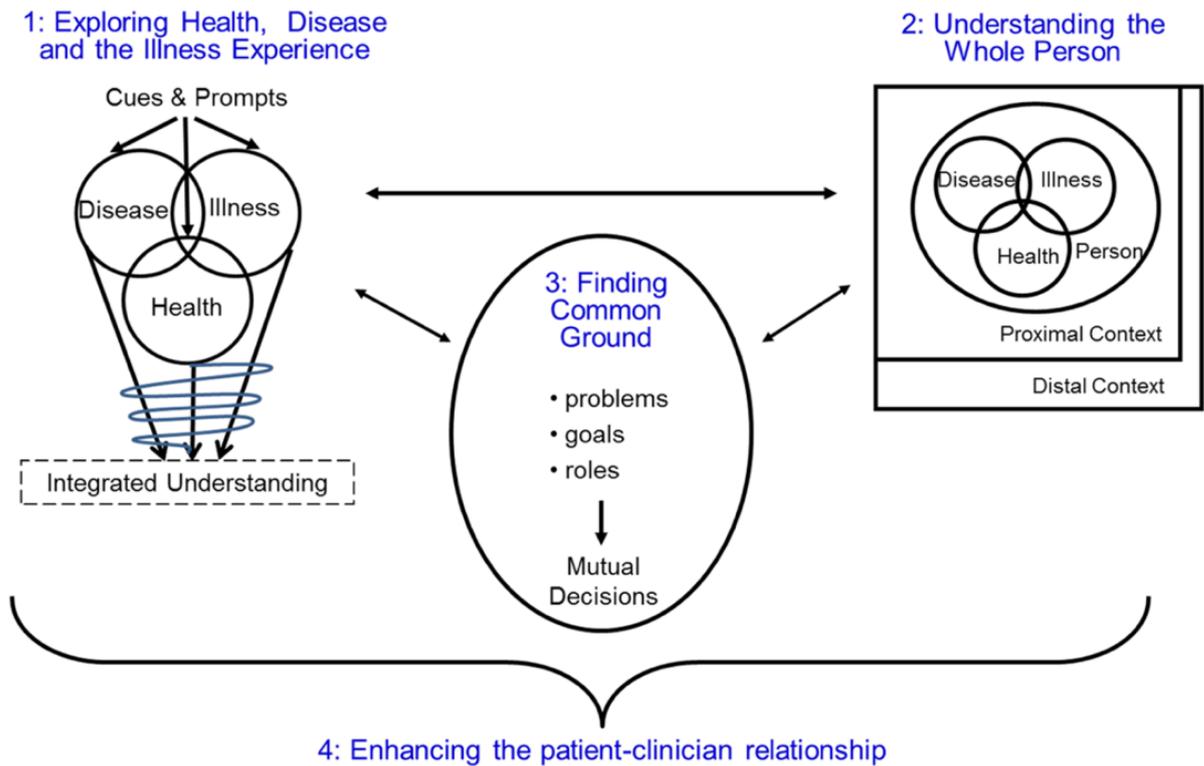


Figure 1. The patient-centered clinical method: four interactive components⁹.

Source: Stewart M, et al.⁹

The third component of the method, which constitutes the task of finding common ground - of the physician and the person being cared for - was considered by Moira Stewart the most important in predicting positive outcomes¹⁴ for the patients and, therefore, has currently achieved great prominence, constituting a central task of patient-centered medicine¹³.

The fourth component highlights the importance of the development of the subjective dimension of the professional - self-awareness and the recognition of the unconscious aspects of the relationship as transference and countertransference, among other points - on which we can observe the influence of the works by Rogers and Balint, whose works are decades old and still relevant, considering the insufficient space reserved for the discussion of the aspects referring to the several ways in which the doctor-patient relationship occurs in the context of medical care in Brazil, especially in medical education¹⁵.

In the same vein, Ruiz-Moral, in his 2007 article - many years after the publication of Balint and Rogers' works, but that sheds light on the same issues addressed by these authors - "Doctor-patient relationship: challenges for the education of health professionals"³, discusses the value of mastering the doctor-patient relationship and its implications for medical education:

Evidently, this development of Clinical Communication or Clinical Relationship (CR) in the care setting has been accompanied by a



development in the field of medical education, which, however, although increasingly widespread, is still deficient in view of the importance that CR has within clinical practice. The reasons for this delay in teaching CR are related, among other factors, to the difficulty in combining appropriate and effective teaching strategies, but also to the excessive weight that biomedical approaches have in the teaching of medicine in our universities [...] CR [...] opens a new door in education and is one that aims to consider the professional himself as an object of study and attention, aspects of self-knowledge and personal growth of the physician as a fundamental part of medical education³. (p. 621)

There are studies that indicate that among the benefits of PCCM for physicians are job satisfaction, better use of time¹⁶ and fewer complaints from patients. Patients, according to some studies, feel more satisfied with the method^{17,18}.

For the authors of the method, care implies that the physician is integrally present and engaged with the patient. The notion of the impartial and emotionally disconnected physician, who cultivates a safe emotional distance, is replaced by an idea in which the physician and patient are interconnected in such depth that the physician can fully immerse himself in the patient's concerns. The authors ponders that, although boundaries may become blurrier than in the traditional, unidirectional relationship, closeness restores a sense of connectedness of humanity that has likely been severed as a result of physical and emotional suffering⁹.

Regarding the confluence between Evidence-Based Medicine (EBM) and PCCM, the authors report that:

In summary, evidence-based medicine and the patient-centered clinical method are not conflicting ideas, but synergistic concepts. The playing field between the two can be understood as an area of creative tension. Complexity science (Plsek and Greenhalgh, 2001, p. 627) labels the circumstances in which there is "insufficient agreement and certainty for the next choice to be obvious, but not so much uncertainty and disagreement as to cause the system to be thrown into chaos." All this requires complex adaptive behavior. These areas of human interaction form the genesis of moral actions, from which real value arises. The patient-centered method explicitly addresses this domain⁹. (p. 14)

This requirement for complex adaptive behaviors in the field of action between EBM and PCCM described by the authors can refer us again to the reflection on the importance of a reflective medical practice with approaches that favor the development of more subjective dimensions of professionals, since medical education.

Narrative medicine

The publication of the book "Narrative based medicine"¹⁹, in 1998, by the editor of the British Medical Journal, Trisha Greenhalgh, can be considered the milestone



of the constitution of Narrative Based Medicine (NBM), a term coined by the author together with Brian Hurwitz, using the word “based” as an explicit reference to EBM.

The term was coined deliberately to signal its distinction from evidence-based medicine, countering the supposed shortcomings of EBM. NBM is conceived in a context in which EBM was considered a truth that should underlie all decisions in the medical field, and will then oppose the view that medical practice would be a rational practice par excellence. For NBM, there is, in the clinical encounter, the imponderable, aspects that EBM does not consider, such as, for example, narratives about individual experiences, about the impact of the disease on patients’ lives.

According to Greenhalgh and Hurwitz¹⁹, in conventional medical education, students learn to view medicine as a science and the physician as an impartial investigator. Evidence-based clinical decision making often starts from an incorrect premise that clinical observation is completely objective, and should, like all scientific measurements, be scientifically reproducible.

On the other hand, although Greenhalgh and Hurwitz appreciate the narrative of disease experience and the intuitive and subjective aspects of the clinical method, they do not reject the principles of EBM. For them, true evidence-based practice truly presupposes an interpretive paradigm in which the patient experiences illness in a unique and contextual way. It is only through this interpretive paradigm that a clinician can meaningfully draw on evidence to achieve integrated clinical judgment¹⁹. Greenhalgh is also a senior researcher at the National Institute for Health Research, and is recognized as one of the most important authors of EBM today.

One of the important developments of this approach was the publication, in the USA, of the book *Narrative Medicine*²⁰ in 2006, by the American internist Rita Charon, in whose preface, *Narrative Medicine (NM)* - a term now accepted among several authors - is defined as “Medicine practiced with narrative competence to recognize, absorb, interpret and be sensitized by ‘stories’ of diseases”. According to Charon, narrative competence enables one to recognize patients and their illnesses and their family contexts. This can lead to more humane, more ethical, and more effective care²⁰.

The author coined the term NM, appropriating the term *close reading* -- listening or attentive reading --, a formalist method of literature analysis and which constitutes the signature method of NM, according to the author²¹.

The technique emerged in the 1920s in England by authors who sought to overcome the traditional conception of belief in the author as a necessary figure for the interpretation of works. Later, in the 1930s and 1940s, it was revived in the USA, by authors - quite divergent in intellectual formation and ideology in relation to the British - who composed a movement called New Criticism²². The new critics adopted an immanent approach to the literary text, affirming the existence of a “correct” and structuralist reading, which should be under the guidance of an objective theoretical device, applicable to any literary text. The structuralists were concerned with elaborating a kind of structural grammar of literary texts, in which it would be possible to encompass the structuring forms of narratives in a universal way. These critics elaborated a systematic and particular examination of the works, seeing them as an object that is the result of a particularization of possible structures²³.



In the field of narrative medicine, close reading is widely cited, taught, and applied, emphasizing the singular, the particular, to the detriment of the general, through attentive reading of each word, syntax, the order in which sentences unwrap, as well as formal structures. Rita Charon is very emphatic about the importance of not missing details. At Columbia University, where she teaches, she uses a reading guide to remind readers to look for aspects in the text such as: temporality, context, narrator, metaphor, sensory aspects, details, descriptions, perspectives represented, genre, mood, and movement²⁴.

According to Rita Charon, the narratives produced by patients are capable of bringing other important aspects besides the “codified” diagnosis. As the account is developed, deep and therapeutic understandings of symptoms and sufferings may emerge. If there is no room for speech, not only the treatment, but also the suffering may become fragmented²⁰.

NM has also been influenced by post-structuralism and social constructionism. John Launer, another important author of the method, whose work is close to Charon’s, emphasizes the importance of NM in the context of primary health care. He describes an approach that he calls “conversations that call for change”²⁵ (p. 36), which uses concepts originating in family therapy. For him, the conversations are not like a vehicle for treatment, but treatment itself, a process that involves moving from an idea of problem solving towards an idea of problem dissolving. The clinician, rather than playing the role of a counselor or fixer, becomes a questioner and a proposer of restructured stories. According to the author, the conversation should be a process in which two people interweave their original stories so that they can create a new story, in a process of co-creation²⁵.

The author Sayantani Das Gupta, coined the term “Narrative Humility”, indicating the posture from which we should witness stories of suffering, highlighting the fact that the patient’s story, at least initially, belongs entirely to him/her. For that author:

[...] we, as careful interviewers and witnesses, invest and become involved in and coauthors of the narratives of our patient’s illness, but we can never claim to understand the totality of another person’s story²⁶. (p. 980)

According to the author²⁶:

Narrative humility recognizes that our patients’ stories are not objects we can understand or master, but dynamic entities that we can address and engage with, while remaining open to their ambiguity and contradiction, and engaging in constant self-evaluation and self-critique, such as our own role in the story, our expectations of the story, our responsibilities to the story, and our identifications with the story-how the story attracts or repels us because it reminds us of countless personal stories²⁶. (p. 981)

Narrative humility allows clinicians to recognize that every story we hear contains elements that are unfamiliar-whether cultural, socioeconomic, sexual, or religious. To assume that our reading of any patient’s story is the definitive interpretation of that



story translates into the risk of closing ourselves off from its most valuable nuances and particularities²⁶.

Narrative humility also addresses the hierarchical imbalance of the clinical bond. It recognizes that the most socially powerful role - the clinicians - must place themselves in a position of a certain transparency. The clinicians must not only see, but be seen, and in doing so, enable themselves to see even more clearly. In other words, by assuming a posture of narrative humility, the clinician is fostering a state in which, as Broyard²⁷ noted, even as the clinician examines the patient, the patient is able to examine the clinician. The witnessing function, so crucial to the physician, becomes mutual, supporting and nurturing both individuals, while enabling a deeper and more fruitful clinical relationship²⁶.

Discussion

The three approaches: a comparative analysis

The Balint method, started in the 1950s, is the oldest. It was consolidated over time, having influenced PCCM and NM, later approaches, appearing at the end of the 20th century. The PCCM has undergone few changes and the NM continues to receive influences, remodeling itself and, although it was created almost simultaneously with PCCM, independently, by different authors, it will be influenced by this method throughout its evolution, which denotes greater vitality of this approach in opening itself to more contemporary schools of thought.

NM has as its focus what is properly produced in the encounter, which is a co-constructed narrative. It does not place the unconscious, the transference, the countertransference - focus of the Balint method - or the person assisted - focus of the PCCM - as the core of the approach. It shifts to a relational object. Person is not relation, but one of its elements. Counter-transference is an individual phenomenon, even if it has been triggered in a relationship. In this way, it is not necessary to resort to the moral imperative that the doctor should “empower” the patient, because NM starts from the assumption that the narrative is really co-constructed, so what the patient brings will really be taken into consideration.

Another aspect that NM can bring regards to materiality: the relationship starts from the abstract later converging into a concrete construction, a narrative. However, one of the side effects of a certain reading of post-structuralism, is that the world is made of a dispute of narratives, which would represent an impoverishment of the approach. Therefore, it is important to highlight the concept of “conversations that call for change”, being a vehicle for problem dissolution (and not resolution) through narrative construction, through linguistic coproduction.

Balint aimed to interfere in the quality of the doctor-patient relationship by triggering a parallel conversational device (the “Balint group”) that obeys certain conversational rules, that is, that functions as a conversational technique. Such a device will influence the clinical encounter through the physician’s transformation by means of his greater awareness of the transferential and counter-transferential processes present in the



relationship; however, there is no prescription of conversational rules for doctor-patient communication. The PCCM, on the other hand, proposes a structured conversational device, and NM offers specific techniques for the development of narratives.

The PCCM argues that EBM and PCCM are synergistic concepts. NM, on the other hand, strongly opposes the flaws in the transposition of EBM theory into clinical practice since its inception, although it does not reject its principles.

In NBM, the concept of humility reinforces the importance of the physician and the patient being both subject and object of the therapeutic relationship, thus the patient must also be able to examine the physician in order to have a deep clinical relationship. This concept dialogues with the PCCM's proposal of care that defends that when the patient stops having a passive posture in the clinical encounter, the physician - if he/she maintains a less objective and insensitive position - will experience new directions that the relationship may take⁹.

The Balint method chooses general practitioners as participants in the groups due to the belief that the atmosphere of a hospital and the technical approach of the specialist are not favorable for the development of their practice. More than that, the author was categorical in his support for the role of the generalist as a long-term personal physician at a time when such concepts were becoming obsolete and generalists were being replaced by specialists in Scandinavian countries and in the USA²⁸.

Although many PCCM concepts originated from work in primary care, the method is intended to have broad application and transferability to physicians at all levels of care, as well as to other health professionals. PHC is highlighted as the most fertile space for NM according to some actors, although it is also present in other contexts such as tertiary care, palliative care, etc.

The authors of both PCCM and NBM give great importance to the teaching of methods in medical schools and residencies. Balint, on the other hand, believes that the teaching of their concepts should not be compulsory, giving preference to more experienced graduate physicians over medical students.

In this way, we aimed to highlight the approximations and distancements between the three lines of approach treated in this study. During the analysis, there was no intention of choosing one over the other. We sought, above all, to know and absorb them, so that it would be possible to recognize the pertinence and specific potentiality to each one of them in the diverse contexts of health professional practice, beginning with medical teaching, having the construction of a therapeutic relationship as a path.



Frame 2. Comparative analysis between the approaches.

| | BALINT GROUPS | PCCM | NARRATIVE MEDICINE |
|---|--|--|--|
| BEGINNING | 1950 | 1997 | 1998 |
| Openness for new contributions | It has undergone little change. | It has undergone little change. | It continuously receives new contributions. |
| Background and reciprocal influences | Psychoanalysis, Hungarian supervision method, free word association. | Balint, Client-centered counseling, Whole-person approach. | PCCM, Balint, Postmodern literary theory, social constructionism, systemic family therapy. |
| Core focus of approaches | Transfer/counter-transfer. | Patient. | Co-constructed narrative |
| Prescribing a conversational device | For the group but not for the doctor-patient relationship. | Structured into four components. | It offers specific techniques for constructing narratives. |
| EBM Reference | Not mentioned | In synergy with EBM. | They counter the alleged shortcomings, but argue for the possibility of synergy with EBM. |
| Sharing power in the relationship | Not mentioned | Moral imperative of practice. | It extrapolates this concept by placing the physician also as an object in the relationship. |
| Practice Settings | Primary Health Care | All healthcare levels | Any setting. It highlights PHC as the most fertile space for narrative production. |

Authors' contribution

Both authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

Both authors have no conflict of interest to declare.

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Resumo

A comunicação, a despeito de ser considerada um aspecto primordial no exercício da prática médica, não ganhou tanta proeminência na literatura e formação médica quanto os aspectos tecnológicos e biomédicos. Em resposta a esse contexto, surgiram campos de conhecimento que se propõem a refletir e fortalecer aspectos da comunicação entre o médico e o paciente. No presente artigo, realizamos uma análise narrativa da literatura de três abordagens de comunicação em Saúde: Grupos Balint, Método Clínico Centrado na Pessoa e Medicina Baseada em Narrativa. Foram destacados aproximações e distanciamentos entre tais abordagens, com o reconhecimento da potência própria de cada uma delas nos diversos contextos da prática médica.

Palavras-chave: Comunicação. Método Clínico Centrado na Pessoa. Grupos Balint. Medicina Narrativa.

Resumen

La comunicación, a pesar de considerarse un aspecto primordial en el ejercicio de la práctica médica, no obtuvo tanto destaque en la literatura y en la formación médica como el que tuvieron los aspectos tecnológicos y biomédicos. Como respuesta a ese contexto, surgieron campos de conocimiento cuya propuesta es reflejar y fortalecer aspectos de la comunicación entre el médico y el paciente. En este artículo, realizamos un análisis narrativo de la literatura de tres abordajes de comunicación en salud: Grupos Balint, Método Clínico Centrado en la Persona y Medicina Basada en la Narrativa. Se destacaron aproximaciones y distanciamentos entre tales abordajes, con el reconocimiento de la potencia propia de cada una de ellas en los diversos contextos de la práctica médica.

Palabras clave: Comunicación. Método clínico centrado en la persona. Grupos Balint. Medicina narrativa.