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Exploration and Practice of Narrative Medical Education Localization from a Dual-Track Integration Perspective —— A Scoping Review of Domestic and International Teaching Practices

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Abstract: Narrative medicine education, as a vehicle for medical humanities practice, cultivates narrative competence, empathy, and reflective abilities in medical students, playing a pivotal role in improving doctor-patient relationships and healthcare quality. Through a scoping review of 250 studies (2011-2025), we systematically compared and analyzed teaching models, practical pathways, and localization characteristics. Globally, a standardized curriculum centers on close reading, reflective writing, and scenario simulation. In China, integration with traditional Chinese medicine (TCM) case studies and the Red Medical Spirit (a medical humanistic spirit centered on the people and selfless dedication, formed during China's revolutionary medical practices) has forged dual tracks of community practice and ideological development. However, challenges persist, including faculty shortages and unidimensional assessment. Future efforts must enhance interdisciplinary integration, refine local theoretical frameworks, and translate educational innovation into clinical practice to advance patient-centered care ecosystems.

Keywords: Narrative Medicine; Narrative Medicine Education; Empathy; Parallel Medical Records; Cross-Cultural Comparison

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Introduction

Narrative Medicine was proposed by Professor Rita Charon of Columbia University in the United States in 2001. It emphasizes listening to patients' narratives of their illnesses, cultivating empathy and reflective abilities in medical practitioners, and integrating medical humanism with clinical practice. Its core philosophy lies in shifting from a "disease-centered" treatment model to a "patient-centered" holistic care approach, serving as an important tool for improving doctor-patient relationships and enhancing medical quality.

In recent years, medical schools both domestically and internationally have gradually incorporated narrative medicine into their educational systems, but their development paths exhibit significant differences. Overseas institutions focus on systematic curriculum development and interdisciplinary integration, while domestic institutions innovate by integrating traditional Chinese medicine culture and course-based ideological and political education, though the overall development

remains fragmented. This paper aims to systematically review the research progress of narrative medicine education domestically and internationally, focusing on the core differences in teaching objectives, course design, implementation pathways, and evaluation methods. It will conduct an in-depth analysis of the underlying causes of these differences, including cultural foundations, institutional backgrounds, and practical bottlenecks, ultimately providing theoretical references and a practical basis for constructing a narrative medicine education system that aligns with China's national conditions, possesses cultural adaptability, and achieves clinical effectiveness.

1.Research Background

With the deepening implementation of the "Healthy China" strategy, medical humanities education has been incorporated into the core reform agenda of the national health system. In 2016, the "Healthy China 2030" Planning Outline first proposed "integrating health into the national education system," establishing a transition path from a "disease-centered" approach to a "people's health-centered" approach. In 2024, four national ministries jointly issued the "Action Plan for Enhancing Medical Humanities Care (2024–2027)," the first national-level policy specifically targeting medical humanities. It explicitly requires "strengthening the cultivation of medical students' empathy and narrative literacy" and incorporates narrative ability into the evaluation system for physicians' professional competence [1]. This policy direction provides institutional support for the education of narrative medicine.

Currently, narrative medicine education is undergoing a paradigm shift. Internationally, over 80% of medical schools in Europe and the United States have incorporated narrative medicine as a required course, forming a systematic curriculum centered on "close reading—reflective writing (Reflective Writing, which involves reflecting on one's practice and patients' experiences through writing)—situation simulation." In contrast, by 2025, approximately 15% of domestic medical schools (over 20 institutions) will offer independent courses, while another 15% will integrate narrative medicine into other courses as modules. These modules are often scattered across ethics, nursing, or ideological and political education courses as elective modules [2]. Although some institutions have explored localized approaches—such as Shanghai University of Traditional Chinese Medicine integrating "traditional Chinese medicine case teaching" and Fudan University introducing "patient narratives into anatomy classrooms," the overall effort remains in a fragmented exploratory phase, with no standardized, interdisciplinary, integrated curriculum system yet established.

Current medical humanities education faces three structural contradictions. First, educational design remains focused on the traditional "doctor-patient" binary relationship, failing to address the needs of the Healthy China strategy for "lifetime health management" (such as aging and chronic disease prevention and control), leading to a disconnect between humanities education and the social determinants of health (SDH)[1]. Second, there is a significant shortage of interdisciplinary faculty, particularly in grassroots medical schools, where teachers generally lack systematic training in narrative medicine, relying excessively on theoretical lectures in teaching and neglecting practical components [3]. Third, domestic effectiveness evaluations have long relied on quantitative analysis of academic performance, lacking internationally recognized multidimensional tools such as the JSPE Empathy Scale, and rarely tracking long-term improvements in clinical decision-making or patient satisfaction [4].

In recent years, the medical paradigm has been transitioning from the traditional biomedical model to the bio-psycho-social medical model, which requires medical education to integrate humanistic care with professional skills. As conflicts in doctor-patient relationships have become increasingly prominent, China's doctor-patient trust crisis urgently requires narrative medicine to strengthen medical students' empathy and communication skills. Data shows that 70% of disputes in doctor-patient conflicts stem from insufficient communication [5], making narrative medicine a core strategy for improving doctor-patient relationships.

Narrative medicine education is an important pathway for cultivating medical students' empathy and professional ethics. Through the power of narrative, we can establish more harmonious and trusting doctor-patient relationships, driving improvements and developments in medical practice. From a theoretical perspective, clarifying the core framework and implementation logic of narrative medicine education can promote its localization and future development. From a practical standpoint, it provides a basis for domestic curriculum reform, faculty training, and evaluation systems. The 2023 "Chinese

Consensus on Narrative Medicine" proposed incorporating narrative skills into the physician qualification examination and promoting educational system reform [2], marking the growing importance of narrative medicine education in China.

2.Research Design

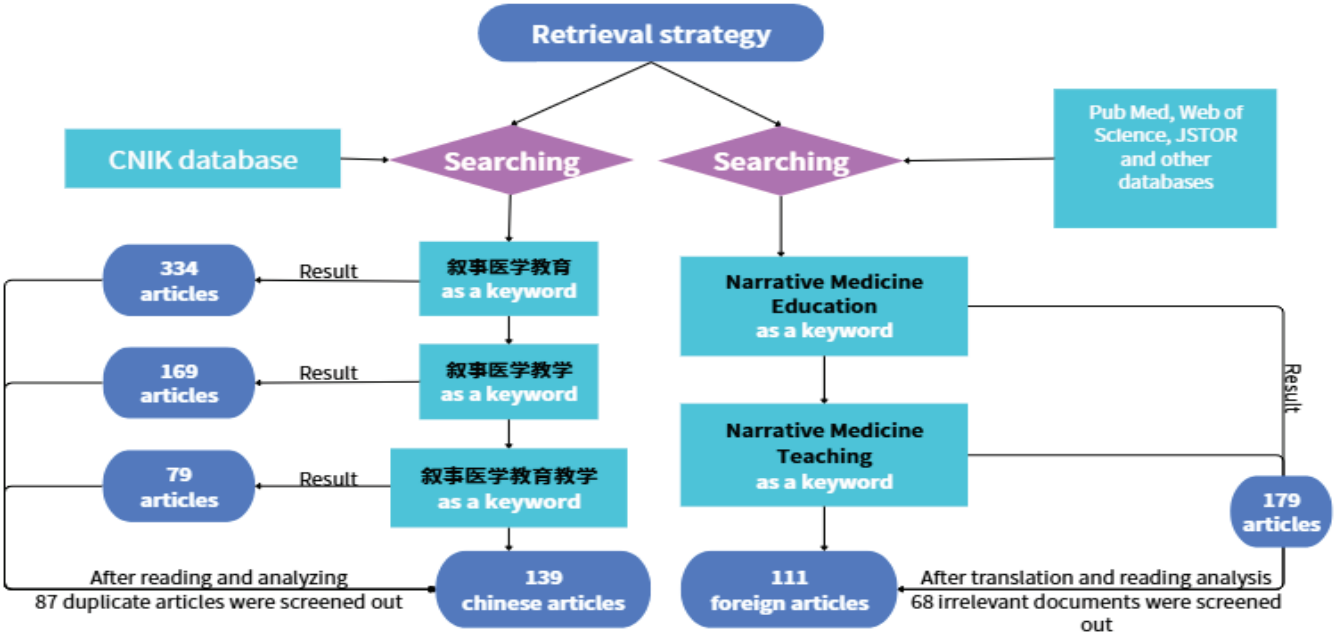
The primary research method employed in this study is a scoping review. This involves collecting, organizing, and analyzing literature from both domestic and international sources in the field of narrative medicine education to draw research conclusions ultimately. By entering specific subject terms and keywords into China National Knowledge Infrastructure (CNKI), PubMed, Web of Science, and JSTOR, and restricting the timeframe to 2011–2025, a total of 523 papers were downloaded. After reading and analyzing the papers, 284 papers that were not closely related to the theme were excluded. Ultimately, 139 domestic papers and 111 international papers were selected for further organization and analysis. The selected papers primarily focused on teaching objectives, innovative courses, and distinctive approaches in narrative medicine education both domestically and internationally. The research process involved comparison, translation, and analysis, with Excel tables created to extract key topics, research methods, and conclusions.

2.1 Literature Search Strategy

For domestic literature, we searched the CNKI database using the keywords "narrative medicine," "education," and "teaching." The search using the keyword "narrative medicine education" yielded 344 papers, the keyword "narrative medicine teaching" yielded 169 papers, and the keyword "narrative medicine education and teaching" yielded 79 papers. After downloading and conducting an initial screening, 87 duplicate documents were excluded, leaving a total of 257 papers. After reading and analyzing them, 118 papers that were not closely related to the theme were removed, and 139 domestic documents were ultimately selected for the study.

For international literature, we conducted searches in databases such as PubMed, Web of Science, and JSTOR using the keywords "narrative medicine education" and "narrative medicine teaching," downloading a total of 179 documents. After downloading, translating, and screening, we excluded documents whose titles and abstracts did not pertain to narrative medicine education and teaching, ultimately retaining 111 documents for analysis, as shown in Figure 1.

Figure 1: Searching Process Diagram



This study set the time frame from 2011 to 2025, which has multiple theoretical bases and research value. First, 2011 marks a historic turning point in the development of narrative medicine in China. The Institute of Humanistic Medicine at Peking University hosted the first symposium on narrative medicine, systematically introducing the theoretical framework of this discipline [6]. This event signaled a major paradigm shift in medical humanities research in China. Selecting this starting year allows the study to be based on a comprehensive diachronic observation, ensuring the completeness of data collection and

the empirical basis for diachronic analysis. Second, this period fully covers the key transitional stages of the development of narrative medicine in China. According to research data, by 2025, 35 medical schools nationwide had incorporated narrative medicine into their required course systems [1], tertiary hospitals had established a "Dual-track Medical Records" model with demonstrable effects in clinical practice, and core journals had published over 800 related papers [1]. This phase encompasses both the initial period of theoretical introduction (2011–2015) and the mature phase of localization and innovation (2016–2025), providing a complete cycle sample for observing the process of disciplinary institutionalization.

Furthermore, the need for international comparative research dictated the selection of the time interval. Narrative medicine abroad has continued to develop since Charon proposed the theoretical framework in 2001, and by 2025, a relatively complete educational certification system had been established. The 15-year span of this study ensures the comparability of synchronous development data between China and foreign countries while effectively observing the "spatio-temporal compression" phenomenon in theoretical dissemination—China, while introducing Western theories, creatively proposed the "Traditional Chinese Medicine Narrative Diagnostic and Therapeutic Model," achieving the integration of the traditional "differential diagnosis and treatment" philosophy with the modern narrative therapy paradigm [7].

In summary, the timeframe of 2011–2025 aligns with the intrinsic logic of disciplinary development while meeting the methodological requirements of cross-cultural comparative research. Through systematic observation within this time window, the complete spectrum of narrative medicine in China—from theoretical transplantation to paradigm innovation—can be presented, particularly the creative transformation pathways of traditional Chinese medical wisdom and modern humanistic medicine. This holds unique academic value for the theoretical expansion of medical humanities research.

The selection criteria for this study's research papers focus on empirical research standards related to teaching practice, course design, and effectiveness evaluation, excluding purely theoretical discussions. An exploration of the characteristics of research themes revealed that "empathy," "Parallel Medical Records" (narrative medical documents recording patients' emotional experiences), and "course design" are high-frequency research themes.

2.2 Analytical Framework

This study analyzes four core areas: teaching objectives, course design, implementation pathways, and evaluation methods. It systematically examines the key characteristics and internal connections of each theme in theory and practice. Based on three key dimensions—cultural differences between countries, the depth of disciplinary integration, and the difficulty of practical implementation—the study compares and contrasts the influence of cultural values on teaching strategies in different educational contexts, the feasibility boundaries of interdisciplinary integration, and the adaptive challenges of teaching models in different social settings.

3.Comparison of Narrative Medicine Education Practices at Home and Abroad

3.1 Educational Objectives

Overseas institutions build their educational systems around multi-dimensional objectives: first, to inspire professional identity through patient stories, guiding students to understand the value of medicine and achieve unity between self-worth and social value; second, to use literary classics and patient narratives to strengthen humanistic foundations, breaking through technical limitations to cultivate healthcare professionals who are both rational and compassionate. For example, Columbia University's "Close Reading-Reflective Writing-Virtual Patient" course increased students' empathy by 25%[8], with its core focus on cultivating the ability to understand and respond to patient stories[9], ultimately aiming at the practical goal of "whole-person care."

Domestically, teaching objectives closely align with the local medical context, exhibiting distinct characteristics: on one hand, they incorporate traditional concepts such as "the compassionate heart of a physician" to inherit the spirit of medical humanities[10], such as Shanghai University of Traditional Chinese Medicine's integration of medical case studies from the Huangdi Neijing, which increased professional identity by 40%[11]; on the other hand, it directly addresses the reality of doctor-patient conflicts, with the core objective of cultivating listening, empathy, and reflective abilities[12], reflecting the practical orientation of narrative medicine in serving China's medical ecosystem.

The fundamental difference in educational objectives between China and the West stems from institutional divisions in cultural values and medical ecosystems. Western narrative medicine education is rooted in individualist culture, with its "whole-person care" objective aligning with the institutional outcomes of the patient rights movement (the U. S. Patient Bill of Rights), emphasizing the cultivation of professional autonomy through individual narratives; in contrast, Chinese educational objectives are deeply embedded in collectivist cultural traditions, addressing the urgent need for resolving doctor-patient conflicts under the Healthy China strategy (the Regulations on the Prevention and Handling of Medical Disputes). This difference reflects the core tension within the medical system: the West views narrative as a tool for patient empowerment, while China positions it as a bridge for rebuilding trust between doctors and patients, with the two respectively pointing to "rights-based" and "relationship-based" medical ethical paradigms [1][9].

3.2 Course Design

Narrative medicine serves as a vehicle for medical humanities education, and the differences in its course design and teaching methods more vividly reflect medical culture and distinct pedagogical philosophies. By 2025, over 20 medical institutions in China will offer narrative medicine or related courses. Among these institutions, eight traditional Chinese medicine (TCM) universities center their curricula around TCM case studies (accounting for 40%). Course names include Narrative Medicine, Literature and Medicine, Warm Medicine, and Narrative Palliative Medicine, among others. Course formats range from required courses to elective courses, and some instructors incorporate narrative medicine as a course module or teaching content into related courses such as ideological and political education, English, ethics, and nursing. Some medical schools have established "workshops" to use extracurricular activities as a platform for interdisciplinary integration, conducting more flexible and extensive teaching and training related to narrative medicine. These courses incorporate the concepts of narrative medicine to varying degrees, adapting to local conditions, thereby highlighting the practical effectiveness of the localization of narrative medicine education in China. For example, Nanchang Medical College offers four narrative medicine-related courses, including narrative medicine, narrative palliative care, and narrative nursing, with narrative literacy as the core concept for teaching experiments; Peking University's School of Medicine and Humanities has developed a narrative medicine curriculum system through five courses, including literature and medicine; Peking Union Medical College's narrative medicine program focuses on narrative palliative care; and Shenzhen University offers a "warm medicine" course that integrates life journeys across different stages of life, emphasizing practical components.

With the development of Dr. Karen and her team's narrative medicine education practice system to date, narrative medicine education abroad has formed a highly specialized and systematic curriculum system characterized by deep interdisciplinary integration and a tiered progressive modular structure. In terms of interdisciplinary integration, through the deep integration of disciplines such as literature, psychology, and ethics, a multi-dimensional teaching and practice framework has been constructed. For example, the integration of literature and medicine, the incorporation of psychological tools, and the ethical dimension of value criticism collectively expand the theoretical depth and practical boundaries of narrative medicine. The course structure adopts a tiered and progressive design: at the undergraduate level, the focus is on laying the foundation for narrative perception and basic skill training, aiming to reveal the limitations of medical discourse; while the graduate and residency stages shift toward the clinical application of narrative skills and ethical reflection, guiding students toward evolving into reflective practitioners. This spiral-ascending path of "textual deconstruction-clinical practice-ethical reflection" aims to achieve a stepwise internalization of medical humanities literacy, ultimately cultivating composite medical professionals who possess both empathy and critical thinking.

The systemic gaps in curriculum design are shaped by the degree of disciplinary institutionalization and cultural cognitive logic. Western systems rely on mature institutions in medical humanities (such as the AAMC humanities education accreditation standards) to build a modular system deeply intertwined with literature and psychology, reflecting a knowledge integration path dominated by instrumental rationality; In China, clinical medicine and the evaluation system of the humanities and social sciences are disconnected. The cognitive logic of traditional Chinese medicine's "inferring internal conditions from external manifestations" (a fundamental concept in traditional Chinese diagnostic theory, referring to inferring internal pathophysiology through observation of external symptoms) aligns closely with the narrative medicine

philosophy of "deconstructing the social implications of disease," providing a methodological foundation for traditional Chinese medicine's narrative diagnostic model[6][9]; However, despite its innovative integration of the holistic perspective of traditional Chinese medicine and the "Red Medicine Spirit" , the course remains fragmented due to the failure to deconstruct the metaphorical transformation mechanisms inherent in traditional Chinese medicine narratives[2][3]. This discrepancy reveals a deeper contradiction: Western course design follows the knowledge production logic of positivism[15], while domestic exploration remains trapped in the superficial transplantation of traditional cultural symbols, urgently requiring the establishment of a methodological framework compatible with TCM's dialectical thinking [13].

3.3 Teaching Methods and Practical Pathways

(1) Theoretical Construction and Practical Pathways of Instrumentalization and Scenario-Based Approaches Abroad

Close reading serves as the cognitive foundation for narrative skill training, with its core focus on deconstructing the multiple meanings of disease through systematic textual analysis. Columbia University has established a disease-tiered reading system (e.g., oncology specializing in The Plague), integrating literary classics, patient autobiographies, and film and television works (e.g., The Ward) based on disease types, forming a cognitive chain from metaphorical interpretation to real-world mapping [14]. At the methodological level, the "3C Model" (Context, Content, Conflict) has been established as a universal analytical framework: by analyzing the historical context (Context) of plague depictions in Shakespeare's plays, the textual symbols (Content) representing disease, and the social power conflicts (Conflict) they reflect, students gain insight into the cultural bias mechanisms underlying the production of medical knowledge. Such training not only enhances textual interpretation skills but also catalyses critical reflection on implicit value judgments in clinical practice.

Reflective writing serves as a critical bridge for the transformation of narrative skills into clinical practice. Yale University's Parallel Medical Records system requires medical students to write narrative texts beyond standard medical records, incorporating patients' emotional trajectories and value aspirations, thereby forcing clinical thinking to transcend the simplistic frameworks of biomedicine [15]. The UK's "DIPEx" database further virtualizes writing training, where students simulate the role of a doctor to respond narratively to anonymous patient stories. The system generates capability assessment reports based on metrics such as empathy vocabulary density and emotional consistency [16], significantly enhancing the precision of narrative interventions through this human-machine collaboration model.

Scenario simulation reconstructs the complexity of clinical narratives through highly realistic scenarios. Stanford University's "End-of-Life Communication" role-playing module simulates treatment decision conflicts (such as the value trade-off between palliative care and aggressive therapy) through multi-party debates, forcing students to practice narrative mediation skills in the struggle for discourse power [17]. Technological empowerment drives scenario simulation toward a hyper-realistic dimension: the "VR Patient Consultation" system at the University of California, Los Angeles (UCLA) uses emotional modeling algorithms to generate virtual patients with psychological depth, enabling students to experience the micro-dynamics of narrative communication through immersive interaction [18].

(2) Theoretical Construction of Domestic Narrative Medicine Course Models and Practice Pathways

Domestic narrative medicine education has constructed a Chinese-style medical humanities education paradigm with both practical efficacy and political-ethical attributes through a dual-track approach of "community practice-oriented localization exploration" and "ideological coupling with the Red Medicine Spirit," achieving the localization adaptation and value transcendence of Western narrative medicine theory.

The community practice-oriented localization path uses the grassroots medical ecosystem as a narrative field, driving the transformation of medical humanities education from abstract theory to embodied practice through a three-dimensional linkage of "pain point identification-story collection-multiple coordination." This path emphasizes transforming real-world issues, such as community chronic disease management and doctor-patient relationship mediation, into educational resources. For example, in Fudan University's anatomy course, the narrative intervention of lung cancer patients [18] forces students to deconstruct the social determinants of disease in real medical scenarios [19]. Technological empowerment further enhances practical effectiveness, with innovative measures such as AR/VR tools simulating elderly medication challenges and narrative nursing interventions implemented via WeChat platforms [20][21], demonstrating the adaptive evolution of narrative medicine

education at the grassroots level in the digital age. Such practices are particularly critical in foundational medical courses like anatomy, as patient narratives can deepen students' understanding of bioethics [22] and, through a "university-community-hospital" collaborative mechanism, reconfigure the systemic thinking of healthcare services, elevating medical humanities from individual literacy to public health governance capabilities.

The ideological path of integrating the Red Medical Spirit is rooted in China's political and cultural context. Red Medical Spirit education relies on the role model influence of clinical teachers [23], using narratives to convey the medical ethics of "people first." Teachers' positive role modeling has an implicit influence on shaping medical students' professional spirit [24], achieving the value reproduction of medical humanities education. This path uses revolutionary medical history as its narrative theme, embedding the "red gene" into course design. It guides students through activities such as parallel case writing and oral history compilation to decode the expressive logic of political ethics like "people-centered" and 'collectivism' in clinical practice [21]. The "Red Medical Case" module at Chengdu University of Traditional Chinese Medicine achieves symbolic co-construction between the Red Medical Spirit and traditional Chinese medicine culture by analyzing the innovative application of traditional medicine during the revolutionary period [13]. This model transcends Western individualism by embedding socialist core values.

The synergistic innovation of these two paths reflects a paradigm shift in narrative medicine within the Chinese context: community practice reshapes the practical rationality of medical humanities through localized narratives, while the Red Medical Spirit reinforces its value rationality through ideological narratives. The dialectical unity of the two not only provides a methodological framework for constructing a medical humanities education system with cultural subjectivity but also establishes the unique contribution of the "Chinese solution" in the global medical education landscape—that is, re-anchoring the collective ethical coordinates of humanistic care in modern medicine dominated by technical rationality.

The differentiation of implementation pathways is the result of the interplay between technical rationality and cultural contextual adaptability. The West employs tool-based methods such as close reading models and VR simulations to pursue the standardization and replicability of narrative interventions, reflecting the institutional preference for quantifiable efficacy inherent in the evidence-based medicine tradition. China, however, adopts a dual-track approach combining "community practice" and the "Red Medical Spirit," whose pragmatic orientation stems from the institutional reality of unequal distribution of grassroots medical resources, compelling educators to achieve resource substitution through localized narratives. This choice of path fundamentally reflects differences in medical technology philosophy: the West reduces narrative to a clinical tool, while China elevates it to a cultural practice for reconfiguring doctor-patient relationships. The two approaches form a complementary framework of technological empowerment and cultural embedding at the methodological level [21].

3.4 Effectiveness Evaluation System

From the perspective of narrative medicine education evaluation, there are differences in the depth of research on teaching methods between China and other countries. Based on the use of the JESP scale to analyze patient satisfaction and medical students' depth of research on narrative texts, medical humanities education internationally has established a systematic framework.

In contrast, domestic effectiveness evaluations primarily analyze medical students' academic performance, which is highly one-dimensional and fails to enhance or implement the substantive content of medical humanities education. However, this has long been the primary method of evaluation in China. The lack of long-term tracking and multi-dimensional evaluations reflects insufficient timeliness in assessment, potentially making it difficult to analyze long-term changes in narrative humanities [4].

Table 1 Comparative Analysis of Four-Dimensional Models

Field	Foreign Model	Chinese Model
Educational Objectives	Fostering professional identity and cultivating the concept of "holistic care"	Alleviating doctor-patient conflicts Preserving the traditional concept of "compassionate medicine"

Field	Foreign Model	Chinese Model
Curriculum Design	Deep integration of literature and psychology A tiered progression system from undergraduate to graduate levels A well-structured and mature curriculum framework	Dominated by traditional Chinese medicine and nursing Innovative teaching of traditional Chinese medical case studies Currently in an exploratory phase
Implementation Pathways	Systematic interdisciplinary courses (e.g. medical anthropology) "Close reading-reflective writing-situational simulation" three-in-one approach	Community narrative practice Integration of the "Red Medicine Spirit" WeChat platform/AR technology-assisted practice"
Evaluation Methods	"Combination of quantitative and qualitative methodsStandardized tools such as the JSPE Empathy Scale Long-term clinical outcome tracking	Academic performance as the primary focus Reliance on subjective scales Lack of patient outcome tracking"

The gap in evaluation mechanisms exposes a serious mismatch between educational objectives and institutional safeguards. Western countries rely on standardized tools such as the JSPE scale and long-term clinical tracking to form an evidence-based closed-loop verification system, whose maturity stems from the quantitative requirements of the medical insurance system for patient satisfaction. In China, however, since narrative ability indicators are not included in the physician qualification examination (Physician Law, 2021), there has been a long-term reliance on crude assessments such as academic performance, leading to a lack of clinical effectiveness verification for the teaching goal of "alleviating doctor-patient conflicts." This institutional lag has plunged domestic explorations into a crisis of legitimacy. When policies require strengthening narrative literacy but fail to establish corresponding cross-dimensional assessment mechanisms, humanities education easily devolves into formalistic performance [3]. To address such issues, China can draw on the multidimensional assessment framework of the JSPE scale, combined with patient satisfaction tracking, to construct a three-dimensional evaluation system encompassing "academic performance—clinical effectiveness—patient feedback."

4.Deepening Localization Exploration: Pathways, Practical Bottlenecks, and Systemic Countermeasures

China's narrative medicine education has formed a distinctive pathway of "medical case teaching—community practice—red narrative" in its localization exploration, integrating traditional Chinese medicine culture and the Red Medicine Spirit. However, its deep development is still constrained by three structural contradictions. Theoretically, TCM narrative diagnosis and treatment have yet to transition from empirical inheritance to theoretical construction. The narrative cognitive logic within the "Four Diagnostic Methods" has not been systematically deconstructed, failing to transform disease narrative resources from classical texts such as the Shanghan Lun into standardized teaching models [13]. At the resource level, the interdisciplinary faculty shortage rate in grassroots institutions reaches 76%, with a more than threefold disparity in digital teaching resource coverage between eastern and western regions. The shortage of faculty is directly related to the lack of systematic humanities education capabilities among clinical instructors [25], necessitating the establishment of a "clinical physician-humanities scholar" collaboration mechanism [26]. The application of AR/VR technologies exhibits significant regional imbalances [3]. At the evaluation level, 90% of institutions still rely on quantitative assessment of academic performance, and only 12% of studies track the long-term impact of narrative education on clinical decision-making, resulting in a systemic gap from the requirements of the "Action Plan for Enhancing Medical Humanities Care (2024-2027)"[4].

To overcome these bottlenecks, a three-dimensional collaborative system of "theory-resources-institutions" must be established. In terms of theoretical innovation, the convergence points between the "preventive medicine" philosophy of the Huangdi Neijing and modern narrative medicine should be deeply explored, and a narrative diagnosis model centered on "differential narrative diagnosis" (a method that borrows from traditional Chinese medicine's differential diagnosis thinking to place patient narratives within their life context and socio-cultural environment for holistic understanding and interpretation), develop a "medical case-parallel medical record" dual-track teaching case repository, and achieve the modernization of

the "inferring internal from external manifestations" cognitive logic [10]. In the future, narrative medicine should be used to reconstruct the core of medical humanities [27], particularly by integrating narrative skill training into cross-cultural courses such as English[28]. In terms of resource integration, a national narrative medicine cloud platform will be established to share the DIPEx-style patient story database. Augmented reality (AR) technology will be utilized to simulate clinical scenarios such as medication conflicts in Alzheimer's disease. Concurrently, "dual mentor system" (clinical physicians + humanities scholars) faculty training will be advanced to alleviate the shortage of interdisciplinary teaching resources in grassroots institutions. In terms of institutional safeguards, narrative skills are included in the physician qualification examination with a weight of ≥15%, and a three-dimensional assessment system of "JSPE empathy scale—in-depth analysis of medical records—patient satisfaction tracking" is established to meet national medical humanities policy requirements and form a closed-loop verification mechanism from education to clinical practice [4].

5.Conclusion

This study demonstrates that the global consensus on narrative medicine education—"whole-person care"—has given rise to distinct practice paradigms across different cultural contexts. In the West, rooted in individualism, narrative medicine leverages the instrumental integration of literature, psychology, and ethics to enhance clinical decision-making precision; China, rooted in collectivism, creatively fuses the holistic perspective of traditional Chinese medicine with the Red Medicine Spirit to construct a dual-track localization pathway of "community practice-red narrative" (i.e., a localization model integrating grassroots community practice with ideological education rooted in the Red Medicine Spirit). This difference fundamentally reflects the dialectical unity of medical ethics' "rights-based" and "relationship-based" approaches [9], cautioning against the mechanical transplantation of Western theories in localization efforts.

In the future, the ultimate value of narrative medicine lies in driving a paradigm shift in medicine from "disease decoding" to "story witnessing." This requires educators to transcend technical rationality and convey humanistic care through role models [23][24], ultimately constructing a medical humanities education ecosystem with Chinese characteristics [27]. The core tension in future development lies in balancing international standards with localized innovation. While drawing on the systematic advantages of Western tiered modular curricula, it is even more crucial to activate the theoretical potential of traditional Chinese medicine's "inferring internal conditions from external manifestations" cognitive logic and the collective narrative of the Red Medicine Spirit. Through a three-tiered collaborative ecosystem (theoretical framework innovation—institutional safeguards—technological resource integration), we can promote the integration of humanistic care from educational design into clinical practice, ultimately serving the ecological reconstruction of "Healthy China" centered on people's health.

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The authors declare that there is no conflict of interest regarding the publication of this paper.

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