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An Overview of Narrative Medicine in China

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Abstract

This paper sketches the history and the author's involvement in the development of narrative medicine in China. It also describes "narrative medicine with Chinese characteristics," explaining why narrative medicine is regarded as a tool to materialize the medical humanities in clinical practice, and detailing the features of narrative medicine in China. The features include the wide acceptance of the "22334 model" of narrative medicine, and borrowing theories and practice from Traditional Chinese Medicine. Finally, the author argues that the medical humanities should be given a "Class-A discipline" status, and narrative medicine should be a class-B discipline under the medical humanities.

Keywords: Class-A discipline; Narrative medicine; Narrative nursing; Parallel chart; Medical humanities

1 My background story with narrative medicine

In 2008, I visited the Institute for the Medical Humanities (now the Institute for Bioethics and Health Humanities) of the University of Texas Medical Branch at Galveston. My main job there was auditing two graduate courses "Introduction to Literature and Medicine" taught by Anne Hudson Jones, and "Religion, Medicine and Culture" by Harold Vanderpool. There I became interested in the history of the field of Literature and Medicine in the US and decided to make it a research project. Jones is a witness of the development of this field and suggested several people for me to interview. "There is this woman Rita Charon who is doing something called 'narrative medicine'. You should interview her." she said to me.

It wasn't until October 2009 when I first met Charon at the 11th annual conference of American Society for Bioethics and Humanities(ASBH) held in Washington DC. I did quite a lengthy semi-structured interview with her there. Apart from her warm personality, what impressed me most were two of her ideas. First, she said she originally regarded narrative as one hemisphere of medicine, but then she realized that "everything we do in medicine—clinical work, research, teaching—is saturated with narrative," therefore it's justifiable to juxtapose "medicine" with "narrative." Second, she said, as a clinician, she knew what worked and didn't work for them: "medical humanities is a concept you can talk about, but narrative medicine is something you can do." This second idea has prompted me to promote narrative medicine (NM) as a tool to materialize medical humanities in the Chinese medical community. Narrative medicine, according to Charon, is "a rigorous intellectual and clinical discipline to fortify healthcare with the capacity to skillfully receive the accounts persons give of themselves—to recognize, absorb, interpret, and be moved to action by the stories of others."[1]

I didn't finish my research until 2011 and fell ill that year and didn't publish my research in Chinese until 2013. But nonetheless, 2011 is regarded as "year zero" of narrative medicine in China.[2] That year, three articles bearing the keyword of "narrative medicine" were published.[3–5] Also in that year, the then president of Peking University Health Science Center (PKUHSC), vice chairman of the National People's Congress, member of the Chinese Academy of Sciences, patho-physiologist Han Qide (韩启德) summoned a meeting at the Institute for Medical Humanities of Peking University (now the School of Health Humanities, Peking University) to discuss what was narrative medicine and how it could be used in clinical practice. Medical humanities scholars, clinicians, narratologists, and writers were invited to attend the discussion. In 2013, Han read my paper "From Literature and Medicine to Narrative Medicine"[6] and wrote a letter to me, saying that he had recommended it to the then executive vice president of Peking University (PKU), Professor Ke Yang (柯杨) and asked her to join the discussion as well on how we could integrate narrative medicine into the medical humanities in our medical school and hospitals. In the letter, he asked me to play a key role in promoting NM and not be afraid to "take longer strides" in the process.

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Encouraged by his support, I decided to translate Charon's book *Narrative Medicine: Honoring the Stories of Illness*[7] into Chinese (Fig. 1). To better understand NM, I attended the Columbia University basic NM workshop in 2012 and then advanced NM workshop in 2014. The Chinese version of the book was published in 2015 and has greatly accelerated the spread and acceptance of NM in the Chinese medical community and among medical educators. With Han's support, the commitment of the Peking University Third Hospital (PKU Third Hospital), and the sponsorship of the People's Medical Publishing House, the Chinese journal of *Narrative Medicine* was founded in 2018. PKU Third Hospital is the host institution of the journal. Rita Charon was invited to write an article to celebrate the inauguration of the journal. In the same year, the second Peking University International Conference on the Medical Humanities (themed "Narrating Birth, Death and Aging") invited Charon to give a keynote speech. Charon gave her talk at PKU to an audience of nearly 400, and over 8000 more audience listened to her talk through live-streaming.

In 2020, the first NM textbook was published[8]—it's a national-level textbook for hospital resident trainees; also in 2020, the Chinese Association of Preventive Medicine approved of the establishment of the Narrative Medicine Association. In 2021, *Introduction to Clinical Medicine*,[9] a national-level textbook for undergraduate medical students included NM in its second edition. In April 2021, in an attempt to take stock of NM clinical practice, the journal *Narrative Medicine* solicited NM practice cases for competition from around the country. By May 16th, the deadline for case submission, 277 cases were submitted. After two rounds of evaluations, 11 cases from hospitals and one case from a medical school were awarded "The Best Narrative Medicine Clinical Practice Awards." In 2019, Peking University Medical Press decided that it would support the publication of a "Peking University Narrative Medicine Series" (four books) with the PKU Medical Publication Fund. In 2021, the first book of the series, Rita Charon and the Columbia University NM group's *The Principles and Practice of Narrative Medicine*[1] was translated into Chinese (Fig. 2). The second book of the series, *Narrative Medicine Cases and Practice in China*[10] was published in 2022, in which clinicians from 12 hospitals collaborated with narrative medicine scholars from three research institutions. NM practices in their respective hospitals are shared and conceptualized in the book. The remaining two books are planned to be published in the next two years. I was privileged to have been involved in all the above endeavors. These developments have played key roles in helping NM to flourish in China.

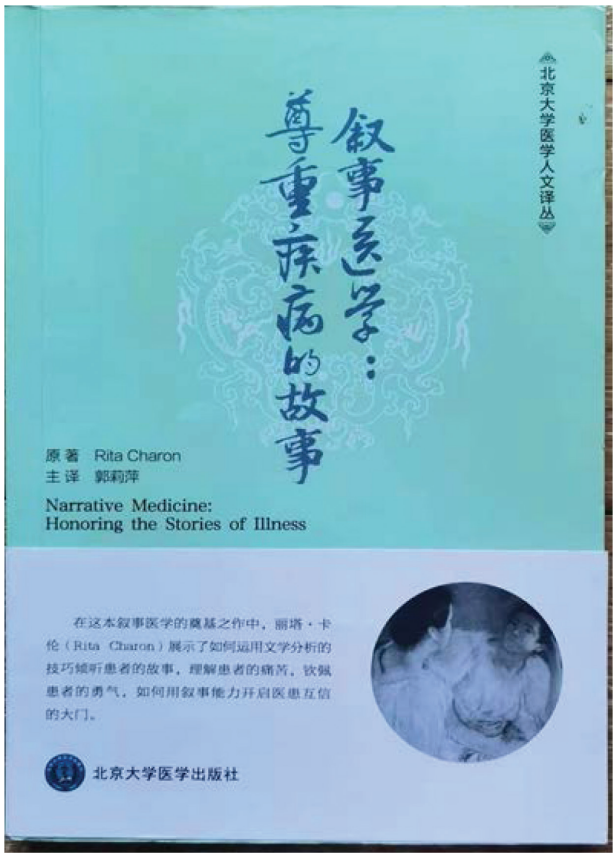

Figure 1 Front cover of *Narrative Medicine: Honoring the Stories of Illness* (《叙事医学：尊重疾病的故事》, 2015). Original author is Rita Charon and the book is translated by GUO Liping (source from: https://book.douban.com/subject/26978743/)

2 Narrative medicine with Chinese characteristics

2.1 NM as the "tool" to materialize "humane care"

Twenty years after the first healthcare reform in China (started in 1985), it was regarded as "basically failed."[11] This reform is characterized by commercialization and marketization of healthcare, which drastically shook the foundation of the previous low-level universal health coverage in the country. This resulted in the poor accessibility and affordability of healthcare for the vast majority.[12] Those Chinese who did not have any form of health insurance at the time postponed their hospital visits until it was too late. Healthcare professionals became the scapegoats of a failed healthcare system. Patients vented their anger towards the system on them. For example, violence against doctors and nurses escalated from 2000 to 2015, totaling 290 cases, with 15 cases resulted in the death of healthcare professionals.[13] To protect themselves, doctors over prescribed tests, procedures, and drugs.[14] This in turn increased patients' economic burden and further eroded their trust in doctors. A vicious circle was thus formed.

The failure of the first healthcare reform led to the ambitious second healthcare reform in 2009, committing to significantly raise health spending to provide affordable, equitable, and effective healthcare for all. After a few years

Figure 2 Front cover of *The Principles and Practice of Narrative Medicine* (《叙事医学的原则与实践》, 2021) edited by Rita Charon, Sayantani DasGupta, Nellie Hermann, Craig Irvine, and Eric R. Marcus. The book is translated by GUO Liping (source from: https://book.douban.com/subject/35495013/)

of implementation, "China has achieved near universal health coverage at a speed with few precedents globally or historically."[15] With less out-of-pocket pay from patients themselves and improved standards of living, people expect to have more "quality care"—in the sense that they could be treated more "feelingly" in their encounter with healthcare professionals.[16] To many, the medical humanities was a means to repair this damaged relationship.

In China, the medical humanities is greatly influenced by the medical humanities movement in the US. Edmund Pelligrino's criticism of US medicine in the 1960–1970s seems to have predicted medicine's problems in China in the 1980s onward: "over specialization; technicism; over-professionalization; insensitivity to personal and sociocultural values; too narrow a construal of the doctor's role; too much 'curing' rather than 'caring'; not enough emphasis on prevention, patient participation and patient education; too much science and not enough liberal arts; not enough behavioral science; too much economic incentive; a 'trade school' mentality; insensitivity to the poor and socially disadvantaged; over-medicalization of everyday life; inhumane treatment of medical students; over work by the house staff and deficiency in verbal and non-verbal communication."[17] Biomedicine's "sins" are the same everywhere in the world. In China, the situation is worsened by the congregation of patients to large tertiary hospitals in big cities with advanced facilities and famous doctors. An attending physician in such hospitals would typically see 30 to 35 patients in four hours in the outpatient clinic.[18] The patients become the "workload" on the busy medical assembly line, waiting to be "processed." Medicine lacks the "warmth" it should have. Again, many believe that the medical humanities is what is needed to make clinicians more humane.[19]

The medical humanities in China began in the 1980s, developed in the 1990s and prospered after 2000.[20] However, the medical humanities is only good at criticizing the inhumane aspects of healthcare and analyzing the reasons for such dehumanization. It is not good at telling and training healthcare professionals HOW to improve their care. Healthcare professionals feel empty-handed and frustrated when facing the unsatisfactory doctor–patient relationship and criticism from the medical humanities, yet feel at a loss as what to do—until they have narrative medicine. On numerous occasions, the audience heard me quoting Charon as saying "medical humanities is a concept you can talk about, but narrative medicine is something you can do." I have promoted NM as a tool to materialize the concepts of "medical humanities" and implement "humane care" in clinical settings in China—for the patients and their families, it's a willingness on the part of the clinician to listen to their stories and respond to their concerns and needs, and take actions to alleviate their sufferings the best s/he can; for the clinician, it's a willingness to always include the patient's and/or family's views and life stories in the entire process of healthcare, whether it's in consultation or decision-making, and to take actions to improve the well-being of the patient (and hence that of the family). This conceptualization has been accepted by many in the Chinese medical community and medical humanities community. I believe this is the actual embodiment of the three "movements" of NM which I'll discuss below.

2.2 Features of NM in China

Charon offers several taxonomies in her two books: the four types of divides between patients and healthcare professionals, the five narrative features of medicine, the five elements of close reading drill,[7] the six principles of close reading, etc.[1] These taxonomies are mainly arguments used to persuade her readers why narrative is an important feature of medicine and close reading "the signature method of narrative medicine." In the process of promoting narrative medicine in China, however, my focus is on the UTILITY of NM in clinical practice, because literature review finds this is the focus of

NM in China,[2] though in Europe there's also a call for "cross-fertilization" between academic narrative medicine and narrative practice.[21] Thus I am more inclined to stress how it can be used to improve the relationship between patients and clinicians, and how clinicians can use narrative methods to improve their practice, acquiring satisfaction from their job by establishing trust relationships with patients, with their own identities, with their colleagues, and with society. Therefore, I have stressed some taxonomies over others, reorganized some, and come up with some new ones.

2.2.1 The "22334 model" of narrative medicine

This model is the taxonomies of NM that the PKU narrative medicine team has advocated for the practice of narrative medicine in China. The first "2" is what Charon calls the two tools of narrative medicine—close reading and reflective writing. However, I prefer to call them "the two tools of cultivating narrative competence," because that's what they are really good at. To practice narrative medicine, clinicians need the second "2"—their "self" and "presence" for the patients, which Charon implies many times in the two books without explicitly calling them "tools." The first "3" stands for the three focuses of narrative medicine, namely empathy, relationality, and emotions (especially negative emotions). Again, Charon has not grouped them together, but in the course of promoting NM and from my own personal experiences of observing doctor–patient interactions in one of the PKU affiliated hospitals, I have found that healthcare professionals should really focus on these three aspects in their practice. By paying attention to patients' emotions, especially negative emotions, empathizing with their views, clinicians build up relationality with patients. In patients' eyes, such clinicians recognize them as individual persons and understand them. They in turn, would more likely trust them and follow their medical advice.[22] The second "3" is Charon's three "movements" of NM—attention, representation, and affiliation. However, "movement" (运动) frequently has a negative and political connotation in the Chinese language (when it is not used to mean "doing exercises"). To avoid the negative association, I have replaced it with "element" (要素) in Chinese. In *The Principles and Practice of Narrative Medicine*, Charon has modified the definition of narrative competence to include "action"—narrative competence is to "recognize, absorb, interpret, and be moved TO ACTION by the stories of others."[1] In my talks to healthcare professionals nationwide and the textbook for hospital resident trainees, I have pointed out that "attention" and "representation" embody the action of narrative medicine and are the major things clinicians "DO." The "4" stands for the four trust relationships ("affiliation") NM advocates the relationship with patients, with self, with colleagues, and with society. The good relationship with patients is regarded as the inner drive for the development of medicine and healthcare. Clinicians' relationship with self is understood in China as identification with their roles of the care giver. Their job satisfaction and sense of achievement play a key role in combating burnout. Good relationships with colleagues is an important determinant for the development of the hospital or the department as a community. A good relationship with society plays a vital role, especially for the Chinese society—when there is mutual trust between the doctor and patient, doctors will not feel the necessity to practice "defensive medicine," and can be encouraged to take some measures for patients rather than to choose to be on the safe side of practice. When patients trust their doctors, they are more likely to "comply" with treatment plans, and thus reduce the huge waste of resources caused by non-compliance.[23]

This "22334 model" provides basic concepts in guiding the NM practice and education in China. In medical and nursing schools, the focal point is in cultivating narrative competence, mostly making use of close reading and reflective writing. The parallel chart, as a form of reflective writing, has great appeal for medical educators in China. Parallel chart is writing "in nontechnical language, about what they (health-care professionals and medical students) witness about their patients' experiences and what they themselves undergo in caring for the sick…[This] does not belong in the hospital chart but must be written somewhere."[7] In hospitals in China, writing parallel charts is regarded as a good way for clinicians to understand and empathize with patients, and to reflect how to improve care. In fact, writing parallel charts has become such a prominent way of practicing NM, that many clinicians misunderstand NM as simply writing parallel charts. They thus complain that they are busy enough already writing hospital charts, and don't have time to take up the extra burden of writing parallel charts. I have had to correct this misconception of clinicians on numerous occasions. In *The Principles and Practice of Narrative Medicine*, the Colombia NM team substitutes "reflective writing" with "creative writing," but creative writing is commonly regarded as a luxury for the busy Chinese doctors.[2]

In NM practice, the three "elements" of paying attention to patients' narratives, representing what clinicians hear from patients to foster affiliation with them, embody the essence of NM. In this process, clinicians pay special attention to the negative emotions of patients, trying to empathize with them and establish relationality with them, all the while making efforts to establish trust relationships with patients, colleagues and society, and identify with their own roles as care givers.

Another important feature of NM in China is the popularity of narrative nursing (NN). Though NN uses a different theoretical framework and techniques—namely those of narrative therapy,[24] it is regarded as a branch of the large tree of NM.[2] NN is frequently practiced on "difficult" inpatients. Nurses would use the

techniques of "externalization" and "deconstruction" to co-author a new and more positive story for the patient. In China, practitioners of NM and NN usually attend the same conferences and training sessions together, but there seem to be more nurses espousing the narrative nature of medical care than doctors—perhaps because nurses spend more time with patients and take care of their various needs, and thus can better appreciate the significance of narrative in their work than doctors.

2.2.2 Borrowing theories and practice from traditional Chinese medicine

There has been a lot of call for the localization of NM to make it fit the culture, specific clinical situation, and doctor–patient relationship in China. Traditional Chinese medicine (TCM) is regarded as a significant resource in such process. At NM conferences, we see practitioners of both biomedicine and TCM, which is rare at other medical conferences.

The Confucian precept "medicine is a humane art" sets the basic requirements for practitioners of TCM, with its emphasis on caring about patients and physicians' self-cultivation in virtue.[25] When a TCM doctor sees a patient, one uses the four techniques of "inspection, auscultation-olfaction, interrogation, and pulse-taking" (*Wàng Wén Wèn Qiè* 望闻问切) to find out patients' problems. Guided by the philosophy of TCM, one regards the patient as a whole person, trying to evaluate how the patient's health condition is affected by time (season), space (environment), psychological state, socio-economic status, and relationship with family members, and co-workers. Therefore, TCM embraces a time-space-social-psycho-bio medical model,[26] which is even more encompassing than the bio-psycho-social model. This model emphasizes the impact of the exterior on the interior. Therefore, finding out the exterior reasons for ill-health is key when seeing a patient. During the consultation, the doctor feels the patient's pulse while at the same time encourages the patient to tell his/her story. The TCM doctor tries to establish a link between these elements and the patient's health condition, analyzing and discussing with the patient what can be done to best solve the problem and improve his/her condition. Compared with the practice of biomedicine where the focus is on the results of various lab tests and procedures, the TCM doctors focuses more on the person and his/her life.[27] In practicing NM, physicians can learn to guide their conversation by this TCM model and learn more about the patient's life story so as to be able to help rebuild a new story.

In the history of TCM, its practitioners have written a lot of reflective analyses in the forms of medical case reports and medical case studies (*Yi An Yi Hua* 医案医话). These are good learning materials for TCM students to understand the flow of thoughts in making diagnoses, and grasp the important influences of time, space, psychological status, socio-economic status and relationship on patients' health condition and diseases. When the TCM practitioners see that reflective writing (parallel chart) is regarded as a tool of NM, they immediately discover the resemblance between the two and find it an ideal way to resume the TCM tradition of writing reflective analyses of medical cases. A framework for writing parallel charts for the modern-day TCM doctors has been proposed,[28] which has become a source of inspiration for doctors and medical students of biomedicine when they write their parallel charts.

The TCM practice effectively "mirrors" the inadequacies of biomedicine just as complementary and alternative medicine do in the US.[29] The only difference is that it might be easier for the Chinese physicians to appreciate this, because TCM is more or less a cultural element they grew up with.

3 Creating a new discipline

3.1 Seeking "Class-A Discipline" status for the medical humanities

Unlike in the West where the medical humanities/health humanities, literature and medicine, bioethics, narrative medicine are parallel fields of study, in China, "medical humanities" is an encompassing concept under which lay the history of medicine, bioethics/medical ethics, the philosophy of medicine, medical sociology, medical anthropology, health law, medical psychology, literature and medicine, and most recently, narrative medicine. People working in these fields can all assemble under the banner of "medical humanities," because they all focus on the human and social aspects of medicine, while "medicine," or biomedicine in China today largely only cares about restoring the functions of the body using the latest medical knowledge and technology.

More than a decade ago, endeavors began to be made in seeking the status of "class-A discipline" (*Yi Ji Xue Ke* 一级学科) for the medical humanities when the Ministry of Education (MoE) revised its "catalogue of academic disciplines." In China, a field of study cannot simply declare itself to be a "discipline," especially a "class-A discipline," even when it has a journal, professional association, and people teaching it at universities, like the medical humanities. It has to be officially acknowledged by the MoE. Universities are allowed to set up class-B disciplines, but not class-A disciplines. Most of the above fields of study are now class-B or even class-C disciplines (*Er Ji/San Ji Xue Ke* 二级或三级学科).

There are two reasons for seeking class-A discipline status for the medical humanities. First, like the proverbial pilot telling his passengers: "I have good news and bad news. The good news is that we're flying smoothly at a high speed, the bad news is that we don't know where we're going." In addition to the three models of relationship between the medical humanities and

medicine, namely the additive, curative, and integrative relationships between the medical humanities and medicine,[30] I believe the medical humanities also has a "directive" role for the development of medicine. There has been an ongoing concern about the nature of medicine—is it to treat the disease or to heal the person who is experiencing illness?[31] Is biological "evidence" more important than patients' stories of illness? Can patients' narratives be used as "evidence" as well?[32] What should we do to prevent crazy scientists from conducting Frankenstienian research on humans?[33] The list of questions can be quite long. In the Chinese context, we believe if the medical humanities is made a class-A discipline, these questions will become more prominent to society, and therefore be more heeded by the medical community.

The second reason is plainly that a class-A discipline will get more resources for development, especially more funding. A class-A discipline has its own evaluators for research grant proposals. Therefore, for researchers in the medical humanities, their grant proposals will most likely be marked "interdisciplinary" and go to evaluators of other class-A disciplines who actually do NOT do research in the medical humanities and may not understand its relevance, and thus regard it as marginal research interest in the "mother" disciplines. Consequently, chances to get funding are slim for the medical humanities, and this directly leads to the paucity of high quality research in the MH. A vicious cycle is formed—the Mathew effect. In 2021, in the MoE's new round of revision of the catalogue of academic disciplines, the medical humanities was put forward again as a class-A discipline, but failed in the third (last) round of vote. In 2022, Peking University and Tsinghua University, the two most prestigious universities in China, were given the liberty by the MoE to set up its own class-A disciplines. Our design for the PKU medical humanities class-A discipline include four class-B disciplines: the History and Philosophy of Medicine; Ethical, Legal, and Social Issues of Medicine (ELSI); Medical Psychology; and Narrative Medicine. Health Politics is another possible class-B discipline in our design.

3.2 Making narrative medicine a class-B discipline

Narrative medicine is new to the medical humanities family. In 2021, Peking University Health Science Center and Peking Union Medical College led the national efforts in making the medical humanities an MoE class-A discipline. NM was proposed as one of the class-B disciplines in our first design. However, in our nation-wide survey, some universities objected including NM as a class-B discipline. One main reason was that NM was not yet widely taught and there were simply not enough people engaged in the teaching and research of NM in China. If PKU succeeds in making NM a class-B discipline, then it will have a modeling effect for the entire country.

When institutionalizing a field of study and making it a discipline, the first step is to be clear about its subject matter. For NM, "narrative" is the indisputable core. This is reflected in the narrative nature of medicine and medical practice, the narrative construction of medical knowledge, and the narrative methods in hospital culture construction and hospital management. Therefore, the subject matter of NM is clear. The second step is to determine its methods. Charon calls NM "an intellectual and clinical discipline" whose purpose is "to fortify healthcare with the capacity to skillfully receive the accounts persons give of themselves—to recognize, absorb, interpret, and be moved to action by the stories of others."[1] The implication of such a definition is that being able to "receive" illness narrative is essential (for healthcare professionals) to the practice of NM. Therefore, NM is a top-down approach to improve healthcare on the part of healthcare professionals. I believe this is Charon's original aspiration in creating NM. Literary methods of close reading, reflective writing, and creative writing are used to cultivate and improve narrative competence—the ability to "receive" the accounts people give of themselves, so that healthcare professionals can better practice NM. I call this "NM in the narrow sense."[2]

In China NM arouses the interests of researchers from other disciplines, such as social linguistics, narrative psychotherapy, and health communication. The public is also zealous in telling their or their family members' stories of illness experience. Social linguists engaged in conversation analysis of doctor–patient communication provide "evidence" for successful and not-so-successful doctor–patient encounters. Narrative psychotherapy, or narrative therapy, provides a theoretical framework for conversation with suffering patients who can really feel the "presence" of healthcare professionals. Health communication provides theories and methods for healthcare professionals to improve the public's health literacy and educate them about the uncertainty and limitations of medicine. This is especially important to curb the public's unreasonably high expectations of medicine—a result of exulting in the "miracles" of medical knowledge and medical technology. Medical progressivism has convinced the public that once they go to the hospitals, their diseases will be cured. If not, then it's must be the fault of the doctor and the hospital. This belief has led to many medical disputes in China. In 2018, a 20,000-word long illness narrative entitled "The middle-aged people in Beijing under the shadow of flu"[34] went viral on the Chinese social media platforms. The writer carefully detailed the illness and treatment experiences of his father-in-law, and reflected on the fragility of life and economic burden of healthcare on the middle-aged. It was read by more than 10 million people and got more than 150,000 likes. Doctors nationwide began to appreciate the power of illness

narrative in promoting health literacy of the public. Many doctors of pulmonary medicine published short stories on social media platform to answer questions raised in the above illness narrative. When the "insiders" of medicine convey the uncertainty and limitations for medicine through stories, especially on social media platforms, they are actually building a favorable environment for medicine and a trust relationship with the public.

Another noticeable trend of NM development in China is using "evidence" from empirical studies to support the "usefulness" claim of narrative in teaching, patients' recovery, patients' compliance, and reduction of medical disputes.[35,36] We believe in the complementary effect of integrating evidence-based medicine and narrative medicine. Narrative means should be implemented in explaining evidence, and evidence should be provided when claiming the positive impact of narrative. All these above groups of people study or describe the doctor–patient encounter and patients' illness experiences in their own way and thus all contribute to the development of NM. I call this "bottom-up" approach "NM in the broad sense."[2] Therefore, apart from the literary methods proposed by Charon and colleagues, methods of discourse analysis, narrative therapy, health communication, and other methods of the "human sciences" can all be used by narrative medicine. I believe that for present-day scholarship, a combination of methods is the reality.

For NM, there is a solid subject matter and viable methods of research, in addition to the already existent journal, academic associations and people engaged in its teaching and research, not to mention the huge number of clinicians practicing it or are learning to practice it. I firmly believe that it IS already a discipline, if only a class-B discipline.

Recently medical humanities failed again to get the class-A discipline status in the PKU vote. This has dampened our spirit to some extent, but we still firmly believe that making MH a class-A discipline and narrative medicine a class-B discipline respectively helps to respond to the problems in healthcare and is beneficial to the healthy development of medicine in China.

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Ethical approval

This study does not contain any studies with human or animal subjects performed by the author.

Author contributions

GUO Liping wrote and revised the article.

Conflicts of interest

The author declares no financial or other conflicts of interest.

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