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Healing the healer: The Impact of Narrative Hospital Management on the Professional Burnout of Medical Staff in China

YANG Xiaolin

Doctor of Management

Supervisor:
PhD Virginia Trigo, Emeritus Professor
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BUSINESS
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Abstract

Professional burnout in the medical industry has reached its peak in the era of evidence-based medicine, which seriously affects the sustainable career development of Chinese medical staff and the improvement of healthcare quality. Narrative hospital management in Chinese narrative medicine system provides new solutions to the problem of medical burnout. This study uses narrative hospital management theory as the framework and hypothesizes that medical staff' professional burnout is mainly affected by factors such as the narrative ecology of hospitals and their own narrative competence (bio-health narrative cognition and workplace narrative ability). In order to verify this hypothesis, this study adopts the narrative inquiry, with 983 medical staff participating in the "Program of Narrative Center for Chinese Hospitals" (PNCCH) interviewed by the researcher and scale-based questionnaires, which involves nearly 5000 medical staff all over China, aiming at constructing a model for professional burnout at the individual and organizational levels. Research results show that medical staff in healthcare organizations that have received training in narrative medicine generally have greater narrative competence than those who have not, and that the former also have relatively lower rates of burnout. The study demonstrates that the improvement of narrative competence is a good remedy to resist professional burnout. The purpose of this study is to provide theoretical basis and countermeasures to solve the problem of medical professionals' burnout. It is expected that more hospitals will pay attention to the improvement of medical staff's narrative competence and the construction of narrative ecology, so as to provide the place of "pyscho-spiritual comfort" for the healers in the context of "Great health" from the organizational level.

Keywords: Chinese narrative medicine, narrative hospital management, professional burnout, medical staff, narrative inquiry

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Resumo

O esgotamento ocupacional na profissão médica está a atingir um ponto máximo na era da medicina baseada na evidência, afetando seriamente o desenvolvimento sustentável da carreira dos profissionais de saúde e a qualidade dos cuidados prestados. Este estudo, realizado no contexto chinês, argumenta que a gestão da narrativa hospitalar, quando integrada no sistema de medicina narrativa, pode oferecer soluções para este problema. Tendo como base uma amostra alargada de profissionais de saúde, a tese utiliza a teoria da gestão da narrativa hospitalar como quadro teórico e formula a hipótese de que o esgotamento desses profissionais é principalmente influenciado por fatores como a ecologia narrativa dos hospitais e a própria competência narrativa dos profissionais (cognição narrativa bio-saúde e competência narrativa no local de trabalho). Para testar esta hipótese, esta tese recorreu à investigação narrativa contando com a participação de 983 profissionais que colaboraram no "Programa de Criação de Centros de Narrativa em Hospitais Chineses" e utilizou um questionário envolvendo cerca de 5.000 participantes de toda a China com o objetivo de construir um modelo que evite o esgotamento quer a nível individual quer organizacional. Os resultados sugerem que os profissionais de cuidados de saúde que receberam formação em medicina narrativa têm, em geral, maior competência do que aqueles que não receberam, e que os primeiros têm também taxas relativamente mais baixas de exaustão, concluindo-se que a melhoria desta competência pode ser uma boa forma de resistir ao esgotamento. Em conclusão, esta tese fornece uma base teórica e propõe ações no sentido de ajudar a resolver este problema esperando-se que mais hospitais prestem atenção à melhoria das competências narrativas das suas equipas e à construção de uma ecologia narrativa, de modo a proporcionar um lugar de "conforto psico-espiritual" para os curadores.

Palavras-chave: Medicina narrativa na China, gestão hospitalar narrativa, esgotamento profissional, pessoal médico, investigação narrativa
JEL: I18, H13

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摘要

医疗行业职业倦怠在“以客观性、技术性、流程性、标准性以及规律性为特征的”循证医学时代达到巅峰，严重影响中国医者的职业可持续发展以及医院医疗质量和服务水平提升。中国叙事医学体系中的叙事医院管理为医者职业倦怠问题提出新的解决方法。本研究以叙事医院管理理论为框架，假设医者职业倦怠主要受医院叙事生态和自身叙事素养（生命健康叙事认知与职业叙事能力）等因素影响。为验证这一假设，研究采取叙事探究法（质性研究）和量表法（数据研究）相结合的方法，对全国上百家医疗机构的近 5000 名医者展开医者叙事素养与职业倦怠相关性调查和自我效能在医者职业叙事能力与职业倦怠之间的中介作用分析，并利用 NVivo11.0 软件对 983 名参与医者中随机选出的 52 名医者生命叙事访谈资料进行分析，构建个人和组织层面的医者职业倦怠理论模型。研究结果显示，在展开“叙事分享中心项目”的医疗机构里工作且接受过系统叙事医学培养的医者，其叙事素养普遍高于没有展开“叙事分享中心项目”的医疗机构里工作的医者，其倦怠率也相对较低。研究发现，医者叙事素养的提升是抵抗职业倦怠的良药。本研究旨在对未来改善医者职业倦怠问题提供理论依据与解决对策，期待更多医院重视医者叙事素养提升和组织叙事生态营造，为大健康语境下的治愈者从组织层面提供“心身安适”的发展空间。

关键词：中国叙事医学，叙事医院管理，职业倦怠，医者，叙事探究

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Chapter 1: Introduction

Job burnout has reached epidemic proportions in contemporary society. The burnout of medical practitioners in the healthcare industry has reached its peak (Perris et al., 2023) in the era of evidence-based medicine that is characterized with objectivity, proceduralism, standardization and regulation, seriously jeopardizing the sustainable development of Chinese medical staff as well as the quality of healthcare and safety of patients. It has become one of the key factors restricting the development of Chinese hospitals. Neither evidence-based medicine nor evidenced-based management have faults, but when medical staff's clinical practice and hospital management procession are absolutely evidence-based and completely discard the narrative thinking that medicine and management should have, then medicine would deviate from its original purpose and the hospital management would lose its original intention. Therefore, the development of healthcare industry will inevitably encounter bottlenecks and crises.

Under the evidence-based hospital management model, medical staff are constantly running like machines and most of them feel overwhelmingly exhausted. Doctors' professional burnout can easily lead to misdiagnosis, missed diagnosis, medical errors, hospital infection incidents and other serious problems that endanger patients' life safety and medical quality. These workplace crises further aggravate workplace burnout. To break this endless vicious cycle, in addition to multifarious methods and interventions mentioned in previous literature, researchers need to find an effective solution within a systematic framework that can not only solve the problem from the root but also make itself a scheme at the level of hospital management.

In other words, burnout among medical staff is not a single-cause problem, but a deep-seated internal crisis which requires system-level solutions. In the past, the research on the countermeasures of doctors' burnout could not incorporate the dual adjustment of organization and individual into a unified theoretical framework, so it could not form a systematical and replicable mode involving both levels' endeavor and efforts to achieve good expectations. Taking "narrative hospital management", an innovative management model complementary to "evidence-based hospital management", as the theoretical framework to alleviate physician burnout, the objective of this study is to understand this relationship and propose measures at

the level of hospital narrative ecology to actively create an organizational atmosphere that can stimulate the growth of the "workplace narrating self" of doctors and maximize the reserve of humanity of the medical practice through good narrative interconnections among hospital/section leaders, doctors, nurses, medical technicians, patients and their families. The study also aims at putting forward a variety of methods at the individual level of doctors to enhance their sense of family narrative connection and find the best way to improve the maturity of their "narrating self".

"Narrative Hospital Management" is an original theoretical construction based on the practice of more than 40 medical institutions across the country under the guidance of the research team of Southern Medical University (SMU for short). In-depth practice and further research show that, as an important branch of Chinese narrative medicine system, narrative hospital management provides a new and system-level solution to the crisis of professional burnout among medical staff. It is an acceptable and affordable solution which can change the overall spiritual state of the hospital leaders and medical staff and create "genius loci" for the hospitals. "Section and hospital administrators' narrative leadership", "medical professionals' narrative competencies" (bio-health narrative competence and professional narrative competence) and "hospital narrative ecology" are the three key words of this new branch. Narrative hospital management leads Chinese public hospitals to shift from the era of "lean management mode" to "value symbiosis mode" in the new centenary development of hospital administration or hospital management, which has been recognized as an independent discipline since 1929 (Davis & Henderson, 1929), and makes unique contributions to the realization of high-quality development of Chinese hospitals.

1.1 Research background

Burnout is, unfortunately, on the rise. It is a pandemic and pervasive problem that has been currently affecting a great number of people across various industries.

1.1.1 Medical staff's professional burnout in the context of high-quality hospital development

Healthcare providers (HCPs) are experiencing unprecedented burnout (Perris et al., 2023). In 2019, the World Health Organization (WHO) classified and updated burnout as an "occupational phenomenon", which is redefined this way: "Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully

managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job." Medscape Physician Burnout & Depression Report: I Cry and No One Cares in 2023 shows that the average burnout rate among doctors rose to 65%, up nearly 30% from the survey in 2018. Burnout among medical professionals has been a more widespread phenomenon since COVID-19 pandemic.

Burnout is directly linked to an impressive list of undesirable consequences such as lower patient satisfaction and care quality, higher medical error rates and malpractice risk (Panagioti et al., 2018), higher medical staff turnover, and medical professionals' own health problem. In U.S., Tait Shanafelt, MD, a pioneer in physicians' burnout research and prevention, has been named Stanford Medicine's chief wellness officer since 2017, one of the first at a U.S. academic medical center. He had led an initiative to combat burnout and improve physicians' well-beingness for more than a decade. Recent years, interventions like mindfulness programs, peer support initiatives, and organizational changes are being explored to mitigate burnout.

In the context of the high-quality development of Chinese hospitals and the public health cause, the professional development ability of doctors is the internal force and the fundamental guarantee for the improvement of medical service level. However, there is an epidemic of burnout among medical professionals in China. The persistence of job burnout not only impacts negatively on the medical staff's individual well-being and sustainable development but also endanger the safety of patients and the clinical diagnosis as well as treatment efficiency.

From the perspective of organizational management, professional burnout will cause medical staff to leave their posts frequently and even give up their medical profession (West et al., 2018), which will directly lead to the loss of technology, medical talents and clinical experience, and then reduce the team efficiency and limit the development of disciplines, resulting in the economic losses of hospitals. In other words, job burnout greatly affects the normal operation of the health care industry, but also greatly hinders the realization of the "Health China 2030 Plan" at the national level. Reducing the burnout rate of doctors is of great significance to the health of doctors, patient safety, medical quality, hospital management level, national health process and other aspects.

1.1.2 The mitigation of burnout in the context of narrative medicine

Narrative is the essence of human existence, permeating all aspects of human life. It is a fundamental human skill that is used to make sense of the world, express ourselves, and relate to others. Therefore, narrative has become an important issue in the building of harmonious

societies in the 21st century. Professor Phelan (2008) of Ohio State University, an internationally well-known authority in the domain of narratology, regards the "narrative turn" as one of the most important movements in contemporary thought.

Since the beginning of the 21st century, narrative has been integrated with other disciplines such as philosophy, psychology, anthropology, sociology, economics, architecture, management, ethics, literary and cultural studies, healthcare, law, and education. This newly emerging inter-disciplinary research are constantly increasing, and relevant treatises are being published one after another. This trend fully proves the important value of narrative on issues such as human survival, life and health, organizational management, and social development (Woods, 2014). It is in this context that bio-health narrative theory, narrative medicine and the mode of narrative hospital management emerged.

In recent years, many studies have been conducted on persuasive effects of narratives in a healthcare context (Frank et al., 2015; Pallai & Tran, 2019). According to some educators, the 21st century is the century of talents with narrative ability + X ability. Narrative competence has been identified as the essential competence for the professions such as teachers and health practitioners. If an individual falls into the state of narrative foreclosure or interpersonal narrative disconnectedness for a long time, serious mental and physical health crises will occur to him or her. Even he or she is medical staff, it is hard for him or her not to encounter psychosomatic health crises when stuck to the situations of narrative foreclosure or narrative disruption.

Narrative medicine is dedicated to cultivating clinicians' narrative competence. In 2000, Rita Charon, a professor and physician from Columbia University, U.S., first used the term "Narrative Medicine" to describe a method of using what she called "narrative competence", which is "the capacity to recognize, absorb, metabolize, interpret, and be moved by stories of illness." (Charon, 2007: 1265) Narrative medicine draws on the tools and methods of analytical and critical methods from literary study to help healthcare providers understand the patients' narrative imperatives. This includes close reading of written and spoken narratives, reflective writing, and group discussion and analysis (Charon et al., 2016). That is to say, narrative medicine aims not only to validate the stories of the patients, it also encourages creativity and self-reflection in the clinician (Milota et al., 2019).

In the world narrative turn, Chinese scholars not only dedicated ourselves to constructing the brand-new theory of bio-health narrative theory, advocating the significance of the growth of narrating self as well as the bio-health narrative ecology to any individual's health and development (X. L. Yang, 2022a), but also established, since 2011, a theoretical framework for

narrative medicine with conspicuous Chinese characteristics that is different from the western (X. L. Yang, 2011a). It takes the narrative conception as its overall framework, and integrates interdisciplinary knowledge such as life philosophy, social ethics, identity, cognitive psychology, social anthropology and literary criticism as its distinctive feature, aims to enhance the inter-personal narrative connectedness in the Chinese healthcare context. By improving the narrative competence of medical leaders and staff as well as the bio-health narrative competency of ordinary people including patients and patient family members in the context of "great health", narrative can empower the construction of narrative ecology in families, schools, workplaces, hospitals, elderly care institutions, and other places.

The year 2011 is called "the initiating year of Chinese narrative medicine". After 12 years of development, Chinese narrative medicine has explored a theoretical system and a practical path suitable for China's national conditions, and eventually the year of 2023 witnessed the publication of the "Consensus on Constructing a Narrative Medicine System in China" (X. L. Yang & Wang, 2023) and the first localized monographs of narrative medicine in China, namely, *Chinese Narrative Medicine and Medical Professionals' Competencies* and *Medical Professionals' Competencies and Career Development*. It is anticipated that the next 12 years will witness the birth, development and gradual perfection of its subbranches, such as, narrative nursing, narrative hospital management, narrative health management, narrative gerontology, narrative pediatrics and narrative oncology.

Since 2008, western scholars have begun to explore the relationship between narrative medicine and physician burnout in the clinical departments such as pediatrics (Bajaj et al., 2023), emergency medicine (Malik et al., 2023), obstetrics and Gynecology (Winkel et al., 2016), neurology (Bajaj et al., 2023). Studies have shown that narrative medicine can prevent and treat physician burnout in different departments or specialties (Perris et al., 2023); in addition, some scholars conduct some kind of narrative training in narrative medicine for doctors, such as poetry reading, text close reading, reflective writing. Butcher (2019) was found to have a significant effect on reducing the professional burnout of doctors. In 2019, Columbia University, the birthplace of narrative medicine, held the "Burnout Phenomenon in the Healthcare Industry Calls for Narrative: Narrative Medicine Workshop". It can be seen as evidence that narrative medicine can play a positive role in solving the problem of burnout.

Since 2019, Southern Medical University has guided the establishment of more than 40 narrative medicine practice bases across the country, launched the "narrative center project" in public hospitals in various cities such as Xi'an, Shenzhen, Changsha, Zhuhai, Zhanjiang, Foshan, Changchun, just name a few, in China. Through the implementation of the project, this

study advocates the creation of good hospital narrative ecology and the enhancement of medical professionals' narrative competencies and proposes that the new mode of narrative hospital management could plays an important role in medical professionals' career development and has positive effects in the prevention and alleviation of burnout.

1.1.3 The narrative turns in the "value symbiosis" era of hospital management

China's public hospitals have encountered development difficulties in recent years, and the development model of introducing high-salary talents and high-cost equipment more than ten years ago has been unable to continue to lead the rapid development of hospitals. The National Health Commission and the State Administration of Traditional Chinese Medicine released the "Action to Promote High-quality Development of Public Hospitals (2021-2025)" in September 2021. The document requires that "with the construction of disciplines, talent teams and information technology as the support, the improvement of medical quality, medical services, medical education, clinical research and hospital management as the focus, and the high-quality development index of public hospitals as the criterion to promote the medical services and management capabilities of public hospitals in China to a new level. By creating a group of public hospitals with top medical technology, excellent medical quality, efficient medical services, fine hospital management and high satisfaction, China's public hospitals as a whole will be promoted to enter a stage of high-quality development."

How to achieve high-quality development in the new context, this problem requires Chinese hospital leaders to actively seek solutions from a deeper level. Hospital management is a discipline with a history of nearly 100 years, from 1929 to the present, its development can be divided into four stages, science - people-oriented - lean - value symbiosis. It is worth noting that Lean medical's development in China still faces some challenges. For example, the complexity of the medical system and the influence of cultural traditions may hinder the widespread application of lean medicine; the size and resource constraints of medical institutions may also affect the implementation of lean medicine. In addition, public medical institutions pay less attention to lean management than non-public hospitals because of their positioning and resource supply.

Due to the special conditions in Chinese healthcare reform, and with the generation Z's entering into hospital workplaces as the main medical force, the leaders of hospitals must figure out a more effective management model instead of lean management. Therefore, the model of "Value Symbiosis" as an upgraded version of both humanistic and lean management seems shining its lights before us. In the transition process of Chinese hospital management from lean

to value symbiosis, to some extent, Chinese experts' efforts on the localized evolution of narrative medicine have become an important catalyst, and simultaneously, the "narrative turn" has brought innovative vitality to Chinese hospital management.

In this situation, since 2021, Southern Medical University, the origin of Chinese narrative medicine, has become the chairmanship unit of the Narrative Medicine and Health Humanities Committee of Guangdong Hospital Association, and 17 hospitals have participated in the pilot study of "Chinese narrative Hospital Management", which witnessed the launch of "Project of Narrative Center in Chinese Hospitals" (PNCCH for short). Later, 40 hospitals join in the project. Leaders from these hospitals have realized the dilemma of Chinese reform on medical system and acknowledged the essence and effectiveness of narrative medicine and narrative hospital management. They are trying to make their hospitals both a "process-oriented organizations" and an "eco-oriented organization". This new model attaches more importance on empowering individual members within the organization, turning them into the co-creators of hospital value, thereby activating the inherent action, reflection, ethics and creativity of each subject.

With the intensification of homogenized competition such as the introduction of medical equipment and talents in public hospitals, how to stimulate the endogeneity of medical staff in hospitals, reduce the occurrence of the workplace burnout rate, and achieve high-quality development in the fourth management revolution of "value symbiosis" is a problem that leaders and administrators of medical institutions must think over. "Narrative hospital management", which is beneficially complementary to "evidence-based management" rises in response to the proper time and conditions.

Narrative hospital management is a new interdisciplinary subject that integrates management theory, philosophy, professional ethics, sociology and cognitive psychology into the narrative framework based on the narrative concept of bio-health narrative and narrative medicine. In a sense, Chinese narrative hospital management is an art that can help hospitals achieve high-quality development and is an indispensable and beneficial supplement to traditional hospital management concepts.

1.2 Research plan

1.2.1 Theoretical underpinnings

"Narrative hospital management" is an innovative hospital management model that, in the

Chinese context of high-quality development, integrates the three disciplines of Chinese bio-health narrative, narrative medicine and Western narrative leadership mechanics. Therefore, the basic concepts of these three disciplines are the important theoretical sources of this study.

Based on the concept of narrative self-development in the bio-health narrative theory, this study proposes that the narrative accomplishment of doctors is directly related to the maturity of narrating self, and the professional narrative competence of doctors is directly related to the maturity of professional narrating self. For the medical industry that serves people's life and health, the growth of professional narrative self-based on narrative self-development is not only related to the sustainable career development of individual doctors (high professional identity and self-efficacy, avoiding job burnout and psychological and physical health crisis), but also related to the life safety and health quality of the service objects.

The conception of narrative ecology in the theoretical construction of bio-health narrative proposes that the seed of one's "narrating self" is rooted in the family and sprouting in a good "family narrative ecology". Since its germination, the narrating self will continue to grow in the individual's educational stage and emerging in a good "school narrative ecology". Furthermore, the maturity of one's narrating self depends on a good "workplace narrative ecology". Every individual must experience the influence of different narrative ecology such as family, school, community and workplace. Only in the safe, relaxed, inclusive and harmonious narrative ecology can each individual's "narrating self" be nourished, and can the individual maintain a positive life state and avoid falling into illness or burnout. However, hospitals in China as a workplace do not provide necessary nutrients and environmental support for the evolution of clinical staff's "workplace narrative self". Therefore, this study developed the concept of narrative ecology construction in hospital workplaces.

Based on key words in Chinese narrative medicine theory, such as narrative competencies of doctors, multi-dimensional narrative connection of hospitals and professional narrative foreclosure, this study developed the narrative competencies scale of Chinese doctors and proposed two ways to improve the professional narrative competence of doctors. The first is in the "people around us among the workplace world" meaning that, in the hospital, medical staff take the initiative to establish friendly and horizontal interpersonal narrative connections with managers, clinical colleagues and medical technicians, patients and their families, so as to accumulate and enrich their interpersonal experience in the hospital career. The second is to actively listen to and read real or fictional stories about birth, death, illness, medical education and professional growth from the "world of medical predecessors", "people around among the hospital world", as well as from "the world of contemporaries", in the purpose of accumulating

indirect interpersonal narrative capital, cultivating interpersonal narrative wisdom, and improving workplace competency. And if the hospital leaders could create a good narrative atmosphere to stimulate the growth of medical staff's "workplace narrating self", then the workplace burnout could be combated to a low rate.

Western experts in narrative management and narrative leadership mechanics believe that narrative is the main carrier of leadership. Narrative organization or narrative management emphasizes the special position of narrative in human communication and organization management. Thus, take a department from a model that embraces the idea that "human beings are intrinsically homo narrans", follows the principle of "management as narrative", and bases itself on the above three newly-constructed theories, this study proposes that only by complementing narrative hospital management and evidence-based hospital management can high-quality management of the "human being", to the "human being", for the "human being" be achieved. It also expounds the five dimensions of hospital narrative management, clarifies the important value of hospital narrative ecology to the maturity of individual narrating self of doctors, and then systematically designs a new concept of "narrative center project" for hospital leaders, contributing a new force from narrative management perspective to the prevention and management of doctor burnout.

1.2.2 Research arguments and research questions

Based on the construction of narrative hospital management theory, this study proposes that the hindered development of narrating self of doctors is an important cause of physician burnout, and the development of narrating self of doctors depends on a good hospital narrative ecology (workplace narrating self) that in turn depends on the narrative competence of doctors at the personal level (personal narrating self), see Figure 1.1. Therefore, to change the current situation, the research and practice of preventing and managing job burnout must be carried out systematically within the narrative framework. Through the practice of the PNCCH carried out in 40 public hospitals across the country, this study used the methods of scale survey and the bio-narrative inquiry to compare the effects of the improvement of narrative competencies and the alleviation of job burnout among medical professionals before and after the launching of PNCCH, and further deepened the management theory of narrative hospital by using the model constructed by the researcher.

Based on the construction of narrative hospital management theory and the development of PNCCH, this study holds the view that the reason why the "helping" profession of doctors, nurses, and health-care workers are anticipated as one demographic that is enormously

vulnerable to burnout's influence lies in that there is a greater demand of maturity in the narrating self, especially the workplace narrating self for helping professionals and when the maturity of narrating self could not reach its requirement, these medical professionals' could not cope with the complicated situation encountered in the workplace. In his book *The Checklist Manifesto: How to Get Things Right*, Gawande (2010: 19) writes: "Medicine has become the art of managing extreme complexity - and a test of whether such complexity can, in fact, be humanly mastered". This complex management art, which involves life safety and medical quality, requires hospital or department leaders as well as clinicians to have a higher level of maturity in their professional narrating self than those in other industries or workplaces.

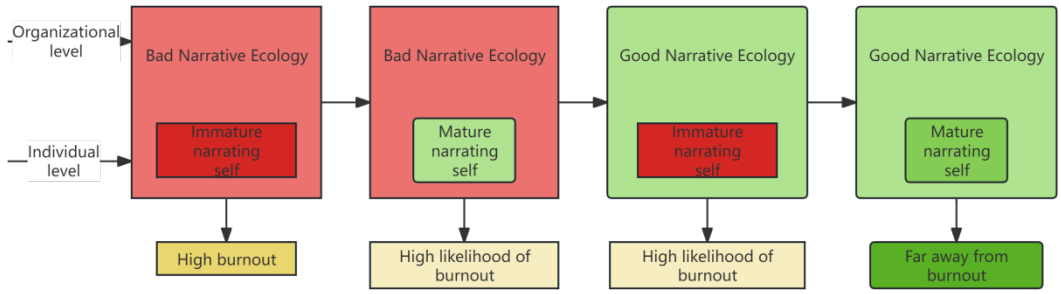

Figure 1.1 Burnout likelihood pertaining to workplace narrative ecology and maturity of narrating self

Source: Developed by the author

Thus, this research acts on the core assumption that the stagnation of the maturing process of the medical staff's narrating self-including their workplace narrating self in a harsh workplace narrative ecology is the root cause of their professional burnout. And there are four main sub-hypotheses underlying this core hypothesis, they are as follows (see Figure 1.2):

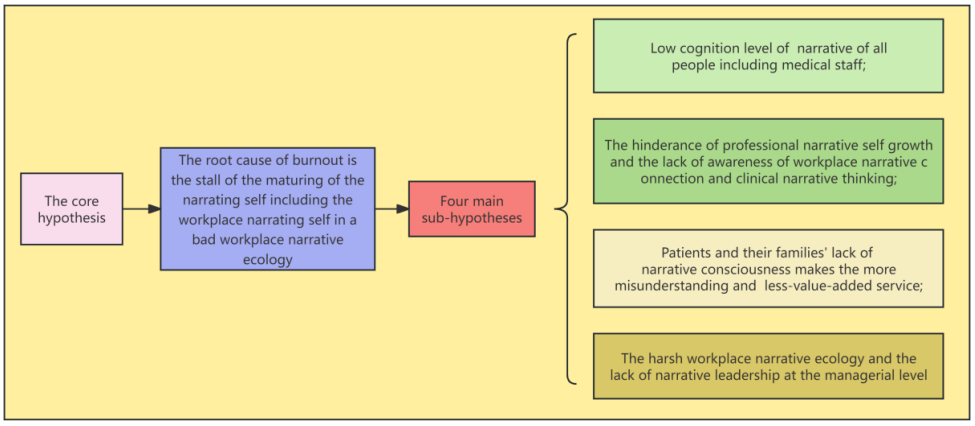

Figure 1.2 The research hypothesis of this study

Source: Developed by the author

First, in the era of network and the popularization of smart products, the individuals' narrating self has not grown to the maturity as it should, and the cognition level of bio-health

narrative of all people including medical staff is generally low. One's narrating self, developed in the individuals' previous family and educational ecology, is the point of departure or springboard of one's workplace narrating self. Life burnout caused by weak family narrative bonding and lack of narrative connection in other social dimensions are important causes of burnout after individuals enter the workplace.

Second, the development of professional narrative competence of doctors has not been fully valued at the organizational level such as hospitals or departments, the growth of professional narrating self is hindered, the awareness of workplace narrative connection and clinical narrative thinking are lacking, and the narrative connection between doctors and themselves, managers, colleagues and service objects (patients and their families) is weak, and to a greater extent, they are like a constantly running machine. Professional enthusiasm disappears in the materialized self.

Third, patients and their families have low bio-health narrative consciousness, and doctor-patient conflicts cause doctors to spend more energy and emotions and fail to achieve value-added services.

Fourth, the workplace narrative ecology is barren and harsh, the overall narrative cultural atmosphere is lacking, and managers of the hospital level and department level do not have good narrative leadership, thus unable to create an atmosphere to stimulate medical staff' normal and steady growth of their narrating self in their workplace.

The research questions of this thesis are as follows:

Research question 1: Can narrative concepts be used to systematically explain the internal (narrative competency) and external (narrative ecology) root causes of the high incidence of medical burnout?

Research question 2: Can we take the newly constructed narrative hospital management theory as the starting point, build a good hospital narrative ecology from the hospital organization level, and improve the narrative competencies of doctors from the personal level, so as to reduce the burnout rate of doctors?

Research question 3: Can the theoretical model of physician burnout at individual and organizational level produced by the implementation of the narrative center project and the results of narrative interviews contribute to deepening the construction of narrative hospital management theory and promoting the high-quality development of hospitals?

1.2.3 Research participants

We sent 5000 questionnaires (this questionnaire combines the scale on narrative competence

and scale on job burnout in one) to doctors and nurses all over China. In addition 2000 questionnaires (this questionnaire combined the Job Burnout Scale and Self-Efficacy Scale) were sent to medical staffs all over China.

Forty hospitals participated in the PNCCH, 28 in Guangdong (13 in Shenzhen, 2 in Guangzhou, 4 in Foshan, 1 in Zhuhai, 2 in Dongguan, 2 in Zhanjiang, 3 in Huizhou, 1 in Yunfu), 3 in Hunan, 2 in Jilin, 1 in Shandong, 2 in Shanxi, 1 in Sichuan, 1 in Guansu, 1 in Zhejiang, 1 in Heibei.

Altogether 1059 narrative medicine tutors from these hospitals have been cultivated in the project, among which 983 participated the narrative inquiry interviewed with 9 questions. All the hospitals participated hold daily narrative activities for administrators, medical staff, patients and patients' family.

1.2.4 Research methods and tools

In order to verify the main argument of this thesis, the study adopted the life narrative inquiry method (qualitative research) and the scale method (using the self-developed Chinese Narrative Competencies Scale for Medical Professionals (CNCS-MP), combined with the Job Burnout Scale (MBI-GS) and Self-Efficacy Scale (GSES).

(1) Based on the systematic exposition of the narrative hospital management theory, a survey was conducted on the correlation between the narrative competency and job burnout among nearly 5,000 doctors in hundreds of medical institutions across the country, and an analysis was conducted on the mediating role of self-efficacy between the professional narrative competence and job burnout among nearly 1900 medical staffs.

(2) At the same time, we conducted life narrative interviews with 983 medical staffs, entered their inner world and life narrative process, and deeply explored the causes and corresponding solutions of their job burnout.

(3) Qualitative research adopted NVivo11.0 software to conduct random sampling analysis of the collected interview corpus and built theoretical models of workplace burnout of medical staff at individual and organizational levels. From the point of view of narrative management, the author puts forward some constructive countermeasures at individual and organizational levels to deepen the construction of narrative hospital management theory.

1.3 Theoretical value and practical significance

Based on the main argument of this research and literature review, this study proposes to use

the narrative hospital management theory constructed on the basis of the management practice of 17 member units of Guangdong Hospital Association as a guiding framework, and further integrates the "Narrative Center Project" into 40 hospitals. By promoting and progressing the research, a good narrative ecosystem in the hospital workplace could be created and simultaneously a group of qualified narrative medicine mentors could be cultivated to become the narrative intervention force of the hospital to relieve staff burnout at the organizational level. Therefore, both the narrating self and the workplace narrating self could be grown steadily into a more mature state, which is the root strategy to prevent burnout.

1.3.1 Theoretical value

(1) Based on the key concept of "narrating self" and "narrative competence" in the bio-health narrative theory established by SMU researchers, this study proposes the concepts of "working narrating self" and "professional narrative competence" for the first time aiming at illustrating the underlying mechanism of professional burnout using the theoretical framework of narrative. The researcher clarifies that the medical professionals' narrative competency is composed of two major dimensions: bio-health narrative competency and professional narrative competence. Their bio-health narrative competency is the fountain and foundation of their workplace narrative competence and there are deep interactions between these two dimensions. Thus, the improvement of the medical staff's bio-health narrative competency can promote the growth of their workplace narrating self and ultimately alleviate job burnout. In addition to personal efforts, the research proposes that the narrative ecology at the level of hospital organization and the narrative leadership wisdom of managers play a very important role in promoting the improvement of narrative competency of doctors.

(2) Borrowing the concept of narrative ecology in the bio-health narrative theory, this study proposed the new concepts of "hospital narrative ecology" and "narrative ecology of clinical departments" for the first time and proposed the important value of hospital narrative ecology to the development of workplace narrating self of medical practitioners. According to findings from the implementation of 40 hospital narrative centers, the thesis makes some concrete measures for the construction of narrative ecology and the prevention and management of physician burnout. As González-Morales et al. (2012) point out, burnout can act as a contagion, crossing over (Bakker et al., 2009) between and among workers in the same social and working environment. Just like a cold, it is possible for us to "catch" burnout from the colleagues around us, resulting in a sort of "collective burnout". Thus, improving "hospital narrative ecology" and "narrative ecology of clinical departments" can effectively prevent professional burnout from

catching burnout from each other. This program with less investment and maximum benefit can solve the burnout crisis systematically from the organizational level and from the individual level and lay a solid foundation for the further deepening of the theory of narrative hospital management with Chinese characteristics.

(3) On the basis of these innovative ideas, this study compared with the view that the high integration of "evidence-based medicine" and "narrative medicine" can achieve the improvement of medical quality, and proposed a new complementary model of "evidence-based hospital management" and "narrative hospital management" (X. L. Yang, 2022b), and proposed an innovative way for the current high-quality development of hospitals.

1.3.2 Practical significance

(1) In the mid period of this study, the CNCS-MP was developed, which was the first scale in China formulated by a trinity of narrative medicine theory builders, educators and clinical practitioners as it can measure the maturity of the narrating self of individual medical staff, especially the state of professional narrating self, and prevent the occurrence of job burnout and other psychosomatic health crises. Many participants said that the process of finishing the scale was the process of improving their narrative consciousness, which led them to reflect and readjust their way of life and work.

(2) The research lasted for almost 5 years due to the heavy task of theoretical perfection as well as practical promotion of the PNCCH. During the research, this study guided nearly 100 hospitals across the country to carry out narrative medicine clinical practice and narrative hospital management practice along three years of continuous coaching of tutoring teams of narrative medicine in hospitals involved in PNCCH. Altogether 1059 coaches fulfilled their 22 hours' course and began to function as narrative seeds in their respective ecology. This research can not only resolve the crisis of physician burnout, but also become a model that can be replicated in more hospitals in order to achieve high-quality management as these narrative medicine coaches all over the country have become the tree of life in Chinese hospitals' present harsh narrative ecology.

(3) Managers are often trapped in the biomedical mode of evidence-based medicine thinking and the digital rule mode of evidence-based management thinking. The deep-seated reasons for employee burnout, doctor-patient conflicts and frequent adverse events are rarely considered from the root. This study goes deep into the grassroots level to carry out narrative exploration, and many of the interview cases can be further used as model cases for the management ability training of narrative hospitals and narrative departments. In the past,

managers tended to learn management-related theories and cases of overall hospital management, mostly leaning towards evidence-based cases, lean and process management cases, and lacking review and reflection from a narrative perspective. The narrative cases in this study can fundamentally upgrade the management thinking of hospital managers, truly break through the management bottleneck, and help hospitals and departments to achieve high-quality development.

(4) In the process of research and concept promotion, many hospital managers and doctors have benefited from it. By improving bio-health narrative competency and career narrative ability, they get out of job burnout and career narrative foreclosure, change their attitude toward life, change the way they treat their families, change the perspective of looking at and dealing with problems, change the perspective of understanding and interpreting life, and stimulate unprecedented vitality and creativity. As more hospitals use narrative concepts to carry out management, the entire medical system can accumulate more positive energy, creating conditions for the high-quality development of hospitals.

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Chapter 2: Literature Review

This chapter sorts and summarizes the relevant research status around the main keywords namely, evidence-based thinking in medicine and management, professional burnout in the context of evidence-based medicine, narrative medicine and narrative hospital management. Departing from the overall literature review, the thesis asserts that there are few effective solutions at both individual and systematical level towards medical staff's professional burnout, which is a severe crisis in contemporary healthcare industry causing many serious negative consequences and hindering the high-quality development of medical institutions in China and thus proposes that narrative intervention through the PNCCH, adopting the theoretical framework of narrative hospital management can be the plausible and practical mitigation mode in the context of New Quality Productive Forces.

2.1 Evidence-based medicine and evidence-based management

For the past 70 years, evidence generation for patient management in clinical medicine has been dominated by Evidence Based Medicine (EBM) with its emphasis on Randomized Controlled Trials (RCTs) while disregarding real-world data (RWD) and clinical experience (Van de Vliet et al., 2023). In other words, the era of evidence-based medicine is dominated by quantification and scientific data. In this era, both clinical medical research and practice as well as hospital management research and practice are exclusively dominated by the evidence-based thinking of the clinicians and the managers.

2.1.1 The development and the peak of evidence-based medicine (EBM)

EBM has a long history. This concept, in terms of words and meaning, is relatively straightforward: medicine practiced based on evidence. However, this literal meaning fails to capture what has come to be understood by evidence-based medicine today, following a campaign launched in the early 1990s known as the EBM movement (Guyatt et al., 1992). The EBM movement focused attention on the need for greater objectivity in medical decision-making and led to the Cochrane Collaboration, which provides reviews of evidence based on comparative research.

The launch of EBM coincided with growing interest in clinical guidelines as a means to improve clinical practice. Such guidelines seek to bring together the best available evidence on specific topics, and the systematic reviews published by the Cochrane Collaboration and other academic groups were important contributors to this development. Indeed, clinical guidelines are intimately connected to EBM in that they provide a means to disseminate what the EBM movement advocates.

Evidence-based standardized care guidelines are beneficial tools that help clinicians ensure technical cure quality. However, EBM was never meant to pave the way for "cookbook medicine". EBM always intended the explicit, conscientious, and judicious use of current best evidence from research and clinical experience to be integrated with a person's needs, values and preferences as they arise from the health challenges (Sackett et al., 1996). Patients are persons who are already powerful in their lives. However, inherent features of health care contribute to disempowerment and distancing between patient and professionals, which results in incomplete professional knowledge of the person's values, needs, preferences and context. The systematic focus on disease/condition/malfunction and professionally defined outcomes promote a paternalistic approach that may be distressing to the person (Greenfield et al., 2014). Without concomitant tailoring to the person, a strong focus on compliance with pathways and guidelines turn care into more of a transaction than a relationship, denying personhood to both patient and professional.

2.1.2 The development of evidence-based management

There has been an enormous effort to develop new models for organization and management, especially in the last decade (Briner et al., 2009). One of these models is evidence-based management (EBMgt for short). The EBMgt was an evolution in the practice of management and organizations that was coined from the "Evidence-Based Medicine (EBMed)" by David Sackett in the 1990s (Sackett et al., 1996).

At the beginning of the 21st century, when Denise Rousseau was serving as the president of the Academy of Management, she stood up and called for the launch of EBMgt movement. EBMgt depends on neither instinct, nor current trends, which can both have unknowing negative influence on decision-making. Instead, actions in the course of EBMgt are based on diverse measurements of one's own values - on a rational level. All measurement results are reviewed, the quality of the evidence is critically examined, and the strategic organization is aligned and adjusted accordingly. In this way, linear thinking is eliminated and a better way of dealing with the dynamic world is promoted.

A few years later, this new model in the field of management produced different responses. Many heavyweight scholars in the field of management, such as Pfeffer and Sutton (2006a, 2006b), each published EBMgt-related monographs, and management schools of many universities also began to teach it as a course. For EBMgt courses, Europe has also established the Center for Evidence-Based Management (CEBMa for short), which aims to assist managers and institutions in making high-quality management decisions and attract members from academia and industry around the world. EBMgt proceeds from the premise that using better, deeper logic and employing facts to the extent possible permits leaders to do their jobs better (Pfeffer, 2006). According to Rousseau (2020), chair of the Health Care Policy and Management program and director of the Project on Evidence-Based Organizational Practices, EBMgt is the "the conscientious use of multiple sources of evidence in organizational decisions".

Evidence-Based Change Management is the science-informed practice of managing planned organizational change. That approach sounds better than what Stanford Professor Jeff Pfeffer sees today: too often managers "do not use the best or, perhaps, any, evidence" in making decisions (Barends & Rousseau, 2018). More and more organization leaders in the beginning of 21st century draw the conclusions that more evidence can help facilitate better managerial, and thus better organizational decisions from their own empirical research and practical experience.

2.1.3 The negative consequences of evidence-based medicine and management

Clinicians or hospital (department) leaders who only have scientific and logical thinking generally lack empathy and imagination, and lose their capacity for holistic health, interpersonal communication, wisdom leadership, narrative inference, and crisis prediction and resolution. There is nothing wrong with evidence-based medicine and evidence-based management, but the absolute evidence-based thinking mode makes the medical and management process frequently encounter crises. Pure scientific and rational thinking will have serious consequences. As Rabindranath Tagore said, "A mind all logic is like a knife all blade. It makes the hand bleed that uses it."

Both of evidence-based medicine and evidence-based management are the driving force of the development of medical science and managerial science. However, many of the leaders embrace only evidence-based thinking, whereas neglecting other thinkings that are complementary to evidence-based thinking and essential for humanistic management. Influenced by the scientism and technological determinism of modern medicine in the high

peak of evidence-based medicine, the mindset of Chinese hospital leaders, especially those leaders who are themselves clinical experts without enough professional training in management, incline to manage their hospitals in a scientific and evidence-based paradigm (Locke, 2011).

The whole hospital is composed of many departments and sections with distinct powers and responsibilities, which are independent of each other, and the interaction between these departments and sections is limited. Such a "deep well system", in which non-communication between departments and sections has long-time been regarded as normal, will unavoidably results in "silo effect". A Communication silo is often the term used to describe internal breakdowns, or blockages of the information flow within an organization. A silo is always vertical, making it difficult or impossible for the horizontal flow of information. It describes the restrictive flow of open communication between departments, teams, management and stakeholders.

Hospital managers who are led by scientific evidence-based thinking generally tend to present facts, reason, rules and data in the management process, while ignoring the fact that the external rules and regulations will hinder the internal growth of hospitals and employees. This will contributes to the leadership gap which will make them more like passive fixers than real leaders and eventually lead to leadership burnout (Daskal, 2017). At the same time, under the guidance of scientific rationality, hospitals use simplified measurement methods to study and verify complex human health systems and guide doctors, technicians, nurses and patients to exclusively pay attention to the quantitative and objective changes in the patients' biochemical indicators, physical indexes and imaging data.

Under such evidence-based thinking, subjective expression of life experience by all individuals appearing in the medical institutions is ignored or suppressed. The technicalities of medical management and the standardization of the system makes medicine lose its essence to a certain extent. Mueller (2018), author of "The Tyranny of Metrics," has argued that " a tyranny of metrics that threatens the quality of our lives and most important institutions", and "becoming aware of the characteristic pitfalls of metric fixation is the first step in helping your organization to recover, and to restore judgment to its proper place.

Evidence-based thinking and evidence-based management have led to doctors and nurses' well-being in jeopardy, conflicts and crises frequently breaking out between doctors and patients, and medical staff's low self-efficacy and low professional identity. The reasons for the low self-efficacy and professional identity lie in the following aspects: (1) high rates of misdiagnosis, (2) incapability in explaining the causes of the symptoms for MUS patients, who

account for about half of the total number of patients seeking for medial sources, and incapability in helping them relieve symptoms according to the existing diagnostic standards and treating guidelines, (3) the low quality of life of patients with long-term serious diseases, and (4) the powerlessness in the peace and hospice of the terminally ill patients. These are all relating to the deep causes of doctors and nurses' professional burnout. The common cause of these above crises is that hospital leaders and medical staff are dominated by absolute evidence-based thinking, and the multi-dimensional interpersonal narrative connectedness that should be maintained among various subjects in the medical context is broken.

2.2 The crisis of medical Professionals' burnout in the context of evidence-based medicine and management

Burnout refers to a long-term psychological reaction caused by an individual's inability to effectively cope with a variety of persistent pressures at work, including emotional exhaustion (EE), depersonalization (DP) and reduced personal accomplishment (RPA) (Maslach & Jackson, 1981). It is part of the larger construct of well-being, defined as "quality of life, which includes the absence of ill-being and the presence of positive physical, mental, social, and integrated well-being…across personal and work-life domains" (Brady et al., 2018). Professional burnout received extensive attention and coverage since the end of 20th century as it has become increasingly the global pandemic. This section mainly shows experts' theoretical contributions on professional burnout and the major literature on the consequences and interventions on burnout.

2.2.1 Basic research on the topic of professional burnout

It was in 1974 that burnout received its first nominal airing as "Staff Burnout", by German-born U.S. psychologist and psychotherapist Herbert J. Freudenberger. The term "burnout" was probably taken from Graham Greene's novel *A Burnt-Out Case*. The term is invented to illustrate the state of "becoming exhausted by making excessive demands on energy, strength, or resources" in the workplace. Burnout, by his lights, was the "high cost of high achievement".

Christina Maslach, one of three people responsible for the gold standard of measuring burnout - the eponymous Maslach Burnout Inventory (MBI) - and the coauthor of the Areas of Worklife Survey, defined burnout as "an erosion of the soul caused by a deterioration of one's values, dignity, spirit and will". Michael Leiter, a Canadian researcher and frequent collaborator

of Maslach, has called burnout a "crisis in self-efficacy". In his 1991 papers, he reviews the central role of self-efficacy expectations in a variety of approaches to organizational performance and management and explores the implications of self-efficacy for the study of burn-out. He proposes that this conceptualization of burnout would allow a more reasonable understanding of moderate instances of the syndrome and would differentiate the concept of burn-out distinctly from the related field of occupational stress.

According to Maslach and Leiter (2000), symptoms of burnout at work can be grouped into three dimensions, see Figure 2.1:

(1) Emotional exhaustion, e.g.:

Feeling chronically tired even when you are not doing much,

Having trouble sleeping at night,

Struggling to concentrate or keep your attention on a task.

(2) Depersonalization or cynicism, e.g.:

Blaming everyone around for the way you feel,

Experiencing "compassion fatigue",

Feeling isolated and struggling to maintain relationships.

(3) Reduced sense of personal accomplishments of efficacy, e.g.:

Prolonged feelings of depression and/or anxiety,

Loss of enjoyment in those parts of your work that you used to like,

Persistent thoughts about your work being meaningless.

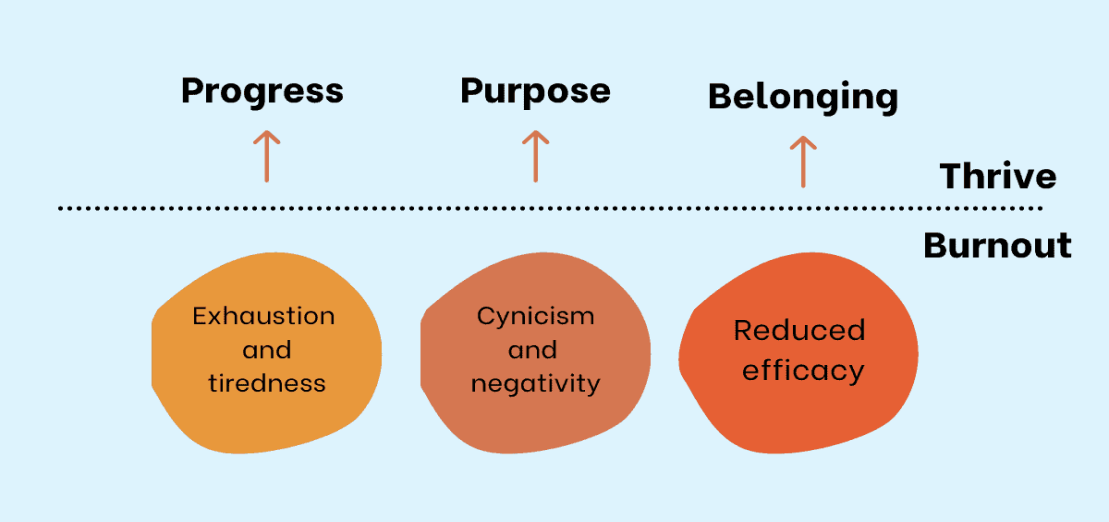

Figure 2.3 The three dimensions of burnout and its counterpart

Source: Lavrova (2024)

Maslach and Leiter (2000) presented in their book *The Truth about Burnout*, defined burnout more in terms of the systemic disconnect between a person's true self and his or her

expectations about his or her work. It represents an erosion in values, dignity, spirit, and will - an erosion of the human soul (Maslach & Leiter, 2000). The six systemic sources of burnout that are discussed in detail in Maslach and Leiter's book are: work overload, lack of control, insufficient reward, unfairness, breakdown of a sense of community and value conflict.

In 1982, Christina Maslach and Jackson jointly developed the "Maslach Burnout Inventory (MBI)" for the development of tools for empirical research on job burnout. Pines (2018), an Israeli researcher looks at burnout in all sorts of inspired contexts, sums up the problem as "the failure of the existential quest" - that moment when we wake up one morning and realize that what we are doing has appallingly little value.

German psychologists Demerouti et al. (2003) developed the Oldenburg Burnout Inventory (OLBI), which divides burnout into two aspects: exhaustion and disengagement. These scales have become an important tool to measure the job burnout assessment of medical staff. Technologies such as Vitrue VIDA Burnout assessments are now able to empower people with insights into where they might be at risk of or exhibiting symptoms of burnout with recommendations on how to prevent or reduce it.

The explicit definition and the scientific design of inventory of burnout can help dismantle the misbelief that burnout is "nothing serious" and remove the incorrect assumption that those who have it do not need occupational and organizational support. Maslach and Leiter (2016) think that burnout is a multifaceted condition of overwhelming exhaustion, interpersonal detachment or cynicism toward one's job, and a sense of reduced professional efficacy, driven by long-term workplace stress. According to Elaine Cheung, PhD, a burnout researcher at Northwestern University, the latest burnout definition clarifies this medical diagnosis, which can help draw attention to its prevalence. She said, "The measurement and definition of burnout in the literature has been problematic and lacked clarity, which made it challenging to evaluate and classify it". Elaine Cheung hopes the latest definition will make it easier to study burnout and the impact it has on others, which may uncover ways to prevent and address this medical condition (Han, 2015).

2.2.2 Literature on the consequences of medical staff's burnout

In his new memoir *Doctored: The Disillusionment of an American Physician*(2014), Dr. Jauhar, a cardiologist and the author of several narrative about medical bildungsroman, references the quotes of other doctors venting their frustrations with their choice of career - I feel like a pawn in a moneymaking game for hospital administrators. There are so many other ways I could have made my living and been more fulfilled. The sad part is we chose medicine because we

thought it was worthwhile and noble, but from what I have seen in my short career, it is a charade.

This is not a single phenomenon, but a pandemic trend among doctors and nurses in the 21st century. To respond to such threatening trend, Freudenberger dedicated his professional life to developing research around burnout particularly in helping professions. Due to his efforts and other followers, the research topic of burnout has become a well-established construct that has attracted tens of thousands of publications, most focused on professionals directly serving other individuals (also referred to as the "caring profession" or the "helping professions") in recent years (Blanchard et al., 2010; Oakes et al., 2013; Santen et al., 2010). Doctors and nurses are the professions that deal with the people, so hospitals are also the places where burnout is a most common phenomenon (Waddill-Goad, 2016).

Burnout is not something that can be treated pharmacologically. In the healthcare professions (Shanafelt & Dyrbye, 2012; West et al., 2009), burnout is often defined and measured by assessing the frequency of symptoms in two domains, emotional exhaustion, and depersonalization (Hewitt et al., 2020), which are considered as the "core of burnout" (Green et al., 1991). According to Mathieu (2012), the five groups of clinicians in hospitals most affected by burnout were emergency medicine doctors, internal medicine specialists, general practitioners, neurologists and oncologists.

The work by West et al. (2018) focus on physician burnout's contributors, consequences, and potential solutions. Contributors to physician burnout include high workload, long work hours, administrative tasks, lack of autonomy, and work-life imbalance. Consequences of burnout can impact patient care, increase medical errors, and lead to decreased job satisfaction and mental health issues among physicians, see Figure 2.2. Solutions proposed include interventions at the individual, organizational, and systemic levels, such as promoting work-life balance, improving workplace culture, providing mental health support, and reducing administrative burdens.

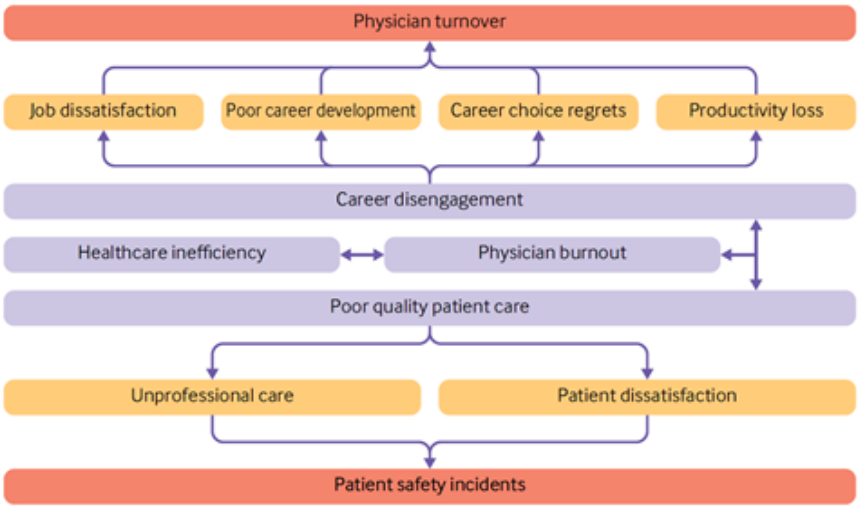

Figure 2.4 Consequences of burnout in hospitals

Source: Hodkinson et al. (2022)

From the highly cited papers in the field of medical staff's burnout, we find that the major consequences of medical staff's burnout are as follows: burnout can affect medical staff's health, and happiness. It can result in serious physical and mental health consequences, including substance use disorder, Type 2 diabetes (Melamed et al., 2006), insomnia (difficulty falling asleep or staying asleep) (Lu, 2023) and suicide ideation (Menon et al., 2020); career development crisis, including job dissatisfaction (McHugh et al., 2011), career choice regrets (Tian et al., 2019). Among medical students, burnout has been linked to various addictive behaviors (Dyrbye et al., 2011).

Job burnout not only has a huge impact on the psychological and physical health of medical staff but also exerts great negative influence on hospital management. The National Academy of Medicine calls burnout among doctors a serious threat to organizational health. According to some research, medical burnout will lead to higher physician turnover (West et al., 2018) in hospitals and a high rate of medical staff will choose to give up medicine career (Christina et al., 2008; W. B. Schaufeli et al., 2009; Shanafelt et al., 2010), resulting in the loss of skills, talents and knowledge, thus resulting in financial losses for healthcare organizations (Sinsky et al., 2022). In addition, patient violence and medical workers' job burnout are two sides of the same coin - job burnout will promote workplace violence, while workplace violence will also lead to job burnout.

For instance, a surgeon's major surgical error correlates with his or her level of burnout (Shanafelt et al., 2010) and high likelihood of being involved in a malpractice suit (Balch et al., 2011); A physician's high burnout rates are directly associated with medical malpractice and misdiagnosis (Panagioti et al., 2018; Patel et al., 2018), a poorer attitude toward patients, and

lower patient satisfaction (Aström et al., 1990) and some of them are pertaining to cardiologist (Panagioti et al., 2018); As for nurses, the level of job burnout of theirs is directly related to high rates of patient mortality (Schlak et al., 2021) and the occurrences of hospital-transmitted infections (Cimiotti et al., 2012).

2.2.3 Literature on interventions of medical staff's burnout

Ever since burnout was first identified in the 1970s as both a kind of personal and organizational problem, there have been repeated calls for answers on how to cope with it. There has never been a shortage of ideas for how to prevent and alleviate job burnout, which has led to an array of self-help books and pamphlets, workshops as well as therapeutic and coaching programs.

In contrast to the variety of ideas proposed by practitioners, most researchers on the topic of burnout did not begin with a focus on effective interventions. Rather, their goal was to understand and define what the phenomenon was, and to identify its causes and consequences. Numerous systematic reviews and meta-analyses on the interventions to reduce burnout of medical staff have been published nowadays. There were three types of interventions: individual-focused, structural or organizational-directed, and combined interventions.

(1) Individual-directed interventions of burnout

Individual-directed interventions typically include yoga, breathing practices, mindfulness techniques (Irving et al., 2009), psychosocial intervention (Clough et al., 2017), religious/spiritual practice (Doolittle et al., 2013; Shaniuk, 2020), cognitive behavioral therapy, self-care workshops (De Simone, et al., 2019) stress management skills (Wiederhold et al., 2018), improved communication skill (Clough et al., 2017), nurturing close relationships outside of work, and stress coping strategies.

Another approach to addressing burnout, especially within healthcare professionals, has been mindfulness (Kabat-Zinn et al., 1985). Mindfulness is defined as a "non-elaborative awareness of present-moment experience" (Chambers et al., 2009) that involves intentional, nonjudgmental, present-focused attention (Thomas & Otis, 2010). The potential of mindfulness to address burnout may lie in its use as a relaxation technique, which could reduce exhaustion or improve emotion-focused coping with distressing events at work and help people feel a greater sense of efficacy and confidence.

In one study on burnout recovery, researchers found that how fast people bounced back after burnout depended on the coping mechanisms they used to deal with symptoms. For example, those who did not address their problem (i.e. used avoidance-based coping interventions and mechanisms) developed more severe burnout symptoms over time.

Since there is limited evidence for the effectiveness of interventions at individual levels aimed at reducing burnout in medical staff, some researchers conduct studies to try to mitigate burnout by designing peer-support groups program. In today's modern hospital environment, many medical staff work in a less ingrained way with their colleagues and experience disconnectedness at the workplace.

One way to think about burnout is to consider it as the result of a long-term mismatch between the individual and either the work or the working environment. The mismatch can be interpersonal. For example, the individual might have trouble getting along with their boss or perhaps another coworker.

Many studies have proposed the personal strategies or individual practices as preventative and prescriptive practices that promote self-care, including having hobbies, spending time with family and friends, focusing on a healthy lifestyle with suitable gyms or exercises, adequate sleep and practicing mindfulness. Although they are proven to strengthen resilience (Newell, 2017), they seem to fall short in addressing deeper, emotional stressors that medical staff experience. Therefore, hospital leaders and medical organizations should find suitable interpersonal practices which may provide more opportunities for adequate emotional and deeper levels of engagement.

(2) Organization-directed interventions of burnout

Burnout is a system issue, thus addressing the problem of burnout of the medical staff is the shared responsibility of individual physicians and the organizations. As Maslach and Leiter (2022) mentioned, "Burnout is a red flag for an organization", "When the canary goes down, you do not focus on how to make the canary more resilient. You fix the coal mine." According to the study by Maslach and Leiter (2000), workplace leaders and administrative officers have a significant role to play in the promotion of healthy workplace environments.

Comparing workers to cucumbers in vinegar, Maslach and Leiter (2016) said, "We should be trying to identify and analyze the critical components of 'bad' situations in which many good people function. Imagine investigating the personality of cucumbers to discover why they had turned into sour pickles without analyzing the vinegar barrels in which they had been submerged." How can we stop blaming cucumbers for becoming pickles? How to mitigate the acidity in the environment? Individuals cannot yoga or meditate their way out of burnout. Organization-level interventions are needed.

However, most hospitals operate under the erroneous framework that burnout is solely the responsibility of the individual medical staff. Engagement is the positive antithesis of burnout, which is characterized by vitality, dedication, and absorption in work. There is a strong case for

organizations to invest in efforts to reduce burnout of the medical staff and promote engagement, see Figure 2.3. Thus, The American Medical Association points out three important strategies. The first is to establish an organizational culture that values the holistic health of medical staff. Hospital leaders need to enhance their awareness and abilities to face up to the issues of medical staff's overwork and take the medical staff's psychological well-being as an important consideration in the hospitals' decision-making process.

Figure 2.5 Driver's dimensions in the mitigation of burnout

Source: Balch and Shanafelt (2018)

Interventions to reduce burnout need to be implemented at organizational and structural level of healthcare systems, complemented by intervention at the individual level. Many research demonstrate that the improvement of work environment is a good system-level solution for medical staff (Carthon et al., 2021). Further, leadership is a vital enabler to address burnout from organizational leaders and managers as well as policymakers. If someone is in a position of leadership in the organization, it is important to be alert to the mismatches that can lead others into burnout - and to take whatever action is available to fix them. This can be very important for the lives of the people involved, which can also be valuable for the effectiveness of the organization. M. Yang and Fry (2018) study the role of spiritual leadership in reducing healthcare worker burnout and its positive influence on organizational commitment, work unit productivity, and employee life satisfaction.

Philosophically, since the drivers of burnout originate in the workplace and work environment, burnout can be viewed and addressed more as a system issue rather than as a personal mental health diagnosis. While individually directed interventions may help individual medical staff, they will not address the systemic issues that drive the burnout problem in the first place. And burnout is hard for individuals to fix on their own - it takes collaboration between physicians and health organization leaders.

Panagioti et al. (2017) showed that those that combined several elements such as structural changes, fostering communication between members of the health care team, and cultivating a sense of teamwork and job control tended to be the most effective in reducing burnout. However, such intense organization-directed interventions were rare and were not widely evaluated.

Shanafelt and Noseworthy (2017) summarize 9 organizational strategies to promote physician engagement to reduce burnout at Mayo Clinic. They are: (1) harness the power of leadership, (2) acknowledge and assess the problem, (3) develop and implement targeted interventions, (4) cultivate community at work, (5) use rewards and incentives wisely, (6) align values and strengthen culture, (7) promote flexibility and work-life integration, (8) provide resources to promote resilience and self-care, and (9) facilitate and fund organizational science (Shanafelt & Noseworthy, 2017). Although the specific way each of these 9 strategies is operationalized must be adapted to fit the organization, the dimensions themselves have broad applicability. In this research, leadership from the highest level of the organization are the keys to making progress.

According to LeNoble et al. (2020), although interventions have been initiated for many of these sources of burnout, two major drivers, namely, isolation and fragmentation, are still in dire need of attention and mitigation strategies. On one hand, many medical professionals conduct their work largely in isolation from their colleagues. Differences reinforced by interprofessional cultures prevent meaningful interactions among team members when they do work together (Tetzlaff et al., 2018). On the other hand, because of the stigmatization associated with seeking help for burnout (Shapiro et al., 2015), medical practitioners often become burdened by loneliness, further intensifying their feelings of burnout (Rogers et al., 2016).

Even the design of burnout interventions can further a sense of isolation, because mindfulness or well-being-focused interventions are individually driven and can often put the onus on clinicians to be better at not becoming burned out. A new report from researchers at Leeds Beckett University reviews the most effective ways to treat and prevent burnout and work-related stress, and revealed organizational interventions in the workplace may be more effective than individual interventions alone. And the evidence of this study suggests that organizational interventions produce longer-lasting effects than individual approaches (Bagnall et al., 2016). More recent studies also describe the causes of burnout as collective, and impossible for an individual to fix without a systems perspective.

Having a healthy medical workforce can reduce sickness absence, lower staff turnover and boost productivity at the hospitals. Thus, it is the hospital leaders that should consider how to solve the burnout problem at the organizational level instead of with purely individual efforts.

Employers cannot afford to wait until staff burnout happens. The hospital leaders should learn how to recognize an early phase symptom, before it blossoms into a crisis. That is to say, the hospital leader or management should consider the preventive interventions for medical staff burnout. Changing aspects of an organization's culture and working practices might be considered alongside individual level interventions to prevent burnout more effectively.

The study, "Effect of Organization-Directed Workplace Interventions on Physician Burnout: A Systemic Review," shows that burnout more often stems from organizational or system-level factors, and interventions to prevent and mitigate burnout may be more effective when they focus on changing the system rather than individual physicians. It reviewed 50 studies that evaluated the efficacy of workplace-driven interventions on physician burnout (DeChant et al., 2019). Researchers such as Thomas Craig et al. (2021) suggest that physician burnout is not reduced by technology implementation.

Some studies briefly list strategies used at the organizational level to alleviate burnout (Montgomery et al., 2019), the relationship between organizational culture and burnout (Williams et al., 2007) or a review of burnout intervention strategies (Patel et al., 2018), but no in-depth study was conducted. There are also a few studies on specific clinical professionals' organizational burnout interventions, such as primary care providers' organizational interventions (Gregory & Sean, 2015), and tissue interventions for gastroenterologists and hepatobiliary surgeons (Lacy et al., 2018).

In general, systematic intervention studies on medical burnout led by hospitals and jointly participated by medical staff with sound research method are rare. However, burnout interventions at individual level fail to confront the systemic workplace causes of burnout. Therefore, some researchers suggest that in the designing of burnout intervention, we can make full use of the rich literature and evidence found in organizational science (Aboumatar et al., 2017). Organizational science-driven initiatives can be identified as important strategies for addressing physician burnout as well as enhancing teamwork (LeNoble et al., 2020).

In the COVID-19 pandemic, burnout has increased to levels that pose a threat to maintaining a functioning healthcare workforce. Elevated burnout and other indicators of stress are anticipated to persist long after the pandemic (Kok et al., 2021). Barello et al. (2020) study the burnout and somatic symptoms among frontline healthcare professionals at the peak of the Italian COVID-19 pandemic. Naldi et al. (2021) study the COVID-19 pandemic-related anxiety, distress and burnout and its prevalence and associated factors in healthcare workers of North-West Italy. In China, D. Hu et al. (2020) perform a large-scale cross-sectional study to

investigate the frontline nurses' burnout, anxiety, depression, and fear statuses and their associated factors during the COVID-19 outbreak in Wuhan, China.

There are some noteworthy findings in the 2024 Medscape Physician Burnout & Depression Report "We Have Much Work to Do", see Figure 2.4 and Figure 2.5:

(1) 83% of doctors surveyed cited professional stress as the primary contributor to their burnout and/or depression.

(2) As in previous years, the number of work-related bureaucratic tasks was cited as the primary reason for burnout (62%). Spending too many hours at work (41%) and lack of respect from administrators, employers, and coworkers (40%) also were contributing factors.

(3) Additionally, the Report found 48% of the physicians surveyed felt their employers do not recognize the pervasiveness of burnout among their medical staff.

Similar to the report in 2023, physicians in emergency medicine reported the highest burnout rates (63%). They were followed by ob/gyns, oncologists, pediatricians, and family physicians.

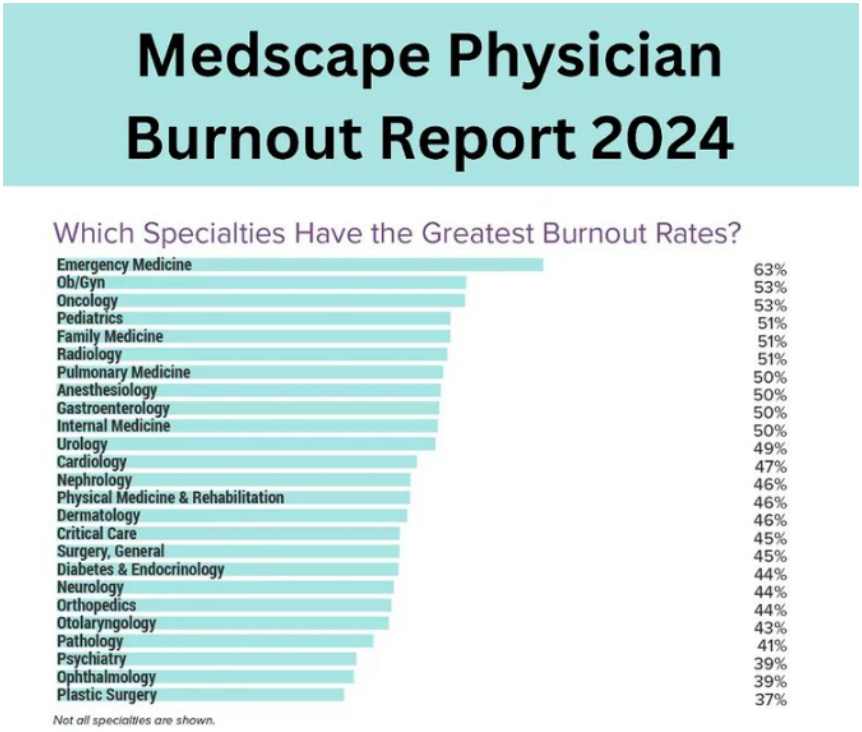

Figure 2.6 Medscape physician burnout report 2024

Source: McKenna (2024)

According to the data and related studies released by the World Health Organization in 2020, the job burnout rate of Chinese doctors is as high as 69.5% ~ 73.9%, of which 15.1% ~ 28.4% of doctors have serious job burnout. Chinese literature mainly discusses the current situation of clinicians' job burnout and related factors, for example exploring the correlation

between occupational identity and job burnout by combining the corresponding scales or discussion on the mediating variables of occupational identity and burnout.

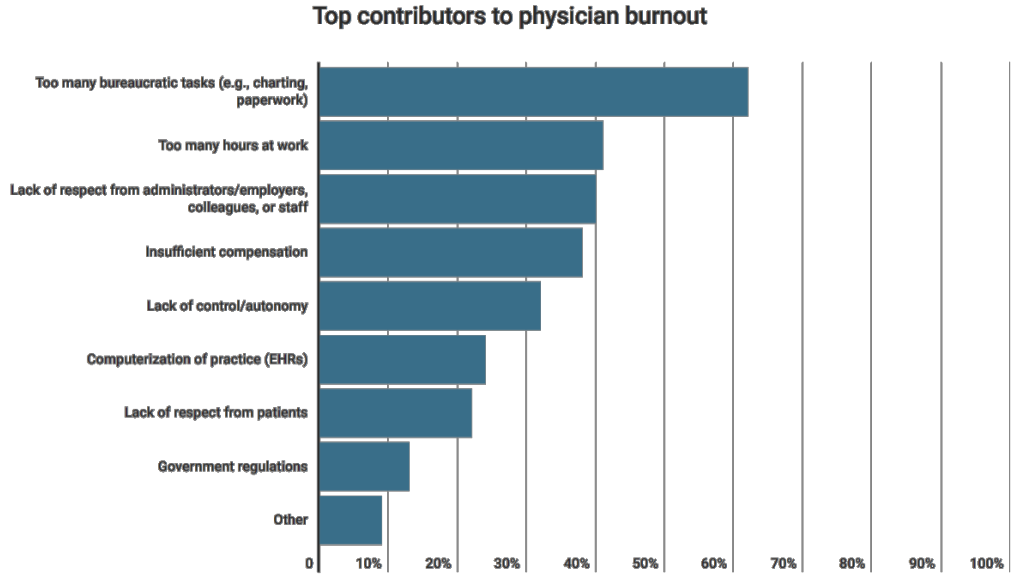

Figure 2.7 Top contributors to physician burnout

Source: McKenna (2024)

This systematic review suggests that negative impact of burnout include association with anxiety and lower job satisfaction at the individual doctors' level, and prone to committing medical errors influencing patient safety and higher turnover intention at the organizational level. Burnout was higher among doctors who worked over 40 h/week, working in tertiary hospitals, on younger age group within the profession (at age 30-40), and with negative individual perception to work and life (Liu & Liu, 2020).

Z. Hu et al. (2021)'s study performed a national cross-sectional survey to investigate the severity of burnout and its associated factors in ICU doctors and nurses in mainland China. The study concludes that the burnout rate of ICU doctors and nurses in mainland China is 69.7% and provides baseline data about burnout among Chinese medical staff predating COVID-19, which could help in the analysis and interpretation of burnout during the COVID-19 pandemic.

A study examined the correlation between alexithymia, social support and burnout among emergency nurses in China (Pei et al., 2021), which showed that among emergency nurses in China, alexithymia was correlated with burnout, depression, and social support. Alexithymia was the factor most strongly associated with burnout. These data suggested that providing better social support and alleviating alexithymia might decrease rates of burnout among emergency nurses.

Organizational intervention methods mainly include improving communication between superiors and subordinates, providing on-the-job training and career planning for medical

workers. Social support intervention can reduce nurses' professional burnout (Feng et al., 2017). It is believed that organizational intervention strategies include the enforcement of organizational support role, improvement in the working environment, establishment of a fair and just incentive mechanism as well as an internal support system, and the broad its possibilities in career development. Through the improvement of these organizational factors, the mitigation of physician burnout can be achieved (Huang et al., 2011).

According to some research, it suggests that the hospital should modify clinical work processes, shorten working hours, shorten the rotation of resident doctors, and establish a fair management mechanism (Cheng et al., 2019), and other suggestions includes reasonable allocation of human resources and creation of a clean, warm and humane working environment so that nurses can feel cared for; establishment of a complete hospital information system to simplify the work procedures of nurses, paying attention to the psychological care of the medical staff, setting up multiple promotion channels and a reasonable reward and punishment system with clear rewards and punishments (Nie & Li, 2019).

From the above literature, we can see that most of the strategies that healthcare institutes are implementing seem to largely target individual medical staff. Due to the complicated characteristics of Chinese public hospitals, it is not easy to perform systematic reform on the hospital level. It seems that there are many more other "severe crises" to cope with and compared with these crises, workplace burnout is seemingly a small thing, although it has been endangering invisibly and insidiously the development dynamics from within. Almost all these researchers have no ability to draw the big picture and implement innovative system-level resolution. In other words, there are few research on the managerial support or organization-targeted interventions to burnout. In order to make the hospital decision-makers to take the burnout crisis seriously, the researcher takes the advantages of the power of narrative.

2.3 Narrative medicine and narrative management

Maria Giulia Marini, president of European Narrative Medicine Society (EUNAMES), on the board of Italian Society of Narrative Medicine, examines all aspects of narrative medicine and its value in ensuring that, in an age of evidence-based medicine defined by clinical trials, numbers, and probabilities, clinical science is firmly embedded in the medical humanities in order to foster the understanding of clinical cases and the delivery of excellent patient care (Marini, 2015).

2.3.1 Narrative medicine

Influenced by various schools of thought, including cultural studies, medical humanities, literary theory, social anthropology and cognitive science, bio-psycho-social medicine, holistic care, and postmodern ideas, the conception of narrative medicine emerged late in the twenty century in response to the inadequacies of the bio-medical model (Hurwitz & Bates, 2016; Zaharias, 2018). Medicine practiced with narrative competence is defined as narrative medicine, which has been proposed and applied as a model for humane and effective medical practice (Charon, 2001). In recent years, more and more western and Chinese scholars endeavor themselves to various topics in the development of narrative medicine.

2.3.1.1 Western narrative medicine

Narrative medicine is an innovative model for improving health outcomes, and along with scientific ability, physicians need the ability to enter into the narratives of their patients (Charon, 2001). As a pioneer of narrative medicine, Rita Charon advocated the conception of Narrative Medicine (NM for short) in 2001 and has long been committed to the promotion of narrative medicine and the training of medical students. Charon (2001) believes that NM is a narrative science with a theoretical basis that includes: narrative theory, aesthetics, phenomenology, theory of mind, psychological and traumatic research and suggests later that the foundations of narrative medicine include “literature and medicine, narrative ethics, medical humanities, healthcare communication, and primary care medicine”.

Inspired by the field of literature and linguistics, Charon (2001) believes that the narrative competence is the acknowledgement, absorption, and interpretation of the human disease story and being moved to action by it, which can be applied to the clinical work of medical care. Charon suggested that doctors read literary works to promote narrative thinking and engage in reflective writing regarding the stories of themselves, of patients, of colleagues, and of society in the purpose of enhancing respectful, empathetic, and nurturing healthcare in the context of NM. The modes of reflection in NM include taking a break from a difficult practice or action, reviewing the details of this experience, and reassessing to find problem solving methods based on the reality and the imagination of multiple possibilities (Murphy et al., 2018).

By accepting, responding to, and reflecting on the patient’s story as the subject, and paying attention to the medical staff’s relation with themselves and their families, their relationship with peer colleagues and administrators, with patients and their families as well as those with society, narrative medicine has positive significance for the medical staff’s self-identity formation, professional identity formation, doctor-patient relationship, ethical empathy, and the

construction of shared responsibility (Alcauskas & Charon, 2008).

Diorio and Nowaczyk (2019) believe that narrative medicine, which teaches doctors to focus on patients' stories rather than a cut-and-dried checklist of symptoms, can help improve care for patients because their whole story is being heard. It can also help doctors work through their emotions while at the same time enhancing their feelings of empathy. Narrative medicine is not limited to listening to patients' stories, it also includes writing about them (Nowaczyk, 2012). Nowaczyk said that the very act of writing can hone doctors' observational skills and enhance the connection they feel with the patient. Beyond that, the exercise of writing can also work like therapy for doctors (Nowaczyk, 2012). Writing about a patient's death, for example, can help a doctor process the emotions she feels.

2.3.1.2 Chinese narrative medicine

Major experts on the field on narrative medicine in China include Guo Liping from School of Health Humanities of Peking University, who introduced Charon (2015)'s conception to Chinese academic circle in 2015 and published papers and paper collections (Guo, 2020), since then, Li Fei from School of Humanities and Social Sciences of Peking Union Medical College, whose research mainly focuses on "narrative medical records" (Li et al., 2022), Jiang (2018) from School of Nursing of Second Military Medical University, whose research interest lies in design of narrative nursing curriculum and its practice in clinical care for patients and the author of this thesis Yang Xiaolin, from Center of Narrative Medicine of Southern Medical University (SMU), who has educational background in narrative theory and medical education and dedicates herself to the establishment of Chinese Narrative Medicine system since 2008.

Researchers from Taiwan, China have also gained interest in narrative medicine since 2008 (Chu et al., 2020). Four major themes of narrative competency have been conceptualized and generalized: narrative horizon, narrative construction (including narrative listening, narrative understanding, narrative thinking, and narrative representation), medical relationship (including empathy, communication, affiliation, and inter-subjectivity), and narrative medical care (including responsive care, balanced act, and medical reflection), and Figure 2.6 shows its integrated conceptual framework (Liao & Wang, 2023). This is the best conceptual framework for narrative competency up till now. Combining these findings, narrative medicine has become one of the most acclaimed models for practicing effective and humane medical care. However, no measuring method for medical staff and medical students' narrative competency had been ever invented and no holistic Chinese narrative medicine system had been constructed before SMU researchers' academic efforts in this domain.

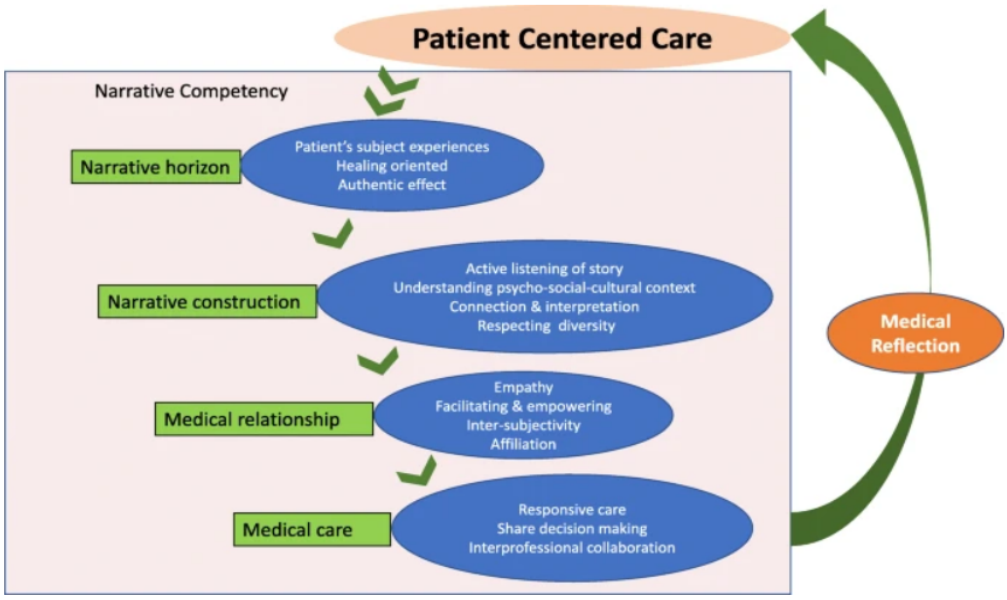

Figure 2.8 Integrated diagram of narrative competence conceptual framework

Source: Liao and Wang (2023)

The year 2011 is called "the initiating year of Chinese narrative medicine" by the academic circle. Before the initiating year, SMU held the national forum of narrative medicine and illness narrative in 2009 and integrated the notion of narrative medicine into the courses of "Medical English" and "Medical English Writing" for the doctorate candidates in 2010. During the year 2011 to 2014, Chinese researchers published several essays in narrative medicine (Y. F. Wang, 2013; X. L. Yang, 2011a, 2011b; Zhang, 2011), which were considered to be the earliest Chinese literature and SMU began to offer narrative medicine courses in the continuing education of undergraduates, postgraduates, resident physicians and medical staff. Subsequently, it guided many medical colleges and training bases to offer narrative medicine courses successively.

In 2014, the first public account of Narrative Medicine Course was opened in China and in 2019, the first national textbook *Narrative Medicine Humanities Reader* edited by SMU researchers has been published. Since then, it has guided the establishment of more than 40 narrative centers across the country to provide space for the improvement of bio-health narrative competence and workplace narrative ability and nearly 1059 narrative medicine junior tutors have been cultivated to provide teaching force and practicing instructors for the development of narrative nursing. After 12 years of local development of Chinese narrative medicine, a theoretical system and practice path suitable for China's national conditions have been explored (X. L. Yang, 2023; X. L. Yang et al., 2024).

In 2023, I published a series of monographs such as Chinese Narrative Medicine and Medical Professional Competencies, Narrative Competence and Professional Development and

Narrative Hospital Management: From Lean Management to Value Symbiosis. In these monographs, the author puts forward a narrative medicine framework definition that conforms to China's national conditions: "Chinese narrative medicine" aims to build a multi-dimensional harmonious interpersonal narrative relationship by improving the clinicians' professional narrative competence and the bio-health narrative awareness of the public (including patients and their families). It is a medical education and clinical medicine model that allows narrative to play a positive and dynamic role in hospital management and cultural inheritance, medical professional identity and professional reflection, disease diagnosis and whole-person treatment, interpersonal communication and crisis resolution, mind-body regulation and health management, health communication and disease popularization, hospice care and grief counseling.

In the same year, Southern Medical University developed scales such as "Chinese Narrative Competencies Scale for Medical Professionals", and "Scale for Medical Professionals' Narrative Mediation". The establishment of Bio-health Narrative Sharing Center provides environment and space for cultivating clinicians' narrative thinking, and rich narrative practice experience can create a cozy and comfortable narrative atmosphere. Through the cultivation of narrative competencies, doctors enhance the awareness of workplace narrative interaction, and in the rich professional narrative connection, their narrating self is constantly nourished, and their spirits and values are also improved and enriched. At the same time, we also hold a variety of patient narrative sharing activities in the narrative center to promote the narrative health communication mode and inspire patients to know how to improve their life narrative integration and life recovery from the perspective of narrative, in addition to external dependence on drugs and scalpels. In the same direction of both sides, the hospital forms a narrative ecology of symbiosis and win-win.

2.3.2 Narrative as anti-burnout interventions

Storytelling is the art of sharing our experiences, thoughts, and emotions in a meaningful and engaging way. It can help us improve our emotional intelligence, connect with others, and find purpose and happiness in our work. The human experience has a storied nature (McLean & Thorne, 2006). Humans organize life experiences through narratives (Sarbin, 1986); through self-defining life stories, they understand their lives, and provide a kind of identity, meaning, and coherence of individual lives by the self-narrative methods of reconstructing the past and expecting the future (McAdams, 2006). Narrative may have played a fundamental role in humans' ability to bond and navigate challenging social settings throughout the long era of

human evolution. Research shows that storytelling has a special capacity to improve memory and retention (McGregor & Holmes, 1999), reduces stress hormones (Brockington et al., 2021), increases oxytocin and dopamine (Zak, 2015) and fosters empathy and trust (Narva & Marturano, 2023). The catharsis of storytelling can assist with processing, instead of repressing workplace emotions, thus can alleviate job burnout.

Since the end of the 20th century, there has been a narrative shift in the field of humanities and social sciences. Researchers have adopted qualitative methods such as narrative inquiry, narrative review and narrative analysis to study some subjects. The same goes for burnout research, which includes a narrative overview of burnout among health professionals, medical students, interns, and psychologists (Dyrbye & Shanafelt, 2016; Johnson et al., 2018), as well as a narrative exploration of burnout by mental health workers and NHS Surgeons. Since 2008, sporadic studies have begun to explore the preventive effect of narrative medicine (or concurrent intervention with other methods) on the burnout of professional medical staff in different departments, such as pediatrics (Birigwa et al., 2017; Hester et al., 2020), pediatric oncologist (Sands et al., 2008), oncology (Saint-Louis, 2010), obstetrics and gynecology (Winkel et al., 2016) and neurology (Butcher, 2019).

Clinical staff are constantly “drowning” in data and have limited time to interact with patients during clinical visits while reviewing relevant information in their charts. Meanwhile, there is little daily communication between medical colleagues, and this alienated relationship among doctors and patients makes no difference between real doctors and AI doctors who are dealing with their own data without any deep exchanges. Besides collegial narrative connectedness, some researchers also believe that narrative communication between doctors and patients can effectively reduce job burnout. Some researchers suggest that the common enemy of patients and medical staff is the keyboard, which distracts the real human interaction and keeps doctors busy processing data. In 2018, the Institute for Public Policy Research released a report titled “Better Health and Care for All.” The report predicts that AI will free up an average of more than 25 percent of clinicians’ time to care for patients (Darzi, 2018). At the University of Colorado, doctors began bringing computers out of the office to provide patients with a variety of in-person services accompanied by a human assistant. In this state of personal connection, doctors’ burnout levels decreased significantly, from 53% to 13%.

By exploring how AI solutions reduce provider burnout and embracing AI-driven solutions, health care systems can take a proactive stance in tackling the challenges at hand and create significant value for their patients, employees, and operations. One of the most important impacts of AI technology is the opportunity to free more clinicians from the shackles of various

burdensome electronic records and onscreen work, thus clinicians could devote more time to face-to-face communication with patients. However, when the workplace narrative atmosphere is not good and the medical staff has no awareness of interpersonal narrative bonding with colleagues and patients, the medical staff who gain more time will not spend it on face-to-face interactions with patients.

Many recent studies have shown that improving the professional narrative competence can build professional identity and alleviate workplace burnout of people from different professions (Perris et al., 2023). As a systematic course and conception to enhance medical professionals' narrative competence, narrative medicine had been gradually regarded as an intervention method to combat burnout (Primerano & Alampi, 2019; Zaharias, 2018). It allows us to amplify our relational, clinical and organizational skills (Zaharias, 2018). Many studies have confirmed that empathy (Williams et al., 2017) and harmonious relationships can protect medical staff from burnout, which are important aspects of narrative medicine. According to Lijoi and Tovar (2020), narrative medicine provides an antidote to high levels of work dissatisfaction and burnout and it can connect health professionals to their original motivation to care, cultivates the ability to engage with patients and stimulates professional growth.

In March 2019 Burnout in Healthcare: The Need for Narrative, A Basic Narrative Medicine Workshop was carried out by Columbia University (the birthplace of narrative medicine), which was focused on the well-being of medical staff. The chapter NM for detecting and mitigating burnout of content and outcomes of narrative medicine programs: a systematic review of the literature through 2019 in Remein et al. (2020), summarized the related researches on the relationship between narrative medicine and burnout alleviation. Becker and Dickerman (2021) propose that narrative medicine could help medical trainees foster empathy and resilience and renew compassion and a narrative medicine curriculum is plausible and accepted within the educational system of a PICU fellowship program ad burnout metrics improved after participation in the narrative medicine sessions.

In China, researchers found that the training of narrative medicine for neurological surgeons could increase the doctor-patient communication efficiency and thus ameliorate their job burnout (W. Wang & Da, 2022); Some studies have shown that the narrative competence of doctors is related to job burnout, and improving the narrative competence of doctors can reduce job burnout (Niu et al., 2023).

However, these researchers have no theoretical attainments and contributions to the Chinese narrative medicine, which make them unable to grasp the deep substance of narrative to cope with the problem of burnout at a higher level, thus, that research do not offer systematic

level resolution using the narrative or narrative medicine conception as a framework to address the crisis of workplace burnout in healthcare industry. It seems that the researcher has been called to be engaged in this topic.

2.4 Narrative hospital management and professional burnout

After "burnout" has been officially recognized by the World Health Organization (WHO) in 2019, the responsibility for its management has shifted from the individual towards the organization.

2.4.1 "Evidence-based management" and "Narrative management"

We can see that when the pitfalls of evidence-based management become more and more obvious in the time of Volatility, Uncertainty, Complexity, and Ambiguity (VUCA), narrative management has become a remedy for the plight and predicament. Narratives as bridge the barrier between leaders and employees (Gill, 2011) enable symmetrical communication and humanistic connectedness - thereby facilitating understanding and sense-making for effective organizational change (Barker & Gower, 2010; Maitlis & Christianson, 2014). The potential of narratives for cultivating managerial wisdom is already shown in academic literature (Bostanli & Habisch, 2023; Paton & Kotzee, 2021). It was the business narrative expert Denning (2006) who highlighted the influence of leaders' narratives on individuals in an organization. John P. Kotter, master of leadership and chair professor at Harvard Business School, put forward the conclusion that "managers without narrative competence do not understand management" (Kotter & Cohen, 2012), urging managers to actively learn the concept of narrative management, form managers' workplace narrative thinking, and improve narrative wisdom in the management process.

Different from purely using "brain" (scientific rationality and evidence-based thinking) to manage, narrative management is a kind of management art that uses narrative from within the heart (humanistic rationality and narrative thinking) as the guiding framework. Narrative management system focuses on improving narrative quotient of hospital leaders, creating a good narrative management ecology, deepening management connotation and humanistic rationality, and realizing value symbiosis. And value symbiosis is a management ideal that is similar to the conception of narrative ecology in the conceptual framework of bio-health narrative and narrative management.

2.4.2 Narrative management in modern organization

Storytelling is the simplest, most efficient and most cohesive management tool. Howard Gardner, a professor of cognitive psychology at Harvard University, proposed that stories are the main carrier of leadership, and that great leaders must be the master of telling stories. The 21st century is the century of narrative ability + X ability talents, and narrative has become an important indicator to evaluate the soft power of talents. In his book *The Dream Society: Giving Emotional Value to Products* (2001), Rolf Jensen, director of the Copenhagen School of Future Studies, proposed that in the information society of the 20th century, the best products won the development, and in this century, the best stories won the development. Jensen predicts that the most important skill in organizational management in the 21st century is the ability to tell stories, and that the highest-paid people in the 21st century are the storytellers.

Under this research background, many foreign universities and management training institutions have gradually opened courses such as “Introduction to Narrative Organization Development”, “Manager and Leaders Story-telling Training” and “Narrative and Management” in recent years. Many management scientists predict that in the future, “narrative management” will continue to gain the attention of researchers and practitioners in the management field; many experts also propose that “narrative career development consultant” will become an important emerging career to assist organizations and enterprises to achieve high-quality development. Narrative histology or narrative management emphasizes the special status of narrative in human communication and organizational management, following the narrative management paradigm of “human beings are essentially a narrative man” (homo narrans) (Fisher, 1994), “all forms of human communication can be regarded as narrative” (Fisher, 1989) and “management as narrative”. Narrative is an important basic ability of human evolution, and also an interactive medium to form a “community of life” or a “community of shared future” (Dunbar, 2020).

The experts in the field of “storytelling organization/narrative management” mainly focus on the following points:

First, the narrative organization and management are based on the post-modern model. The new model of narrative in the post-modern era focuses on the common rationality of the community and the collective and pays more attention to the organizational activities of communication, interaction and dialogue. According to narrative histology, “organization as narrative”, every enterprise and every organization is an organic narrative ecosystem composed of different levels of narrative relations, so the development of organization follows certain

narrative principles.

Second, the story is the core part of organizational life (Yost et al., 2015), which shapes organizational culture and influences organizational behavior. Any organization or management activity can be understood as a narrative (Cooren, 2001). There are two main relationships between story and organization: one is "story reproduction organization", the other is "story construction organization". The former means that the narrative manager can summarize the common meaning system from the narrative text of different members of the organization to fully understand the integrity of the life world of the organization; the latter means that when the story about the organization is spread and discussed, whatever its authenticity and purpose, it will affect the development of the organization to some extent.

Third, narrative management and evidence-based management are complementary to achieve high-quality management. Evidence-based management emphasizes the need for scientific-oriented thinking when making high-quality decisions. However, managers' narrative-oriented thinking is equally important for high-quality management. Veterans who are good at telling and interpreting stories are those who can organize them efficiently (Boje, 2017). Narrative skills can improve managers' leadership, influence, and problem-solving skills (Boje, 2017).

Fourth, narrative management is more humanized and has a better effect than rule management. Peter Ferdinand Drucker (1909-2005), known as the "father of modern management", believes that talent is the core of organizational management, and today's managers should pay close attention to the mental and physical health of employees. Traditional management methods can ensure stability but cannot ensure high-quality sustainable development. Narrative is essential for organizational development and survival. Modern practices outside of traditional management are often popular, but narrative is a basic phenomenon for all countries, societies and cultures, which can have lasting and positive effects on management. Narrative, like glue, firmly connects employees with the organization's overall development goals and cultural ideas.

Fifth, narrative is both a research theory and paradigm as well as a research method. Organizations or enterprises can take "narrative analysis" or "narrative inquiry" as methods to conduct qualitative research (Boje, 2017). Narrative research is called "science with rich imagination", and narrative is also called "data with a soul" (Nadar, 2019). American writer and psychotherapist Thomas Moore on the definition of the soul: it has to do with depth, value, relatedness, heart, and personal substance.

There is rich literature on storytelling management and narrative organization in various

industries while scarce literature on narrative-based hospital management in western academic circle. Among them, some confine themselves in the use of narratives to transform patient-care mode, impact health policy making (Fadlallah et al., 2019; Pedersen, 2016) or in the role of patient narratives in healthcare innovation (Pedersen, 2016); few discuss the narrative relation management in a ward or sectional level (Scholander et al., 2023).

At present, except for the article "Empowering Hospital Management and High-quality Development by Narrative Medicine" published in the journal of Medicine and Philosophy (X. L. Yang, 2022b) and chapters about narrative hospital management in the monograph of Chinese Narrative Medicine and Medical Professionals' Competence (2023) by the researcher, who has been dedicating herself to the construction of Chinese narrative medicine system, there are no other monographs or discussions on the topic of "narrative hospital management" in China. Some of the researchers simply identify narrative management as storytelling or psychological management. As a matter of fact, narrative paradigm in management should be seen as a new science based on the theory of cognitive narrative and bio-health narrative.

2.4.3 The mitigation of professional burnout in the context of narrative management

Human being are the most important assets of any organization, and evidence-based management models incline to view employees as tools and costs, but leaders with narrative intelligence do not adopt this view. From the perspective of hospital leadership training, narrative play a crucial role in developing practical wisdom along the narrative paths and serve as an effective tool for practically wise leaders to fill the leadership gap, and from the perspective of the well-being of individual medical staff, narrative play an essential role in enhancing their ability to see themselves and each patient as a complete human being, who need narrative bonding, narrative response and narrative empowerment (X. L. Yang & Wang, 2023), and moreover, for their sustainable career development, they further need the formation of their own narrative identity about their clinicianship or nurseship, which can serve as a sort of anti-burnout remedy.

Organizational managers should be aware that burnout is an organizational problem (Shanafelt & Noseworthy, 2017). Many organizations mistakenly view burnout as the sole responsibility of the individual (W. B. Schaufeli et al., 2009), and under this frame of thinking, organizations rarely provide systematic burnout intervention strategies. However, leaving employees to deal with job burnout through purely self-regulation is undoubtedly the managers' ignorance of their responsibilities on this issue. Dr. Maslach said in an interview that self-care does not alleviate the burnout problem because it shifts the responsibility from the employer to

the employee. She uses the “canary in the coal mine” metaphor for job burnout (Maslach & Leiter, 2022). On their way into the coal mine, the birds are healthy and thriving. When they come out sickly, they are undoubtedly declaring: if we go back inside, we will be in danger (Moss, 2020). However, most of these “coal mine organizations” do not have a handle on how to gauge the impact. What is worse, most of these organization leaders turn blind eyes to the serious burnout and fail to take any effective prevention and management measures at the organizational level. As Heffernan (2011) says, leaders who ignore existing problems doom to lead organizations or teams astray.

Many studies have shown that in addition to individual endeavors, the intervention of organizations at the management level is also of great significance for the relief of professional burnout (Montgomery et al., 2013). Survey from the 2021 Global Leadership Forecast shows that leaders who spend more time “engaging” have higher job loyalty among their subordinates and a lower risk of burnout or turnover. A management saying that “people do not quit companies; they quit their boss” or “employees do not leave Companies, they leave Managers” (J. F. Lewis, 2024) is widely accepted, which shows that the staff’s work satisfaction and stress levels are powerfully affected by the leadership skills of their immediate supervisor. A recent study shows a direct relationship between the quality of your boss and your burnout and job satisfaction levels (Shanafelt et al., 2015). Especially for the generation Z medical staff, never mind how well paid, or “great fit” a job may be, they will leave if their reporting relationship is not healthy.

In a hospital with a badly regulated narrative ecology, patients want to tell stories, but the doctors frequently interrupt them, and it is impossible to establish a talk turn that focuses on patient stories. The patients in this situation are just like breathing underwater and are destined to be drowned. Similarly, in hospitals with poor narrative ecology, we can also see that various medical staff are drowning, as their voices and stories are unheard by the management staff. If the narrative ecology is not changed in time, more lives including hospital leaders and medical staff will be drowned. The medical staff perform like a machine under the bigger machinery system. The objectification of the medical staff is inevitable in this ecology, which unquestionably leads to the burnout of the staff. That is to say, the staff burnout is actually a kind of organizational failure. “Narrative management” advocates the establishment of harmonious narrative ecology not only at the hospital level but also at the department level (X. L. Yang et al., 2024).

2.5 Summary of literature review

Burnout among medical practitioners has become a mounting public health crisis, yet few system-level solutions have been identified to improve outcomes.

(1) Numerous studies around the world suggest that burnout at medical workplace has become a global phenomenon. Western scholars have launched a lot of meaningful studies on the topic of medical staff's burnout including its contributors, consequences and countermeasures, which offer references and reflections to my research. However, few meaningful research on the same topic could be find in Chinese literature and many of them do research for research's sake, collect and analyze data for data's sake. They could not offer practical solutions for the amelioration of burnout. Few individual medical staff actively combat burnout and most of them regard burnout as a synonym for tired. There are very few literatures on physician burnout from the perspective of public hospital leaders. Most public hospital leaders turn blind eyes to the crisis of physician burnout and have not taken effective "burnout reduction and management program" from the organizational level.

(2) Narrative medicine is still an evolving area of medical education and clinical practice, yet its value for medical staff is becoming increasingly well documented around the world. However, the majority studies of narrative medicine mainly focuses on how doctors' attentive listening to patients in the context of narrative-based medicine acts as an intrinsically therapeutic tool (Zaharias, 2018), while the narrative provides meaning, context, and perspective for the patient's predicament. Our research believes that narrative medicine is a kind of humanistic science that attaches great importance to the individuality, particularity, subjectivity through the concern about narrative imperatives of each person in the healthcare context and the person not only refers to the patients, but also the medical staff. We propose that narrative sharing atmosphere created by hospital or department leaders and clinicians of high narrative competencies not only help them cope with complex interpersonal relationships and inner dilemmas but also connect them with a broader chain of humanity through the exploration of the common and essential human life experiences. Therefore, some special subbranches of narrative medicine can be further explored, among which narrative management is the most urgent one. However, there is none such efforts in Chinese literature.

(3) Scholars generally believe that the causes of job burnout can be divided into three categories (Maslach, 1993; W. Schaufeli & Enzmann, 2020): Personal (burnout is seen as the result of internal factors within the individual), interpersonal (burnout is seen as the result of a poor relationship with others at work) and organizational (burnout is seen as a mismatch

between the individual and the work environment). However, few research could integrate system-level solutions to address burnout of these three categories into one logic framework. To involve all these three categories into a holistic narrative framework, this research designs the scale of narrative competencies of medical staff from two dimensions, namely, with one being the bio-health narrative competence (corresponding to the maturity of narrating self) and the other the professional narrative competence (corresponding to the maturity of workplace narrating self). The items designated in the scale could correspond to almost all the contributors of medical staff's burnout listed in the literature. It is innovative in that the researcher combines the life-work-workplace elements relating to burnout into the scale for the first time. This design can make the medical staff participated in the PNCCH enhance their narrative competency by exerting individual and organizational endeavors to face the challenge of their burnout.

(4) Different from the previous literature, this study uses terminology from bio-health narrative theory and Chinese narrative medicine to frame a logic conception of narrative hospital management for the phenomena and the problem-solving methods of hospital burnout, such as narrative ecology, narrating self, workplace narrating self, interpersonal narrative connectedness, professional narrative competence, professional narrative foreclosure, narrative integration and narrative mediation. In the past, the research on the countermeasures of occupational burnout of doctors could not incorporate the dual adjustment of organization and individual into a unified theoretical framework, so it could not make both sides work together to achieve good expectations. This study takes narrative hospital management as the theoretical framework and aims to alleviate physician burnout. On the one hand, it proposes measures at the level of hospital narrative ecology, and actively creates an organizational atmosphere that can stimulate the professional narrative self-growth of doctors, so that the human nature of doctors can get maximum respect from the good narrative connection with managers, colleagues, patients and their families. On the other hand, it puts forward a variety of methods at the individual level of doctors to enhance their sense of family narrative connection and find the best way to improve their narrative self-maturity.

Using the theoretical key words of narrative hospital management to explain the burnout of doctors, we assume that narrative management paradigm in the healthcare context has potential to suit the diverse communication needs of the heterogeneous individuals including hospital decision-makers, administrators, clinicians, nurses and patients as well as their families. And the study also acts on the assumption that the root cause of job burnout lies in the external narrative ecology of hospitals/departments (organizational level) and the inner growing state of medical staff's narrating self and workplace narrating self (personal as well as organizational

level, which can be measured by the newly invented CNCS-MP by the researcher). The research hypothesizes that the contributors for medical staff's burnout in western countries are similar to those for Chinese. But there are some distinct contributors, for example, as only-child in their family, who have less opportunities to establish interpersonal narrative bonding with others during their growth, the young generation of medical professionals face more crises in the growth of their narrating self, and they are more self-isolated and have less intention to communicating with others.

According to this study, the concept of narrative hospital management believes that medical staff are "individuals" first, and advocates "human first, doctor second" as well as "human first, nurse second". Hospitals with humanistic management conception first pay attention to the psychological and physical needs of medical staff and provide conditions at all levels to heal the medical staff first, so that medical staff can better heal their patients. "The patient comes first" is a natural, healthy, and necessary truth when we are with patients. However, medical staff is never shown the off switch. If they do not build the habit of putting themselves first when they are not with patients, job burnout is inevitable. This also means reflecting on the fact that life requires attention in multiple facets, including family, career, community, spirituality, and the inner self. When hospital leaders can help medical staff strike a balance between serving their patients and taking care of themselves, burnout is bound to subside.

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Chapter 3: Conceptual Framework

Narrative hospital management is a new hospital management mode developed in the Chinese context by Chinese narrative medicine scholars in the scope of big health and high-quality hospital development, where scholars actively integrate the new concepts of bio-health narrative, narrative medicine and narrative leadership.

3.1 Theoretical source of narrative hospital management

3.1.1 Bio-health narrative theory

The narrative paradigm is a trinity philosophy of reason, value and action (Fisher, 2021). Narrative is ubiquitous because humans are born with narrative rationality, but they are also subject to the emotions and ideas that narrative reveals, which generate new life attitudes and concrete actions. The theory of bio-health narrative is a new health humanities model with its own key words such as “narrating self”, “bio-health narrative competence”, “narrative ecology”, “narrative foreclosure”, and “narrative empowerment” and its distinct logic system.

3.1.1.1 Narrative ecology: a key concept in the bio-health narrative theory

In the context of bio-health narrative, there are three systems that affect the life process of each subject, which are, (a) “the internal life growth: narrating self”, (b) “the advantages and disadvantages of external narrative ecology” and (c) “time system”. In the growth process of each person, the situation after various refinement corresponds to each person’s unique “inner life narrative system”, including stated of self-narrative connection, the interpersonal narrative consciousness and narrative adjustment ability, and the accumulated narrative capital all through one’s life. “External narrative ecology” refers to the external narrative environment of the family, school, workplace, and community. “Time system” is every static moment connecting each life subject dynamically. The combination of “inner life narrative system” and “external narrative ecosystem” is the accumulation of the past, which determines the who I was, who I am, and who I aim to be.

Each person’s story cannot be only for itself, so every inner life narrative must contact and react with the external narrative ecosystem. The different combination of the “internal life

narrative state" of each life subject and the "external narrative ecosystem" where the individuals live seem to be a static present, but when they are connected by a dynamic series system - "the time system", they become dramatic. The time system is relatively simple, because the event presents a regular and linear forward state, but with the passage of "time", the change of the stack, we call it "story", along the time axis, will stack a story line.

Narrative ecology conception can be interpreted from two different dimensions, either as "ecology narrative" or "narrative ecology". The latter was used in this study. "Narrative ecology" and "ecological narrative" are also two completely different concepts. "Ecological narrative" and architectural narrative, economic narrative, medical narrative, health narrative all belong to a narrative type. While "narrative ecology" refers to whether the narrative atmosphere about a certain region, a certain field or a certain topic is positive and harmonious, whether the interpersonal narrative connection is close, whether the narrative content is rich, whether the narrative perspective is diversified, whether the narrative practice is on a daily basis.

In the Imperial Book (《御书》), there is a classical saying that "众生心污，则土亦污，心清则土亦清". It means that when the minds of the living beings are polluted, the whole environment becomes polluted; and when the minds of the living beings become pure, the environment becomes clear. It well explains the relationship between individual narrative competence and the narrative ecology in which we live. Life cannot exist independently of the bio-health narrative ecology in which he/she lives. When most people in a place show naive, closed or pathological narrative styles, and only a few individuals have matured, open or healthy life narrative styles, then the overall bio-health narrative ecology of this place is in a bad state. A few individuals among them are eventually affected by the overall ecology and tend to become pathological. Then this place will appear gloomy, dark, and lifeless. On the contrary, the whole place will be filled with sunshine and full of vitality.

Every living individual starts from the family, and with the increasing role in his or her family (mother or father, wife or husband), workplace and society. And one's life progression is to some extent a process of continuously entering into a larger bio-health narrative ecosystem, in which any poor or harsh narrative ecology may have a serious impact on their future health and happiness. In fact, each person can be an active builder of their own narrative ecology, rather than a passive recipient. We can resist, criticize and counter the bad narrative ecology, so as to avoid becoming the victims of the bad narrative ecology, and also become the creators of the positive narrative ecology by improving our own narrative consciousness. However, for individuals before entering the workplace, the development and maturity of the narrating self

is very dependent on the narrative ecology of their existence and its leaders (for example, the main caregivers in the family and the teachers at the schools).

3.1.1.2 Narrating self: A key concept in the bio-health narrative theory

Narrative is the foundation of human beings, and the continuous growth of narrating self is an important basis for human beings to maintain health and happiness. At the peak of the development of science and technology in the modern world, human beings are farther and farther away from their own nature. The "narrating self" of children, teenagers, adults and the elderly are hidden, and the narrative ecology of families, schools, hospitals, workplaces and nursing homes is worrying, which has become a stumbling block to human health, harmony and happy life. The narrative turn appearing in the field of life and health is the deepest call for the world to return to human nature.

Bio-health narrative theory mainly puts forward the following points of view:

(1) Human beings have four types of self: (a) "experiencing self", (b) "narrating self" (Harari, 2022), (c) "mirroring self" and (d) "narrated self" (life narrative styles). Among them, "narrating self" plays a key role in whether the life process can be smoothly pushed forward and whether the mental and physical health can be guaranteed. It is of great significance in the aspects of filtering the negative experiencing self as well as negative mirroring self. The bio-health narrative conception advocates three main self-narrative adjustment modes - narrative integration adjustment, narrative reading adjustment and narrative creation adjustment. These three narrative adjustment modes all depend on the active participation of "narrating self". In general, although all four types of "self" are indispensable, "narrating self" is the core driving force for "me" to achieve growth, change and development during life. Narrating self is closely related to the subject of life's happiness, health, concentration, creativity, imagination, empathy, decision-making, action, leadership, wisdom, causal inference, emotional control, life recovery, crisis prediction and resolution.

(2) By evaluating whether a person's narrative competence is good, we use it to judge whether the "narrating self" plays an active and leading role in our life process. In the bio-health narrative context, narrative competence refers to the ability to flexibly use one's narrative capital and narrative wisdom to cope with various major events in the life progression by combining narrative situations of different dimensions such as family, education, marriage and childbearing, illness, workplace, aging, disability and death on the basis of maturing of one's narrating self and accumulation of various narrative experiences and a comprehensive quality of active narrative interaction and timely narrative intervention with others. For human beings,

narrative competence is the most basic survival and development competence.

(3) The concept of bio-health narrative uses "bio-narrative procession" to describe the dynamic process of the whole stage, whole process and all elements of an individual's life. The life process is an objective time process, while the life narrative process is a process of "narrating self" as the kinetic energy. Therefore, we judge the state of an individual's life process from the development and maturity of the individual's narrating self. The whole life process is divided into six stages: (1) the germination and seedling period of narrating self (corresponding to infancy and childhood), (2) the rooting and seedling period of narrating self (corresponding to childhood and adolescents), (3) the consolidation and growth period of branches and leaves of narrating self (corresponding to youth), (4) the flowering period of trees of narrating self (corresponding to early middle age), (5) the maturity and fruiting period of narrating self (corresponding to late middle age), and (6) the return and breeding period of narrating self, see Figure 3.1.

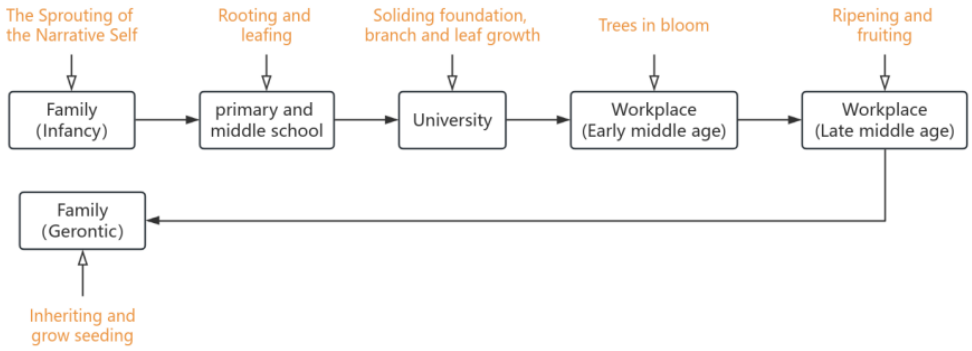

Figure 3.9 The maturing process of individuals' narrating self

Source: Developed by the author

However, not every individual follows such a development rule and can reach a narrative self-maturity that matches the stage of life. "Maturity of the narrating self" refers to the narrating self's ability to respond to complex situations. The extent to which one can adaptively tell the stories of one's inner and outer experiences in life situations (Drake, 2017), that is, the life subject's acceptance of the complexity of his own life situation and the life situations of other characters. Some individuals who grow up in a bad narrative ecology have slow or even stagnant narrating self-growth and may still be in the lagging growth period of their narrating self in adulthood. This is the fundamental reason for life and health crises.

(4) Every living individual must experience the influence of different narrative ecology, such as family, school, community, workplace and society. Only in the safe, free, loose, inclusive and harmonious narrative ecology can his "narrating self" be nourished and

inspiration be activated, otherwise the “experiencing self” can only retain the fragmented memory in his brain. These fragmented memories are chaotic, and they can even affect individual narrative identity. First of all, with the effective company of parents and other major caregivers, “narrating self” obtains the opportunity and possibility of growth in a good narrative ecology, and then makes the life subject dare to fully show its “narrating self” in school, community, workplace and other space. When the narrative ecology of school and workplace is worrying, the “narrating self” will also degenerate, and the mental and physical health crisis of the life subject will inevitably appear.

After combing through many social problems and phenomena, bio-health narrative theory scholars found that the root cause lies in the bad narrative ecology. The development of the “narrating self” that dominates human health has been frustrated all the way from family, to school, to the workplace and society. At home, children are trapped by their studies, and parents suppress the cultivation of their children’s narrating self; in school, students are burdened by various subject knowledge, and the classroom becomes a forbidden area for narrative interaction; in the workplace, employees and managers are confused by performance, the workplace narrative ecology is desolate…. It is difficult for the person to grow into a “healthy self” with the corresponding narrative growth quotient that matches the life stage which he or she is in currently. To reverse this situation, we must start from the improvement of narrative ecology and the narrative quality of life and health of the whole people.

There are two ways to develop narrating self: one is to experience the complex and changeable human and world affairs; the second way is reading, watching or listening to other people's stories. For most people, the “narrating self” does not reach the maturity of narrating self until about sixty. Confucius said: “六十耳顺”. It means that you know how to listen to and follow others, when you are sixty years old. After 60 years of constantly learning from the experience of their own life course and interactions with others, the individual has reached the most mature state of life, knowing how to live in harmony with themselves and friendly interactions with others. Although such a life has had suffering, but the overall is good. If you really cannot get along well with yourself or others in your age of 60, it is likely that this life is a bumpy life.

“Experiencing self” and “mirroring self” can affect individual health through the life narrative style formed by “narrated self” under the filter and regulation of “narrating self”, which has dynamic generating ability. The experiencing self is more related to the “inner subjective feelings and emotions of me”, and the mirroring self is more related to the “external viewpoint and evaluation of the self”. With the filtering process of the “positive narrating self”,

these two selves (experiencing self and mirroring self) will generate an “open and healthy life narrative style”; on the contrary, under the influence of the “negative narrating self”, the “closed and pathological life narrative style” is generated, and over time, it becomes “healthy self” or “sick self”. The narrating self is the bridge between the inner self and the outer self, and the medium of expression. The narrating self has the adjustment ability that the “experiencing self” and the “mirror self” do not have.

When the life subject encounters difficulties, the narrating self is often an important force to help himself out of troubles and frustrations. If living in a family or a crowd, every individual will have an experiencing self and a mirroring self, but the narrating self may or may not develop. Just as humans lose their language ability without adequate verbal stimulation prior to the critical period of language development, so too does the development of the narrating self have its own critical period and its own laws of development. In the barren environment of narrative ecology, the development of narrating self will be blocked, the dynamic role of narrating self will be weakened, and gradually move to a closed, even pathological self. In a good environment of narrative ecology, narrating self keeps growing, its dynamic role is getting stronger and stronger, and it gradually generates an open and long-term healthy self.

“Narrating self” is from childish to mature under the dual action of the connection with self (experiencing self) and others (mirroring self). If they are not connected with others, they will fall into a state of interpersonal narrative disconnection, and the narrating self will be “negative”, “naive”, “stagnant”, “locked”, or even “pathological”. In this state, the narrating self not only fails to improve the relationship with the self but also cannot adapt to the relationship between the self and the world, and may even fall into a certain locked state of narrative, which seriously affects the mental and physical health of individuals. That is to say, the narrating self may be closed in the inner self, and with the advancement of time, the narrating self may not grow internally.

“Open, mature narrating self” means that the life subject remains open to the self-narrative. In the rich interpersonal narrative connections, take the initiative to draw from the “mirroring self” to lead your life story to a higher level, help yourself and others from inside and out of different stages of life; integrate your own life narrative into a larger, more coherent, and more meaningful life narrative; mobilize the “inner ability” and “inner resources” of the self and others to maintain psychosomatic comfort. An open narrating self can not only maintain your own personal health but also empower the people around you through your own narrative intelligence, which can achieve a “better life”.

“Foreclosed, underdeveloped narrating self” refers to the life subject during life due to

insufficient narrative connection or narrative ecological problems caused in a serious life events or long cognitive curing after formation, is unable to maintain the openness of the self-narrative. In the weak interpersonal narrative connection, the subject is dominated by negative stories in the "mirroring self", loses the leading role of narrating self, and unable to help oneself understand the identity and identity changes in different stages of life from the inside to outside. If the locked narrating self does not get narrative care from the people around it, it will suffer from disease.

The development of narrating self has its laws. In order to enable individuals to develop a narrating self of corresponding maturity at different stages of life, in addition to allowing individuals to experience life a little more, it is also necessary to give them opportunities at different stages to read and listen to various family stories, life stories, myths, historical legends, biographical stories and literary stories, from which they can draw nutrients for growth. After all, everyone's life world (family, school, workplace) at the beginning of life is limited, and these stories outside of real life experiences can accelerate the maturity of narrating self, deepen the individual's correct cognition of self, others, the world, birth, aging, illness and death, make individuals plan for the future life difficulties they may encounter in advance, and reduce the possibility of falling into psychological and physical health crises.

Seen from above illustrations, we can say that narrating self is the original force that promotes the evolution ad progression of human life. For human individuals, the richer one's narrative capital, the more integrated the narrative horizon, the more integrated the life narrative, the smoother the life narrative process, the higher the quality of life, the healthier the mind and body, the longer the life span, and the more likely to achieve a good death. The ego exists only in its interaction with the narrative ecology in which it is located, or in its interpersonal interaction with others. The life story of each self is interwoven and interacted with the larger story, and the stories of many selves together form the larger story, which is connected into the story of history. Human history is the sum of all life narratives.

Chinese bio-health narrative scholars found in their research that the weak interpersonal narrative connection of doctors, especially the professional narrative connection (peer connection and doctor-patient connection), means that doctors lack the ability to accumulate experience, career reflection and career growth. The young generation of doctors born in the Internet era and the era of the popularization of smart electronics products are gradually sucked into the screen, the narrative self-development is slow or even stagnant, and the clinical narrative thinking is almost lost, which directly leads to the serious impact on their health, happiness, empathy, diagnosis, inference, communication and crisis resolution. However, the

vast majority of doctors are not aware of this. Therefore, we must systematically improve the narrative competence of life health and professional narrative competence of doctors and internalize it in life and work.

3.1.2 Narrative competence of medical staff in Chinese narrative medicine

Narratives can be seen everywhere in medicine. Narrative medicine is an important supporting discipline for the successful transition from the era of evidence-based medicine to the era of precision medicine. In the context of the continuous development of "Great health" and "artificial intelligence" technologies, doctors' professional narrative competence will gradually become an important indicator for evaluating the strength of medical talents (B. Lewis, 2016). In the future, the focus of competition in the medical field will focus on those who have professional narrative competence and the competition for medical talents based on humanistic ethics and spirit. The concept of "Great health" advocates a shift from "disease-centered" medicine to "people's health-centered" medicine. The transformation of medical institutions from "disease" to "people" is mainly reflected in whether they create a good hospital narrative ecology and whether medical staff have good narrative competence and clinical narrative thinking, whether the unique life stories of individual subjects as administrators, doctors, nurses, patients and patients' families are respected, and whether harmonious interpersonal narrative relationships are built among them.

3.1.2.1 Overall overview of the development of narrative medicine in China

The scholars of Chinese narrative medicine believe that despite the emergence of various cutting-edge technologies and advanced equipment in modern medicine, narrative interactions between clinicians and patients should still be regarded as a powerful tool for disease diagnosis and treatment decisions, because the patient's illness narrative is one of the most important pieces of evidence for these important processes in healthcare. Evidence-based thinking relies on "big data" and cold numbers, while narrative thinking focuses on turning cold data into "thick data" and "warm data" through narrative interactions between clinicians and patients. Narrative medicine education can provide future doctors and young doctors with successful cases of efficient diagnosis due to their awareness of listening to patients' detailed stories, while presenting failure cases of misdiagnosis and missed diagnosis due to lack of narrative thinking. To enhance the comprehensive professional qualities of clinicians in dealing with this complex art of clinical practice, the concept of narrative medicine advocates a high degree of integration of narrative thinking and evidence-based thinking. This model provides a solution to the many

crises that have emerged in the era of evidence-based medicine.

Narrative competence is a comprehensive ability. Subjects with this competence are good at forming interpersonal communication intelligence through reading, telling, writing and reflecting on stories, and know how to actively listen to and respond to other people's stories to enable their narrating self to change and grow, help themselves and others to get out of the narrative foreclosures, and reconstruct the harmonious relationship with themselves, their families, others and society. Narrative competence of doctors is not only of great significance to harmonious doctor-patient relationship and medical treatment, but also vital to their whole health, professional identity and development. The professional narrative competence of doctors refers to the competence that doctors actively apply to self-health management, professional identity, interpersonal communication, patient education, disease diagnosis, disease popularization, crisis resolution, whole-person treatment, hospice care, grief counseling and other medical practices.

Chinese narrative medicine has gradually developed a unique Chinese logical discourse system, core keywords and curriculum system, which involves three main levels. The first is the narrative hospital management level starting from hospital managers. It is committed to identifying and appointing hospital-level leaders and middle-level cadres with narrative leadership. The purpose is to create a harmonious and good hospital narrative ecosystem and strengthen the organization cohesion, enhance workplace vitality, and achieve high-quality development; second, from the level of professional narrative competence of medical staff, this level focuses on doctors' respect for patients' life stories, aiming to improve doctors' diagnostic efficiency and professional enthusiasm, and ensure patients' life safety, improve patient experience and satisfaction, reduce physician burnout, and harmonize the doctor-patient relationship; third, from the perspective of patients and the public, aiming to pay attention to the improvement of their bio-health narrative consciousness, stimulate the patient's inner strength, and cooperate with drugs, scalpels and other rehabilitation methods. Improving people's correct understanding of birth, aging, illness and death are the fundamental ways to achieve big health.

As mentioned in the previous chapters, Medicine is the art of managing extreme complexity - and a test of whether such complexity can, in fact, be humanly mastered (Gawande, 2009), this complex management art, which involves life safety and medical quality, requires hospital decision-makers or department leaders as well as clinicians to have a higher level of maturity in their professional narrating self than those in other industries or workplaces. According to the assumption of this research, the medical staff's narrative competence is directly related to

the maturity of narrating self, while professional narrative competence is directly related to the maturity of workplace narrating self. The stagnation or underdevelopment of one's narrating self will lead to depression and life burnout, while the stagnation of workplace narrating self will lead to job burnout. Therefore, it is of paramount importance to develop a scientific measuring method for medical staff's narrative competence.

However, there is still a lack of relevant scales based on the theory and practice of Chinese narrative medicine in China. This study developed a scale based on the practical experience of more than 40 narrative sharing centers across the country. The final "Chinese Narrative Competencies Scale for Medical Professionals" consist of the narrative cognitive ability scale and the narrative behavior ability scale. Both the sub-scales have good reliability and validity and they can provide a scientific and effective evaluation tool for Chinese narrative medicine research, education, and practice.

3.1.2.2 Compilation of the narrative competence scale for Chinese medical staff

Narrative is the basic relationship between people, and interpersonal narrative connection is an important embodiment of intersubjectivity. Bio-health narrative competence is the survival basis for every living subject to maintain long-term health (X. L. Yang et al., 2020). The Chinese conception of bio-health narrative advocates that every life subject maintains a high degree of integration of self-family-career-community in his or her career development. Although each stage has its main life tasks, "maintaining humanities subjectivity" and "developing the narrating self" are the highest tasks throughout life. Otherwise, people will lose their humanities and suffer from life burnout or career burnout. We should actively establish narrative connections with people related to the workplace and other social circles. If we do not open ourselves to others in the workplace, we will close many "windows of possibility" because "others" means multiple possible worlds to everyone. In the career development stage, in addition to professional identity, we still have multiple identities. Only by maintaining a good narrative connection between family, workplace, and society and maintaining the benign development of our narrating self can we continue to have a "good life".

Therefore, the measurement dimensions of medical professionals' narrative competencies should consist of family, workplace and society, among which workplace and family are the two areas of life where modern people invest the most time and energy. After taking off the work role, they immediately take on the family role, and then continue to fulfill the work requirements the next day. If the two roles of "work" and "family" conflict with each other and constantly compete for personal time and energy, it will bring stress and strain to the individual,

and emotional exhaustion is a manifestation of these consequences (Blanch & Aluja, 2012). Therefore, in order to reduce these consequences, medical staff's family role should be considered and the measurement of their narrative competencies cannot be confined solely from hospital and career-related issues.

This work-family resource spiral is called "work-family enrichment" (WFE) or "family-work enrichment" (FWE), which is used to describe the positive benefits derived from spillover between work and family. WFE or FWE is formally defined as "the extent to which experiences in one role improve the quality of life in the other role" (Greenhaus & Powell, 2006). According to the previous studies, social support from supervisors, coworkers, and family is associated with greater WFE, as are family-friendly organizational policies and family-friendly work culture (Lapierre et al., 2018). A medical professionals' workplace narrative ability is closely related to his or her identification with the basic narrative values of family narrative connections. Those medical staff who have better family narrative connectedness, are more likely to experience FWE as it can positively influence the workplace performance, whereas those who have better good workplace narrative ability can in return enhance their family performance. Therefore, these two dimensions ought to be fully included into the compilation of the scale.

Chinese narrative medicine is a two-way action. While improving the narrative competence of doctors, patients' and people's bio-health narrative awareness is also enhanced in the process of multi-dimensional narrative interaction in the healthcare context, which is an important basis for "big health realization" (X. L. Yang & Wang, 2023). However, many researchers and practitioners who do not have a deep understanding of the essence of narrative medicine equate narrative medicine with "storytelling" or other hospital publicity methods or a "narrative therapy" under the discipline of psychology, which seriously affects the healthy development of narrative medicine in China. The development of scale can reverse the misinterpretation of the connotation of this potential and valuable subject. At the same time, in the process of reading and responding to the relevant items in the scale, doctors can stimulate their own reflection on their own narrative cognition and narrative behavior, which is of great significance.

According to the connotation of bio-health narration and narrative medicine theory, combined with the nature of Chinese clinicians' work, this study compiled the "narrative cognitive ability scale" and "narrative behavioral ability scale" respectively from the cognitive and behavioral situations, each of which presets three dimensions. In this study, after two rounds of expert correspondence and pre-survey, the first draft of the narrative cognitive ability scale and the narrative behavioral ability scale were formed. The experts recognized the contents of the questionnaire, indicating that the questionnaire had good content validity, and at the same

time, some experts put forward constructive opinions, and the experts were highly motivated.

In addition, this study carried out two rounds of questionnaire survey. By filling out this scale, doctors can conduct self-tests to know which aspects they have the corresponding competence, and which aspects need to work hard. The process of filling out the scale is the process of improving the narrative consciousness of doctors. Hospital managers can also make corresponding management strategy adjustments by mastering the narrative competence of clinicians and provide guidance for departments with low narrative competence.

3.2 Theoretical overview: A new theory of narrative hospital management in the context of value symbiosis

Narrative hospital management aims to improve the hospital management level and cohesion and promote the hospital to achieve high-quality development in the new context (X. L. Yang, 2022b). By improving the narrative leadership of managers at all levels of the hospital, narrative hospital service brand value creation and harmonious communication in all dimensions are achieved. The implementation of the Program of Narrative Centers for Chinese Hospitals (PNCCH) is the carrier of narrative hospital management. The establishment of the narrative center provides a physical space for the cultivation of doctors' narrative thinking. At the same time, rich narrative practical experience can create a strong narrative atmosphere and accumulate valuable experience for exploring a more scientific training system (X. L. Yang, 2023).Through the cultivation of narrative competence, the individual spiritual world and values of doctors can be improved and enriched, and finally a narrative ecology of win-win and common development can be formed.

3.2.1 Narrative management enables value symbiosis and high-quality development of hospitals

The popular hierarchical management system (hierarchical structure) adopted before the 21st century formed the imperative and decisive relationship between the "I and it" (I and It) of the upper and lower levels of the organization, lacking the space for dialogue (Anderson & Cissna, 1997). Since the 2020s, the world is undergoing an epochal shift in leadership and management. The traditional vertical leadership model, based on individual power, is facing a major challenge in a century. The new leadership model of the new generation in the workplace embraces the "horizontal connection" within the workplace, more reflecting the characteristics of cross

functional teamwork and networked organization. Narrative is the best medium to create and maintain horizontal connections. Only by creating a narrative atmosphere and fully stimulating the symbiotic relationship between "I and You" as the main body in the workplace, can there be room for dialogue. This is the value symbiosis model that the Z era embraces.

As Han Byeong-chul points out in The Burnout Society, the power of life that Foucault (1990) once proposed has been replaced by the power that the meritocracy imposes on modern people. This makes the workplace increasingly devoid of mutual warmth and humanity. Globalization, new technologies, and the unique circumstances in which the younger generation is growing up, coupled with changes in how organizations create value and interact with those they serve, have significantly reduced the effectiveness of purely prescriptive, top-down leadership. The "Age of Power" or "Age of Entitlement" is a thing of the past. Millennials are more comfortable with "being influenced" and "empathized with" than with "being controlled." Influence is the ability to change the thoughts and actions of the managed in a way that is acceptable to the managed. The prerequisite for having influence is the establishment of symbiotic values and a cooperative mindset.

The Book of Changes (《易经师卦彖》) written by ancient Chinese says: 曰："师，众也。贞，正也。能以众正，可以王矣。" That means if you can command the soldiers, make them obey the command with sincerity, and carry out a just war, you can rule the world. As a leader, he must be able to lead the public and convince the public. In addition to excellent professional knowledge, he has got a strong interpersonal stickiness and is always willing to establish a narrative community relationship with surrounding employees to encourage employee morale and inspire team spirit. In this era of greater pursuit of equality and respect, every young medical staff is eager to be noticed and hopes to become a value community of the organization and grow and progress with it. Therefore, to manage young medical staff more efficiently and give full play to their drive and growth, hospital leaders should know how to use narrative management strategies.

In the medical context, the metaphor of "value symbiosis" can be used to describe the shared value created by the whole hospital and its members at all levels by constructing a harmonious and healthy narrative ecology. To achieve high quality development, hospitals must build a symbiotic value network. The logic of symbiosis is not a concept of control and ownership, but a concept of empowering each other, co-creating value, and sharing development. Under this concept, doctors are no longer regarded as the object or object of management, but as the core of hospital value, self-organizing and self-motivating creative

subjects. The real meaning of a manager is no longer to give orders, but to unite different individuals, give full play to the collective creative potential, and stimulate the internal power of collective creative vitality (Li, 2021). Patients and their families are no longer the carriers of disease diagnosis and research, but the co-builders of harmonious doctor-patient relationship and health narrative ecology.

Narrative hospital management emphasizes the collective wisdom of hospital and department employees. As the saying goes, "One person cannot see as clearly as many people, one person cannot hear as clearly as many people, and one person cannot think as carefully as many people." "Han Feizi Guan Xing" (《韩非子·观行》) also mentioned that "天下有信数三：一曰智有所不能立；二曰力有所不能举；三曰强有所不能胜。故虽有尧之智，而无众人之助，大功不立；有乌获之劲，而不得人助，不能自举。故势有不可得，事有不可成". It means that there are three inevitable principles in the world: first, there are always things that wisdom cannot accomplish, second, there are always things that strength cannot lift, and third, no matter how strong the strength is, there are always opponents that cannot be defeated. Therefore, even if one has the wisdom of Yao without the help of others, he cannot achieve great achievements; even if one has the power of Wu Huo (the strongman of the state of Qin during the Warring States period in ancient China) without the help of others, he cannot lift himself up. The above stories show that anyone's success requires the help of others, mutual assistance and cooperation.

The overall goal of narrative hospital management in China is to create a good hospital narrative ecology and realize the transformation of the management mode of hospital value symbiosis, which is mainly reflected in the following aspects**:**

First, actively carry out the construction of management system and consolidate the theoretical foundation of the new direction of narrative hospital management.

Narrative hospital management is to improve the level of hospital management in the context of big health and new medicine, and to build the overall narrative ecology of the hospital and improve the narrative consciousness and narrative intelligence of managers at all levels.

Second, take the narrative hospital management as the framework to create a good narrative leadership ecology of all hospital dimensions.

The hospital narrative ecology is closely related to the career development, healthy survival and personal destiny of each life subject working in the hospital. Narrative plays an important role in forming a "common discourse basis" and triggering a "common action direction" at different organizational levels, such as hospitals or hospital departments. Hospital leaders with

good narrative awareness are good at encouraging employees at different levels in communication, management and service, using personal and collective narrative wisdom and narrative capital, and constantly transforming them into the benefits of hospital development.

Narrative leadership is a tool to stimulate the sustainable development of doctors and the cohesion of hospitals/departments. The narrative quotient of managers is a kind of "soft power" and "intellectual power". The Book of Changes (《易经》) advocates that in the event of a major problem, one must deal with it gently. It is mentioned that "自古以柔方可制刚，正如老子所言，柔弱者生之徒，刚强者死之徒。尧舜帅天下以仁而民从之，三盘道运柔方得尊位，是故事事柔之行，亦即合天之行也，领导之行均如是耳", which means that since ancient times, the soft can control the rigid, as Lao Tzu (老子) said, "the weak live, the strong die." Yao and Shun (ancient Chinese Kings) ruled ancient China with benevolence and ancient Chinese followed and respected them." In other words, the key to effective leadership of hospital and department managers is not to use rigid authority and system, but to use flexible narrative ecology and guidance.

If hospital managers do not give full play to the positive dynamic role of narrative empowerment and narrative wisdom, as an organization, they may fall into the state of narrative foreclosures (X. L. Yang et al., 2020), which directly leads to the lack of openness, stability and inclusiveness in the narrative process of the hospital, the lack of vitality and the slow or even stagnant development of various undertakings in the hospital, which is not conducive to the sustainable development of the hospital. Narrative is the source of organizational power to maintain stability or produce change (Vaara et al., 2016).The integration of narrative ideas can transform the solidification, stagnation or negative stories into an open narrative process, so that the organization is in a dynamic narrative space full of possibilities. All members are writers and promoters of the narrative process of the hospital, and this joint effort leads the personal story and the organizational story to a better direction. Narrative hospital management realizes the interactive and endogenous growth of each subject through the construction of narrative ecology at all levels of enterprises or organizations.

Third, use the narrative mediation and management intelligence to resolve the contradictions and hidden crises at all levels of the hospital.

Limited by evidence-based management thinking, hospital managers often fail to take into account the human nature and value aspects when dealing with the relationship with the management objects, and have many conflicts with the management objects; influenced by scientism and technology supremacy, many doctors blindly rely on evidence-based medicine

Diagnosis and treatment of diseased organs and diseases, and lose the holistic view and humanistic consciousness of diagnosis and treatment, "seeing the disease but not the person", the relationship between the doctor and the patient is tense and antagonistic, the potential conflicts between doctors and patients are not resolved in time, and the doctor-patient crisis is about to break out without knowing it. This leads to a more serious crisis for the hospital. The relationships formed between hospital-level and department-level managers and medical staff are more professional or occupational relationships, ignoring the construction of human relationships between subjects.

In 2020, Academician Han Qide, who was the former president of Peking University said in an interview by *China Science Daily* that the main problem in the contradiction between doctors and patients lies in the doctor. The root cause is that hospital managers lack basic narrative management awareness, do not build a harmonious narrative culture, do not actively guide doctors to comprehensively improve their personal narrative competence and narrative resolution ability in crisis, and do not understand that narrative connection is the cornerstone of interpersonal relationship. The application of narrative management concept can greatly improve the narrative adjustment ability (self-regulation) and narrative mediation ability (interpersonal crisis adjustment) of managers and medical staff, and integrate the multi-dimensional vision gap between managers and medical staff, between medical staff and patients and their families, and between hospital staff and society, reduce professional burnout, eliminate management blind spots, and resolve hospital crisis, promote the harmonious relationship between all dimensions of the hospital, and achieve the goal of high-quality development of the hospital.

Fourth, take the formulation of narrative guidelines as a symbol to achieve a connotative shift in excellent and innovative hospital management.

In the context of hospital management, the shift of humanism from "disease" to "human" is concentrated in the following aspects: "Whether medical institutions attach importance to the construction of narrative ecology; Whether hospital managers pay attention to improving the narrative competence of administrative and department managers and their medical staff; Whether hospital administrators respect the life stories and career development stories of medical professionals; Whether healthcare professionals respect the life stories of patients and their families; Whether narrative (narrative education, narrative regulation, narrative empowerment) is used as a necessary means to recognize, prevent, manage and treat disease." Through the preliminary formulation of the Chinese narrative hospital management Guide manual, the hospital realizes the humanistic connotation value of the management concept, and

effectively transitions from extensive development to the connotative development stage of green environmental protection.

3.2.2 Narrative leadership quotient in narrative hospital management

Narrative is the most important and powerful tool in a leadership toolbox (Gardner, 2011). Narrative quotient is the number one quality for managers. In the context of narrative hospital management, the manager's narrative quotient (NQ) can be defined as flexibly applying the basic concept of narrative to the construction of family intimacy and happiness enhancement, and the formation and management of the manager's professional identity and career planning, creation of core narratives for medical institutions or departments, construction of interpersonal narrative relationships and management narrative ecology in different dimensions, narrative thinking training for clinical doctors, medical quality control and crisis resolution, inheritance of management culture and management experience. In terms of cultural and management experience inheritance, he is good at accumulating narrative capital through reading, telling, writing and reflecting on stories of himself and others, forming interpersonal narrative intelligence, and maintaining a comprehensive quality of healthy and harmonious relationship with himself, family members, management peers, management objects and other members of society."

The narrative leadership quotient is the secret weapon to achieve ultimate management success. Why do we work tirelessly and energetically under some leaders, but languish and half-heartedly under others? The underlying reason lies in whether managers have a good narrative leadership quotient and whether they can create a narrative ecology that stimulates employees' vitality in the workplace. Smooth interpersonal narrative relationships are the cornerstone of effective management. Two-way narrative communication with empathy can generate closer emotional and instinctive connections within the organization and stimulate creativity and cohesion. The real stories in different dimensions of the hospital are springboards of elastic thinking and emotional bridges. Therefore, narrative leaders can make full use of their accumulated narrative capital and narrative intelligence to devote themselves to management work.

Hospital managers with good narrative awareness will inspire employees at different levels to use narrative structure and narrative logic in communication and management. Plato said, "Storytellers lead society." What these assertions emphasize is the narrative quotient of managers. The core of the manager's narrative is to connect the manager's personal self-story with the group story related to the hospital organization. The Book of Changes contains a lot of

profound management wisdom, and many of its discussions coincide with narrative management concepts. In "The Book of Changes, Xici Xia" (《易经·系辞下》) Confucius said, "君子安其身而后动，易其心而后语，定其交而后求，君子修此三者，故全也。危以动，则民不与也，惧以语，则民不应也，无交而求，则民不与也", which means "A gentleman must first settle himself before he can act; To communicate with others, we must compare hearts before we can further talk about the affairs of the world; Make sure you know who your friends are before you ask them. If a gentleman can have these three aspects of cultivation, he can be called a flat and noble person. If they are not yet stable and insist on taking action, the people will not support it. If you intimidate people with threats, they will not obey in their hearts. If there is no friendship with the people, then the people will not participate." These few sentences fully illustrate the importance of managers "settling down", "changing their minds" and "establishing friendships". And all three are related to managers' narrative quotient.

The first sentence means that managers must first "settle down" themselves and have good self-identity and stable family relationships before they can do a good job of managing others. As the old Chinese saying goes, "Only when you are settled can you build your life." If you are anxious to start a career without settling down, you will not succeed. If a manager's own narrative competence is low, family narrative connection is weak, and he often neglects to accompany and listen to his children, partners and parents, it will undoubtedly lead to poor parent-child communication and disharmonious relationships, and he will also be in an unhealthy living state. It is impossible to build a harmonious family atmosphere among family members who have close connections and mutual trust with themselves, let alone establish a healthy and harmonious narrative connection with the surrounding world.

For hospital managers, Confucius's second sentence 易其心而后语 refers to the narrative intelligence of perspective-taking and empathic interaction. This sentence means that before we talk to employees, we must first understand their situation and status, take the initiative to think from their perspective, and then engage in narrative interaction, so that we can gain the trust and support of the other party. Employees will definitely not obey a leader who considers his own interests and development at all times. This is what Confucius said: "惧以语，则民不应也。" "If you intimidate people with threats, they will not obey in their hearts." In other words, a manager always uses his position and authority to issue orders in a threatening manner. This type of management will not be responded to by everyone.

Confucius said: 定其交而后求, "Make friends before asking", which means to establish friendships with others before asking them to do anything. The basic relationship between

people is narrative relationship. Interpersonal narrative connection is a dynamic interactive process in which people communicate and influence each other through narrative as a medium, including parent-child narrative relationship, sibling narrative relationship, and husband-wife narrative relationship, teacher-student narrative relationship, peer narrative relationship, colleague narrative relationship, and professional narrative relationship. The sense of trust, belonging, mission and cohesion between organizational managers and employees actually come from meaningful relationships. Only by first developing a harmonious and harmonious relationship with colleagues can we ensure the smooth and efficient implementation of management activities.

Narrative connection is the cornerstone of interpersonal relationship. “Settling down”, “changing their minds” and “establishing friendships” respectively represent the establishment of narrative connection with oneself, family members and others, and the community (the unit and the organization and the wider society), and gradually exert their narrative influence and become a leader. In the context of hospital management, if management cadres can improve their narrative cultivation in these three aspects, change their positions and empathize when doing things, and actively establish harmonious interpersonal narrative connections with people in daily work and life, they can achieve no bias and comprehensive success.

The narrative quotient of hospital leaders is composed of three levels of narrative competence, one is the leader’s ability to tell the story of self, the other is the ability to inspire internal employees to tell the story of everyone related to the development of the hospital, and the third is to create the overall story of the hospital and inspire the ability of staff to share the story of us in the development of the hospital. When managers tell their stories, the stories reveal their values. Stories are not abstract principles, but tangible experiences of our lives. Hospital leaders’ stories reveal who they are and lead others to identify with them. Leaders are the narrative guides of hospitals or departments, and they will gradually surpass the initial goal of individual narrative and form a more meaningful collective narrative of hospital development in the two-way or multi-directional interaction with the responders.

The narrative quotient of managers involves the following dimensions: “the observation of narrative ethics”, “the application of narrative reflection”, “the acceptance of uncertainty”, and “the maintenance high quality interpersonal narrative communication”, “narrative competence and narrative humility”. Hospital leaders strengthen personal value through storytelling, gain reflection and interpersonal ethical judgment in management, accept and tolerate uncertainty in stories, encourage other hospital employees to share stories, learn from the stories of themselves and others, and create an overall hospital culture based on common values.

3.2.3 Narrative ecological construction in narrative hospital management

In modern society, if a hospital wants to achieve high-quality development, it must focus on improving its warm and soft power. The most important of these is the hospital's narrative ecology and the professional narrative competence of hospital employees. As an emerging humanistic management model, narrative hospital management can, on the one hand, enhance the cohesion within and between departments, promote the coordinated development of each department, and improve the overall medical service level of the hospital; on the other hand, it is conducive to the formation of fate and value community of managers and patients, promote the construction of humanistic hospital, and create a warm medical treatment.

3.2.3.1 Hospital narrative ecology and the growth of clinicians' narrating self

Clinicians' narrative are a precious resource offering insights into how clinicians perceive professional and personal challenges (Moniz et al., 2017). Such narratives reveal the practice of medicine but also inform about the clinicians' embedment in their profession and the healthcare context. The "narrative growth quotient" refers to a person's ability to understand and express their own life story, and how to use this ability to play a positive dynamic role in self-growth and career development. Among the four kinds of self, "narrating self" can grow, and only when "narrating self" grows, the life narrative style of "I" will be continuously optimized. When the "narrating self" is in an open and growing state, we can conclude that the subject has a good narrative growth quotient. This concept emphasizes how individuals construct their own unique life stories by examining their past experiences, emotions, and perceptions, and through these stories shape their identity, discover their strengths, and develop positive worldviews and values.

The narrative growth quotient allows individuals to continuously transform experience and narrative accumulation into growth wisdom. It can be said that the narrative growth quotient is an index that measures a person's "soft power" and "smart power". Every stage of life is interrelated and affects each other, which has an important impact on life-long health. However, relatively speaking, adolescence is a critical period for narrative self-growth, because this stage is also a period for the simultaneous advancement of three major life tasks: career, social relationships and intimate relationships. Narrative growth is the basis for the smooth advancement of "I" in this complex period.

The life narrative constructed by young individuals in the narrative interaction of family members is the seed of career development. The subject of life relies on the original family to spend the infancy, early childhood and childhood stages, so the narrative ecology of the family

has the greatest impact on "narrating self". The adolescent stage is gradually separated from the family, and the influence of the school narrative ecology begins to occupy a greater weight. After having their own career, the influence of the workplace narrative ecology multiplies. In the old age, after gradually withdrawing from the workplace, they return to the family and assume the responsibility of family inheritance, and the ecological impact of workplace narrative is weakened, see Figure 3.2. No matter what stage of life, even in the old age, as long as the narrative growth thinking has been cultivated, the subject can have growth potential.

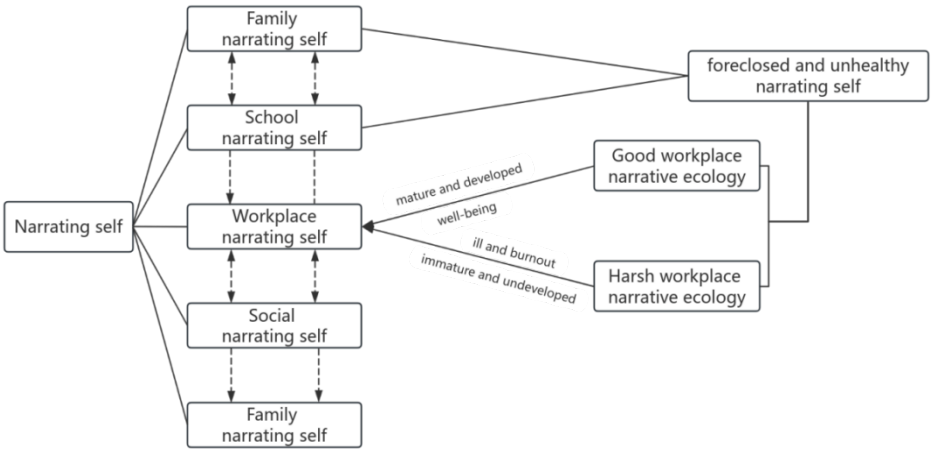

Figure 3.10 Workplace narrating self that is influenced by one's previous narrating self

Source: Developed by the author

One always lives in the family, workplace and community, becoming an integral part of the ecology of this space. Each self's story is interwoven with a larger story (family story, workplace story, national story, regional story, gender story, aging story), and the stories of many selves together form a larger story, forming a narrative ecology of a particular theme. Hospital narrative ecology, as a sort of workplace narrative ecology is a key concept in narrative hospital management theory. It is a metaphor for the soft environment of hospital administrators, clinicians, patients and family members of patients in the medical context.

The hospital narrative ecology is an organic narrative system composed of the narrative competence and multi-dimensional interpersonal narrative connections of managers, doctors, patients and their families. Baldwin, an expert on life narrative research, said, "We not only operate in a narrative environment, but are part of the narrative environment of others" (Baldwin, 2013). In other words, the construction of a hospital narrative ecology is a dynamic process. It is composed of overlapping "sub-narrative ecology". The narrative leadership level of hospital managers and the narrative competence of doctors are the decisive factors in the narrative ecology of the hospital. In a good hospital narrative ecology, in the mirroring self-narrative interaction between leaders and management objects, and in the mirror self-narrative

interaction between doctors and colleagues and patients, the "professional narrating self" continues to grow, activate the stagnant narrating self of patients, and improve their quality of life, see Figure 3.3.

Good workplace culture can bring two advantages to the development of hospital: first, release individual and collective talents, accept diversity, encourage inclusiveness, and establish a sense of belonging, so that members can actively contribute their wisdom and ideas; hospitals with good narrative ecology can bring a comfortable "security" to medical staff." Psychological security" is widely defined as an atmosphere in which people can express themselves and make themselves comfortable. Psychological security is an important source of value for organizations operating in complex and volatile environments. It is an important feature of successful teams. According to relevant research from Harvard University, organizations with good narrative ecology perform better than organizations with unsatisfactory narrative ecology in almost all indicators.

A good hospital narrative ecology builds a value community, or a narrative community. Narrative medicine agrees with Adlerian psychology and advocates that subjects at all levels in the hospital abandon vertical relationships in the workplace and invest in multi-dimensional horizontal interpersonal relationships. In the workplace, we tend to use vertical relationships based on the principles of superiors and subordinates, elders and juniors, master-apprentice relationships, high and low professional titles, high and low academic qualifications, or who wins and who loses, who succeeds and who fails. This vertical interpersonal relationship is the biggest factor that harms individual health in the workplace. In a good workplace narrative ecosystem, leaders will consciously bring interpersonal relationship to the direction of horizontal interpersonal relationship and develop conscious internal growth power in the mutual listening, mutual understanding, mutual response and mutual touching. The narrative community relationship created by horizontal relationships allows individuals to have a healthier, more inclusive, more open and more reflective personality.

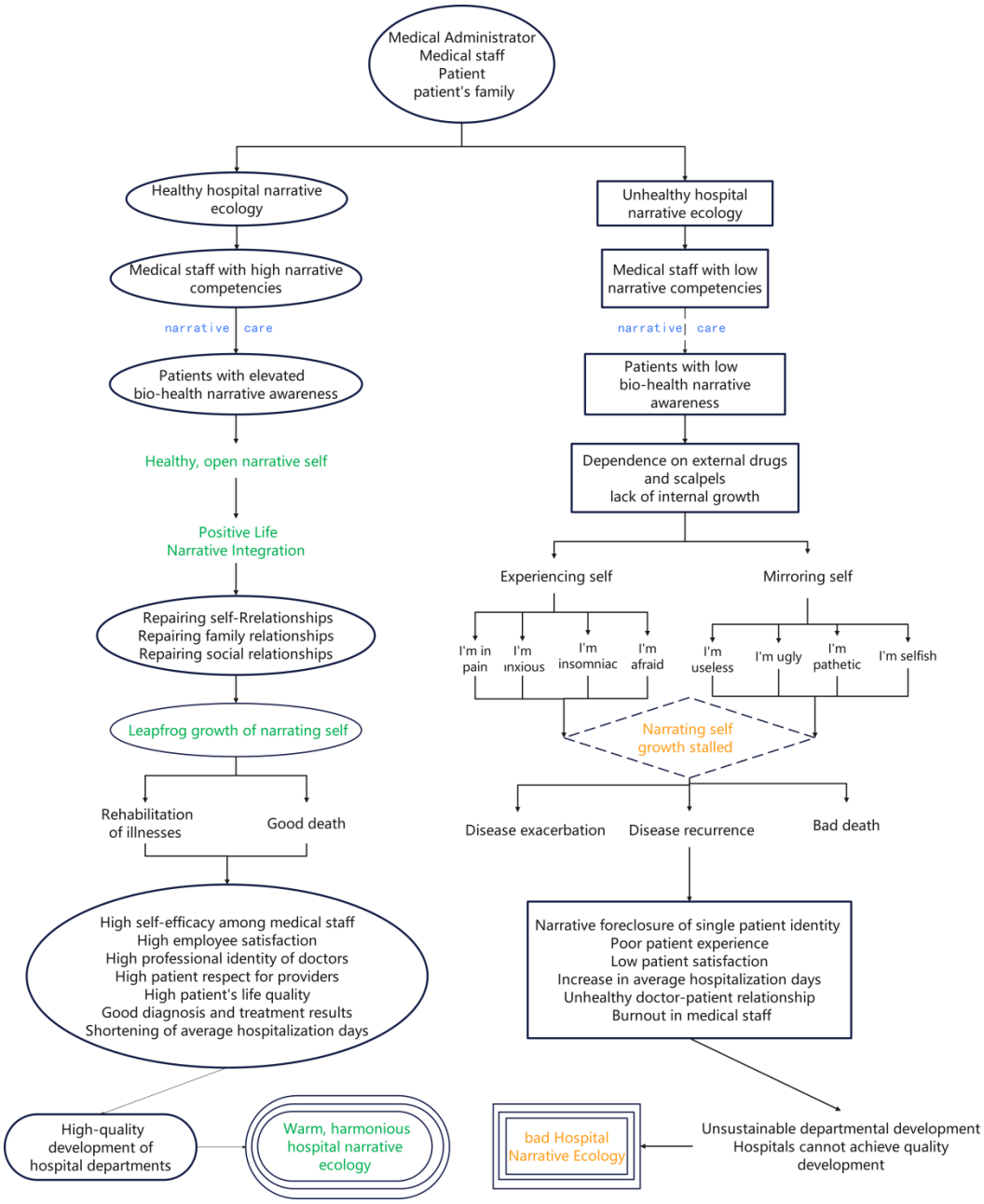

Figure 3.11 The process of changing of the workplace narrating self in good or harsh narrative ecology

Source: Developed by the author

In the hierarchy of needs proposed by Abraham Maslow (1908-1970), “love and belonging” is one of the needs that must be met to be a “complete human being.” From the perspective of a hospital or department, every employee or team member is no longer regarded as a small screw in a complex machine, but a real and vivid life. The construction of the hospital narrative ecology is to respect the existence of every employee in the workplace environment based on “humanity” and “narrative” as the background color, so that he can feel that he can always be heard and seen and feel that his own ideas can also support the sustainable development of the hospital and the department. An important task for leaders is to help employees find their own connection to the organization and experience themselves as part of the system, rather than as

a part that can be replaced or replaced at any time.

Putting short-term results and benefits more important than people is a management model that is far from human nature. When hospital employees struggle to find a sense of identity and belonging at work, they inevitably bring this struggle home with them. In turn, when hospital employees are cared for and protected by managers, rather than exploitable resources; when the day's work is over, everyone will go home with a strong sense of security, accomplishment, and full gratitude. When doctors treat patients as machines to be repaired on the assembly line, they will inevitably mechanize their work and become assembly line workers with mechanical work. Doctors face serious problems such as a low sense of professional identity, unrelieved occupational stress, and an abnormally high rate of professional burnout. In the final analysis, the source of all lies in the destruction of the narrative relationship between the three life subjects of medical institutions, and only by advocating the restoration of the interpersonal narrative connection of the three can we truly return to the original heart of medical treatment and solve the problem of professional burnout.

The hidden benefits created by the construction of narrative ecology are richer than material and monetary rewards. Hospital is a social institution with very heavy labor intensity of staff, and there is no upper limit for material and monetary rewards, which will stimulate everyone to be more utilitarian, which is not conducive to long-term development. "Mencius: Dedication on" (《孟子·尽心上》) says, 以佚道使民，虽劳不怨, which means the rulers serve the people based on the principle of making them comfortable. Although the people work hard, they will not feel resentment. In the context of narrative hospital management, it means that how can managers consider issues from the perspective of medical staff, from the perspective of seeking long-term interests and sustainable development of everyone, start from the creation of a good narrative ecology, sincerely care for the mental, physical and human health of medical staff, and create guidelines to help them improve their comprehensive professional competencies? In such a narrative ecology, despite their hard work, medical staff will not complain, but go all out, make unremitting struggle for the common interests.

In hospitals with good narrative ecology, both leaders and doctors have a strong sense of belonging. In Atlas of the Heart, the sociologist Brene Brown talks about the difference between "fitting in" and "belonging": "Fitting in" is about being like everyone else in order to be accepted by others, while "belonging" is about "following your heart" and letting people around you accept you as who you really are, without having to put on a mask to conform to others. The lack of belonging of team members is a management risk that cannot be ignored for hospitals and departments. Managers who can consciously create a narrative interactive

environment that creates a sense of belonging for team members will significantly improve employee performance, reduce clinical errors and burnout rates, and reduce turnover rates. Therefore, the establishment of a sense of belonging is a management issue that any modern hospital must face. The lack of a sense of belonging roots mainly in the lack of an atmosphere in the hospital or department to make meaningful connections with others.

3.2.3.2 Five basic dimensions of hospital narrative ecology

The construction of hospital narrative ecology requires two aspects of supportive environments: the tangible physical environment and the intangible psychological environment. “Physical environment” refers to various physical spaces established by hospitals to create a good narrative ecology. Currently, large-scale public Grade 3A hospitals in many cities across China mainland already have such physical space. “Psychological atmosphere” is the spiritual atmosphere integrated into every corner of a medical institution. It is mainly established by hospital and department management personnel with good narrative management awareness and value symbiosis concepts. Support and promotion also require medical staff to actively participate in narrative interaction and narrative communication to make it the norm.

Hospital narrative ecology includes the following five main dimensions:

First, the narrative connection and narrative communication between the top hospital managers (secretary and chief and vice deans).

The second is the narrative interaction between the top hospital managers and the leaders of functional departments and clinical departments.

Third, the daily narrative connection and interaction between clinical department leaders and medical staff in clinical departments.

Fourth, the narrative interaction of interpersonal care between clinical medical staff and medical or hospitalized patients and their families.

Fifth, clinical medical staff guide patients and their families to establish a narrative connection about the theme of the disease.

Subjects from different dimensions continue to interact and inspire each other, forming a hospital narrative ecosystem, see Figure 3.4. Leaders can quickly understand their needs by establishing interpersonal narrative connections with those they manage. American management scientist Chester Barnard said that executives are responsible to establish and maintain a system of communication. The leader’s interpersonal narrative connection ability means that on the basis of understanding employees, leaders can get into the hearts of employees, so that employees are willing to treat you as a person with whom they can

communicate candidly and communicate effectively, so as to achieve effective connection. The four core links of narrative connection are - narrative expression, narrative listening, narrative interaction and narrative consensus.

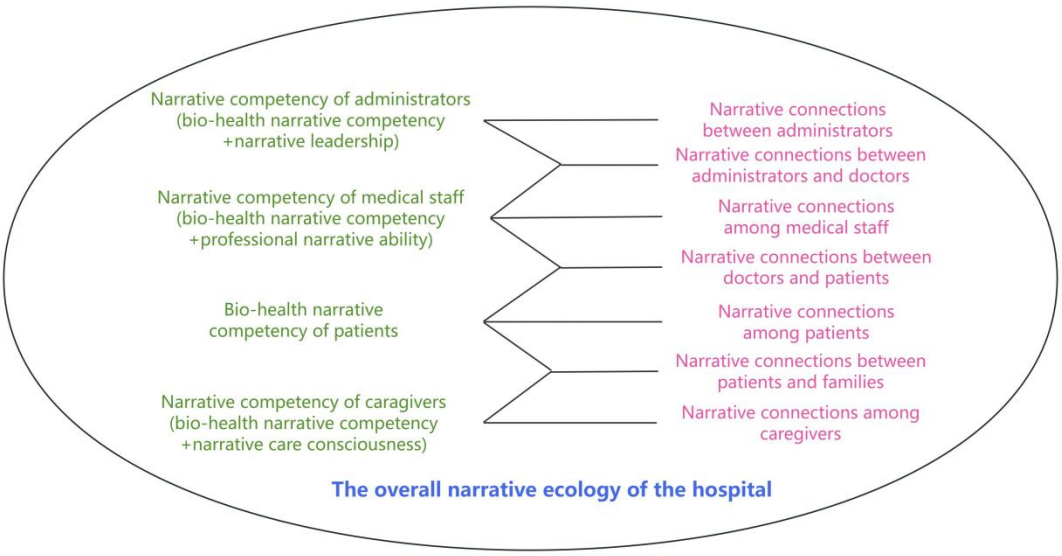

Figure 3.12 The overall narrative ecology of the hospital

Source: Developed by the author

In the first and second dimensions, the “narrative quotient” of managers is crucial. Hospital managers with innovative narrative management consciousness can actively create a good hospital narrative atmosphere and narrative ecology from the overall perspective of the hospital (at the overall level), help different subjects see the stories of different subjects in the medical context, and fully form the visual integration and harmonious relationship. When leaders make good use of the narrative that stimulates common values to organize the actions of hospitals or departments, the barriers between departments constructed by the specialty essence and barn effect can be cracked, and the same frequency resonance between various departments can be realized through continuous tuning.

The department leader is not only the member of the second dimension, but also the leader who leads the narrative of the third dimension and plays the role of connecting the hospital and the department. When the department narrative becomes the core mode of internal communication, the efficiency of the department’s daily meetings will be improved, and the action force of the task will be maximized. The third dimension reflects the routine and closeness of the narrative connection among medical professionals. In the fourth and fifth dimensions, the professional narrative competence of medical staff, who bear the responsibility of connecting the hospital with the external society (patients, their families and the general public) is the most critical, which is also an important dimension for the public to fully feel the

humanistic atmosphere of the hospital.

"The nurse-patient relationship is not a uniform, professionalized blueprint but rather a kaleidoscope of intimacy and distance in some of the most dramatic, poignant, and mundane moments of life" (Benner, 1984). Narrative hospital management advocates that doctors and patients and their families first establish equal interpersonal narrative relationship, rather than playing the role of authoritative experts. Narrative medicine also encourages doctors to make good use of narrative thinking, feel the suffering of patients or their families, and put themselves in their exquisite medical skills and humanistic care and narrative care to help patients and their families in the darkest moments of life to get out of the mire and enter a new life. Sometimes, due to the uncertainty and limitations of medicine, the disease cannot be successfully cured. However, doctors can still use the language to warm the hearts of the patients and their families and face the pain and walk out of the darkness together.

The relationship between a story and a narrative is similar to the relationship between a single star and a constellation. Culture is a "galaxy" woven by different constellations, which is the core narrative of the hospital. Through the common constellation narrative and imagination, the members of the department form "community of narrative", obtain more accurate sense of orientation and give the common narrative identity; through the common galaxy narrative and imagination, the hospital forms "action community", "vision community", "care community", "cultural community" and "value community", and achieve high-quality development in the context of value symbiosis. In a good hospital narrative ecology, both leaders and employees have good narrative adjustment ability, and the core narrative and narrative community can be formed smoothly.

Under the framework of narrative hospital management and hospital narrative ecology, the socialization process of a hospital as an organization no longer completely relies on regulations, procedures, rules and authority levels to control the work activities of members in the organization, but hospital leaders obtain more humanized narrative management tools. The narrative management mode develops the horizontal narrative community relationship, or the value symbiosis culture, instead of the vertical relationship promoted by traditional rules. The culture of value symbiosis can better reconcile the contradiction between doctors' professional improvement demands and managers' operational performance demands and integrate the gap between personal professional goals and organizational goals.

Another measure to improve hospital narrative ecology is narrative supervision and narrative rounds. The Narrative Steering team, composed of multiple members across departments, ranks and years of experience, conducted small-scale focus group interviews

within the hospital, allowing staff at different levels to have the opportunity to discuss the importance of "belonging" to them, collect stories about belonging, while leaving space for people to share their worries and anxieties authentically, and to see the obstacles that may arise in creating a sense of belonging. Through regular narrative coaching activities, the team understands that this is not a flash in the pan or a temporary project, but a long-term investment by the hospital or department to create a positive organizational culture. The diversity of the narrative steering group itself allows employees to see that the creation of a "sense of belonging" is not only the privilege of the human resources department or a certain level of management, but the common responsibility of every employee in the organization

The narrative hospital management concept allows the medical staff, patients and their families in the department to be like people in heaven who help and nourish each other. They establish a life community relationship, where they can rely on each other, live in harmony, and work and grow healthily and happily and it is a paradise for everyone. This harmonious and good hospital narrative ecology is of great significance for hospital managers to guide hospitals to achieve high-quality operation, personal mental health and career development of medical staff, the realization of the health of patients and their families, and the construction of the overall harmonious relationship of the hospital, which can comprehensively improve the medical service quality and sustainable development of the hospital.

3.3 Narrative hospital management and professional burnout management of doctors

Based on the narrative hospital management theory, this study assumes that physician burnout is mainly affected by the hospital (department) narrative ecology, their own narrative competence (bio-health narrative cognition and professional narrative competence) and the bio-health narrative awareness of patients and their families. The construction of "narrative community" in the context of narrative hospital management is a postmodern concept. With the proliferation of electronic products and the development of network technology, the spiritual bond between people is becoming more and more materialized, and the instrumental tendency of interpersonal communication is becoming more and more obvious, which directly leads to the gradual disappearance of narrative community in modern society, especially in workplace organizations with increasingly refined division of labor. The weak workplace narrative connection leads to the obstruction of narrating self-growth of doctors and eventually leads to serious professional burnout.

3.3.1 Hospital narrative ecology and professional burnout of doctors

Close workplace interpersonal narrative connections in all dimensions are the foundation of a good workplace narrative ecology. A good workplace narrative ecology can stimulate the vitality of employees. On the contrary, an unhealthy workplace narrative ecology can drain employees' vitality and enthusiasm. A workplace with a poor narrative ecology is like a "ghost ship." In "Ghost Ship" organizations, employees suffer from low morale, inactivity, physical and mental burnout, frequent leave requests, high resignation rates, and an increasing number of people encountering health crises. It seems that the ship is still sailing forward, but in fact it is full of "living dead". No one is responsible for the direction of the ship and is just drifting with the tide. A common feature of "ghost ship" organizations is "very weak interpersonal narrative connections in the workplace." To enhance workplace vitality, the first priority is to create a good workplace narrative ecosystem.

3.3.1.1 Workplace narrating self-growth and professional burnout

Narrative is the "basic survival ability" of social people, which is used by people to capture experiences, learn from each other and obtain the meaning of life. According to the "Job Skills of 2023 Report" by the online course platform Coursera, narrative competence jumped to first place among the top ten workplace Human Skills in 2023. Robert Half International CEO Max Messmer (2000) says, your career success in the workplace of today – independent of technical expertise – depends on the quality of your people skills.

However, the young doctors of the millennial age, especially the only children, mostly grew up in "failed family education", they grew up in the internet world and are good at showing others the beauty of their lives, and good at hiding their depressed and lost side; Most of them lack interpersonal narrative experience and lose the ability of narrative communication. When they grow up, all they need is the approval of their parents, and when they enter the hospital, what they need is the approval of their peers, and everything becomes extremely stressful and anxious, because they do not know how to create deep, meaningful narrative connections, which haven't existed in their past life experiences, so they haven't learned this skill.

Therefore, after being pushed into the real world of the workplace, millennials encounter more problems and crises than their predecessors. They are less willing to get married and less willing to interact with others. They are more likely to fall into burnout than the previous generation of doctors, but they do not realize that their careers are in crisis. Electronic products and the internet have diverted human attention to the outside world, destroying the "inner world" of human beings, and the inner world has become as dry as a desert. Leaders of medical

institutions who are responsible for young doctors should actively establish a positive interaction mechanism, create a multi-dimensional narrative space, and help them acquire interpersonal narrative wisdom and communication skills. The creation of a narrative ecology in the workplace can prevent them from falling into severe burnout and career narrative foreclosure due to interpersonal narrative disconnectedness and avoid mental and physical health crises.

As the saying goes, “leaders should consider the opinions of their subordinates when making decisions and act as a collective team in order to avoid mistakes and achieve success” A hospital or a department can only create a “confidence that a person will not be punished by managers or colleagues for boldly and frankly sharing his observations, phenomena he discovered, problems he encountered, his inner worries, or mistakes he made.” Only by stimulating the horizontal narrative interaction between leaders and the managed can the harmonious narrative ecology of hospital create the power of innovation and change.

Improving doctors’ narrative competence can alleviate professional burnout. The hospital as an organization cannot completely determine the bio-health narrative competence of individual doctors, because the overall development of the individual narrating self of a physician is closely related to the narrative ecology of family, school and community experienced by the individual. However, the hospital can promote the positive growth of individual doctors’ professional narrating self by creating a good hospital narrative ecology. The growth of the professional narrating self can ultimately enhance the overall maturity of the individual narrating self.

3.3.1.2 Workplace narrative disconnectedness and professional burnout

Doctors become disillusioned with their profession and suffer burnout, largely due to the inability to perform their work in a human way. In short, most of what modern medicine defines as “medical work” is done in the lab, in the doctor’s office, on the computer, and the narrative connection with the patient is broken. As a result, our attention is largely diverted from the patients who give us their lives and souls, and it has become the norm in our medical culture for doctors to stare at the screen and ignore their patients. We increasingly distance ourselves from our patients, ourselves and other colleagues in the medical context. Therefore, to adjust the professional burnout of doctors, we must first restore the humanized working mode.

Narrative hospital management believes that medical staff are first and foremost “individual people” and advocates “person (human) first, doctor second”. The hospital should first pay attention to the human body and mind of medical staff as a subject. To meet the needs,

medical staff must first provide conditions to cure the medical staff, so that the medical staff can better cure the patients. People are the most important asset of an organization, and leaders with narrative management awareness will not treat employees as tools and costs. Burnout research experts also point out that burnout is caused by the collapse of social, cultural or organizational perceptions of human interactions between subjects (called "intersubjectivity" in philosophical terms). When hospital leaders only focus on the instrumental and productive management of doctors and blindly emphasize the technical and service-oriented nature of doctors' "extroversion" to patients, doctors will regard their profession as purely technical work and isolate themselves from their emotions at work. Although shielding emotions has certain adaptive value, it reduces people's happiness and not only destroys relationships with others, but also makes doctors feel confused and burnout about their profession. Therefore, managers should not only regard doctors as tools for providing medical services in the institutions where they work, but should provide employees with subjective, inner and spiritual connections, and provide sufficient humanistic nutrients and existential support.

In the context of narrative hospital management, the only antidote to doctors' job burnout is to establish a horizontal interpersonal narrative relationship with their families, colleagues and patients. Suzanne de Janasz, a management expert at Seattle University, says, horizontal interpersonal skills have become increasingly important in the workplace as organizations have moved away from traditional hierarchical structures in recent years (De Janasz et al., 2014). A subject with an intimate narrative connection is closer to happiness than an isolated individual striving for excellence. In his book *Love, Medicine & Miracles*, pediatrician Siegel (1990) notes that a doctor who has not learned to "talk" to his patients can feel lonely. Indifference does not really relieve people of pain; it only buries the hurt deeper. The interpersonal relationship of modern people is more and more indifferent and distant, and it is difficult for doctors and patients to have a deeper narrative interaction.

Nietzsche said in *Beyond Good and Evil* that when you look into the abyss, the abyss also looks into you. William Osler said that the biggest sadness of doctors is that they exhaust their professional enthusiasm in the busy and confused moments, and become a working machine that cannot stop working day and night Blindly focusing on the disease and not having the interpersonal narrative competence to deal with patients will not only lead to the dehumanization of patients, but also lead to the dehumanization of doctors, making them become robots that only treat the disorders. Bernard Lown, an internationally celebrated pioneer in cardiology, has argued that "doctors of conscience" have to "resist the industrialization of their profession" (Joseph, 2018, February 24). In the process of industrialization of the medical

profession, the doctor is like an assembly line, and the “rich and valuable means of human interaction” that he imagines when he chooses to become a doctor is gradually reduced to “pure mechanical work without humanity.”

The relief of suffering is medicine’s ancient calling, primary goal, and ethical core (Callahan, 1998). Dr. Topol (2019), a famous American cardiologist, geneticist and leader in the development of digital medicine, said that the difference between doctors and machine is that doctors are human beings who can develop interpersonal relationships, and have the ability to reduce the patients’ pain by witnessing their pain and offering interpersonal compassion. When doctors only face patients with a purely objective and scientifically rational attitude and do not pay attention to the patient’s pain, what is the difference between such a doctor and an AI doctor? As machines continue to operate, they will be worn out, eliminated, and scrapped within a certain period. However, when we realize that our stereotyped mechanized and procedural attitude towards patients is the root of diminished sense of personal achievement and satisfaction, we will rise to change ourselves. When the clinicians become more respected by treating the patients as people who need existential concern and narrative care, the clinicians will gain more and more interpersonal experiences and intelligence through the established bonding, which makes them less burnout.

When the clinicians master the ability of active assessment of patients’ suffering by eliciting and editing patients’ narrative besides their biomedical information, a harmonious and humanistic doctor-patient will be established (Phillips et al., 2023). Thus, clinician can enhance their holistic understanding and holistic healing for the patients. The assessment of suffering includes close observation, deep listening, and synthesis of all their clinical, social, cognitive, and biomedical information (see Figure 3.5). In the contrary, when the relationship between doctors and patients becomes a commodity transaction, the patients’ suffering will be unseen and doctors cannot feel a sense of mission, therefore they will easily fall into professional burnout.

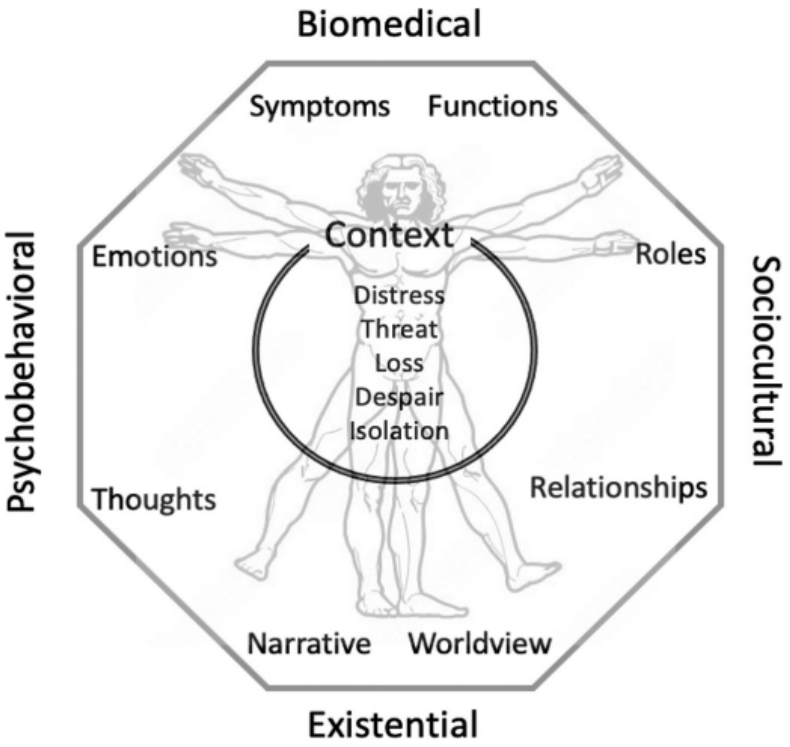

Figure 3.13 The comprehensive clinical model of suffering

Source: Egnew (2018)

The sense of mission is a powerful reason why human beings can quickly refresh from tiredness and get back on their feet after facing difficulties and being knocked down by failures, setbacks and traumas. Dr. Cassel (1982), clinical professor of internal medicine at Cornell University Medical School, once pointed out that "all medical care flows through the relationship between physician". Medical staff must truly like and enjoy communication, collaboration and cooperation between people, so that they can continue their clinical work for a long time. If every diagnosis and treatment work is regarded as a transaction or routine work, doctors will surely burn out quickly.

3.3.1.3 Career narrative foreclosure and professional burnout

People themselves are composed of multiple identities and assume different identities in different narrative contexts, such as father, lover, student, writer, teacher, or manager. However, people in the state of professional narrative foreclosure confine themselves solely to the identity of occupation and regard the external evaluation of their professional identity as the source of all satisfaction, deny the existence of other identities, and do not want to develop their life stories beyond their careers, family, love. The motto of professional foreclosures is "I work, therefore I am." "Subject-I" is gradually objectified in the passive professional identity, and he/she is increasingly unable to actively integrate into the relationship with relatives and lovers,

and the life narrative process is gradually becoming overly stable and lacking of due openness.

Professional burnout may claim some epidemiological kinship with professional narrative foreclosure, one of modernity ’s most pervasive?

The Chinese bio-health narrative concept advocates that every life subject should maintain a high degree of self-family-career-community integration in all aspects of his or her career. The concept of life health narrative holds that each subject is endowed with different identity roles in different life stages, and the number of identity roles will increase with the growth of age, and some identity roles will also change, and with the gradual aging, the identity roles should also be reduced. Single-identity narrative foreclosure ignores the importance of multi-dimensional narrative connection for the healthy development of human beings and treats one’s own life process in an extremely simplified form. In a single identity for a long time, the individual will not be able to adapt to the transformation of identity or the diversity of identity, and fall into relational loneliness over time and lose the ability to feel other beautiful things (X. L. Yang et al., 2021).

Occupational foreclosures often measure their self-worth in terms of their “doing” and “having” rather than their “being.” People who are locked in work are addicted to their work and often lose themselves. The famous modern Buddhist monk Thich Nhat Hanh once said, “Many people are so busy, working so hard, that they have no time to live.” Single-occupation identity narrative foreclosure is a state of work addiction. The underlying reason behind all addictive behaviors, whether shopping addiction, Internet addiction or work addiction, is the absence of active or passive interpersonal narrative connection. Irvin D. Yalom, a master of existential psychology, has found that doctors trapped in professional narrative foreclosure have a myth about compulsively pushing themselves and ignoring human limits. They often only know how to bury themselves in the “doing” of “constantly getting things done”, but do not know how to stop and look at the present moment, explore the “inner spirit” and “common value” (being) that bloom in the process of interacting with each different life subject, and do not understand the important value of the security brought by connecting with people in addition to work.

The opposite of “occupational identity” is “professional burnout” and “professional narrative foreclosure”. Doctors who identify with their own professional values are less likely to fall into burnout and narrative foreclosure. The single occupational identity narrative of the closed person lives to work, whereas normally humans work in order to live. Professional narrative foreclosures do not understand the meaning and value of narrative connection in intimate relationship and will be helpless and even afraid in the face of intimate relationship,

so they “shrink” themselves in work and build a “thick shell” to isolate themselves from the outside world. This is a state of withdrawal in which it appears that the closed person is also interacting with the external world, but in fact, only the “shell” part is interacting with the external world and does not touch the inner emotional connection.

Generally speaking, when life reaches the stage of career development, in addition to improving and perfecting oneself through the “mirroring self” with family, relatives and friends, it is also very important to establish a “mirroring narrative relationship” with colleagues in the workplace, especially service or cooperation partners, because only through reflection and adjustment of the workplace mirroring self can the narrative self-adapt to the workplace environment for a long time and avoid falling into job burnout and other mental and physical health crises. People with career narrative foreclosure are not only unable to establish close narrative connections with family members and friends but are also often unable to establish good narrative connections with their peers and service recipients in the workplace, so their career narrative self-development is immature. If doctors do not open themselves to others in the workplace, we will close many “windows of possibility” because “others” include a variety of possible worlds.

Even if we have chosen a medical career, to make our work more rewarding, we should maintain a variety of identities. For doctors, we are philosophers when we talk to our patients about good deaths, and the fear of death. When a patient tells us his or her story of social injustice or sexism, we are sociologists who listen to them. We are anthropologists when we create narrative links between international stations and quarantine hotels during the pandemic and the various populations trapped in them; we are a psychosomatic healer when in orthopedics, in respiratory medicine, we help young people who jump from buildings and oceans to repair their relationships with their families and guide them through trauma to face life again. We become a hospice nurse when we help the terminally ill patients to achieve life narrative integration, safely passing away, and give timely and effective narrative care and comfort to the patients’ families.

Overall, the professional narrative foreclosure person reduces the three major tasks of life to a single task - the professional task, and the absence of intimate relationships and other social relationships hides a serious crisis. In the stage of career development, in addition to professional identity, we still have multiple identities. Only by maintaining the multi-dimensional narrative connection of family, workplace and society, and maintaining the benign development of narrative self, can we continue to “live a better life”. Although each stage has the main life task of each stage, “maintaining subjectivity” and “developing narrative self” are

the highest tasks throughout life, otherwise people will lose their due humanity and have life burnout or career burnout.

3.3.1.4 Career plateau and the turning point of doctor burnout

To avoid burnout, all physicians need recognition of their professional values. If the hospital cannot create a good narrative environment for doctors, then individual doctors will not be able to give positive value recognition to their daily work. In such a context, the doctor's narrating self cannot play a positive role and cannot filter the negative and negative "experiencing self" formed by the doctor in clinical work. All feelings are overwhelmed by fatigue and burnout. In a positive narrative ecology, the narrating self of doctors can use their imagination to give noble value to tiring work and then find the power to break through the bottleneck of career development in repetitive work. Some scholars refer to the situation in which employees in the workplace are unable to feel sustained career motivation and value as the "career plateau period."

Career plateau is often a precursor to job burnout. Career platform can be divided into individual plateau and organizational plateau. After working in the workplace for a while, most individuals enter a "career plateau" known as a career dilemma. Most of those in the plateau are senior professionals aged 35-42. At this stage, the development of individual skills is becoming more and more mature, and it is easy to feel that the work is monotonous, lack of challenges, and there is no room for growth. Even though he is still the most prominent member in the team, he is no longer recognized because he is too stable and lacks major breakthroughs. According to the research of some career development scholars, the career platform phenomenon is showing a younger trend.

The platform period is a turning point, and those who actively respond will get a golden opportunity to improve themselves, while those who negatively respond will easily fall into job burnout, or because they miss the golden period to reverse the career platform, layoffs and changes in the workplace will even face the crisis of losing their jobs. From a personal point of view, we should actively step out of the original narrative circle and seek opportunities for transformation and growth in the larger narrative circle. At the organizational level, to break out of the development plateau, it is necessary to enhance the Vigor Index by creating a good workplace narrative ecology. "Vitality" refers to the state of having enthusiasm for work, high flexibility, willing to work hard to solve difficulties even when encountering difficulties and not giving up and backing down. The Career Vitality Index is calculated by dividing the burnout period by the average age of the company. The higher the indicator, the more dynamic the organization.

According to relevant research data, except for cutting-edge and emerging industries, the average occupational vitality index of other industries is lower than the normal vitality level. Overall, an organization's career vitality index is inversely related to industry maturity. This phenomenon may occur because when the industry is immature, employees in the organization are working hard to explore and innovate, so their vitality is high. However, in mature industries, employees work step-by-step and organizational dynamics are low. As a mature industry, how can hospitals improve the professional vitality of doctors? Narrative hospital management theory believes that the narrative management model can induce a "sense of good life" (eudaimonia), allow doctors to fully express their best selves in the best state, and greatly increase their absorption and dedication to their work.

3.3.2 Narrative center project and professional burnout management of doctors

3.3.2.1 Physical space construction of the PNCCH

15 years ago, in a Lancet article entitled "The suffering of physicians", Cole and Carlin (2009) reminded that the patient is not the only "whole person" in the consulting room, and that clinicians also suffer from the "dehumanization" of modern medicine. They suggest that a deeper understanding of burnout begins by acknowledging its context: medical staff in many countries live and work in a technocentric and dehumanized environment. To allow vulnerable clinicians to recover life meaning and to avoid professional burnout, Cole and Carlin recommended to fully respect clinicians' narratives in a caring, compassionate, and conversational context. This evidently requires both that clinicians tell their stories and that somebody listens. In the context of narrative hospital management, "somebody" refers to hospital and department leaders as well as people including patients, patients' family and other persons in the world. Hospitals as organizations have the privilege to create the atmosphere of storytelling and listening among them.

Hospital leaders should be aware that professional burnout is an organizational problem (Rego et al., 2015; Shanafelt & Noseworthy, 2017). The narrative hospital management concept proposes that as organizational managers, we should take responsibility to change the narrative ecology that causes staff burnout. To maintain the vitality of departments and hospitals and reduce the harm of professional burnout to organizations and individual doctors, many organizational management consulting and strategic consulting companies agree that it is important to create a happy working environment for the team. Happy environment in addition to the physical space should be suitable for work, make people feel comfortable. "Soft

environment" is also very important, including respect for employees, let them feel that they are a part of the company, rather than a pawn; In addition, creating an atmosphere where team members can learn from each other and connect with a sense of growth can motivate employees to work hard on their own. The bio-health narrative concept advocates in various workplaces, including hospitals, government agencies, enterprises and institutions set up narrative space to play such a role, employees in such a soft environment can quickly recover from exhaustion and burnout.

Narrative space, whether it is the narrative sharing center, narrative warm sun bar, narrative coffee bar at the overall level of the hospital, or the narrative soul harbor, narrative corner and narrative bench set up in the departments and inpatient wards, all provide medical staff with a humanistic space of "leisure in work and growth in leisure". The contemporary German philosopher Josef Piper pointed out in *Leisure: The Basis of Culture* (2003) that leisure was once the most precious philosophical concept of ancient people, but also the root and foundation of culture. People's existence is not only for work. Only with leisure, internal connection and space for vitality recovery can we complete a higher level of life ideal and create richer and perfect cultural fruits.

The narrative center carries out regular narrative reading and sharing activities. On the bookshelves of the narrative centers are all narrative works created by medical staff, literary writers or patients, and all these stories focus on topics relating to birth, aging, illness and death. The work pace and emotional pressure of modern society make the medical staff have no time to stop to think about the true meaning of life and career essence. As William Osler, the father of modern medicine, says, "There is no such relaxation for a weary mind as that which is to be had from a good story, a good play or a good essay. It is to the mind what sea breezes and the sunshine of the country are to the body - a change of scene, a refreshment, and a solace" (Osler, 1999). After a long day in the clinic, Osler suggests that the clinician could refresh his or her mind reading stories, plays, and biographies or autobiographies of notable clinicians and humanitarians of the past and the present.

More than a hundred years ago, Francis Peabody (1927), a professor of internal medicine at Harvard University, had predicted that healers were likely to degenerate into inhuman machines. As Osler observed, medical men, ... "may come a professional isolation with a corroding influence of a most disastrous nature, converting a genial good fellow in a few years into a bitter old Timon, railing against the practice of medicine in general and his colleagues in particular" (Cushing, 1925) without glows of sympathy and affection. The daily work that works like a machine that lacks of "sensibility" and "compassionate attention" (Nolan, 1786)

makes the clinicians rotate under the inertia of the head until the body occurs various problems, like burnout, dizziness, headache, stomachache, insomnia, depression, and even cancer. And the most fundamental way to restore your own health and professional faith is to get out of this rotating mode of inertia. However, without external force to stop the top, it is difficult to stop spinning itself.

This state is a state of professional burnout caused by lack of drive. The leader's serious and ruthless treatment of employees will cause employees to fall into more serious burnout and a vicious circle that is more difficult to break and ultimately affect the overall operation of the hospital. If leaders can use narrative leadership from the source to empower employees with internal drive and internal growth, and guide employees to maintain the habit of reading and writing narrative works on the themes of birth, death, career growth and daily care under the guidance of the concept of narrative medicine, clinicians can get out of the top-rotating fate.

The normal narrative sharing activities carried out by the narrative center are not aimless leisure and small talk, but narrative community building activities guided by narrative management conception in the purpose of establishing "kindly friendship" among "genial good fellows" rather than forming total "strange relationship between colleagues" in Osler's words. Leaders can find problems in close observation, recommend narrative prescriptions for employees that touch their innermost emotions, and stimulate employees' whole-person health and career satisfaction in narrative interaction. A good hospital narrative ecosystem can inspire workplace spirituality in employees. Workplace spirituality means that in addition to being aware of their own inner life, life subjects can also feel that they are part of the group in the workplace, understand the connection between work and the meaning of life and produce benefits, and then love work more and give full play to their own potential.

3.3.2.2 Narrative review activities of the PNCCH

Bearing the consequences of medical errors and doctor-patient disputes alone is an important cause of medical professional burnout. Medicine is an uncertain science. Doctors with narrative competence have a high maturity of narrating self and can effectively deal with sudden or uncertain events. However, most managers of medical institutions do not have the organizational ability to conduct narrative review for adverse events, medical errors and doctor-patient disputes. It is more to clarify the responsibility of accidents, rather than to analyze the deep-seated causes of the problems to avoid the occurrence of similar incidents. Most doctors have no narrative support at the organizational level, and to a greater extent, they bear all the consequences of medical errors and disputes alone. The doctor has to cope with the unstoppable

clinical work, and at the same time has to digest the troubles and emotional exhaustion of the negative experiencing self and the negative mirroring self-caused by these events, and eventually fall into professional burnout (Hodkinson et al., 2020).

Medical errors are said to have become the third leading factor of death in the United States (Hodkinson et al., 2020), after heart disease and cancer. In his book *After Trauma*, the healthcare researcher Nancy Berlinger observed how senior doctors treat medical errors and found that senior doctors and department directors often advocate covering up their mistakes when confronted with such incidents. They are skilled in arguing against unexpected results until they turn "medical errors" into "complex problems". According to Berlinger, the fundamental reason why doctors are used to defending the mistakes that have occurred in terms such as "technical mistakes", "the inevitability of accidents" and "unexpected results" is that the thinking of shirking responsibility has been deeply rooted in the concept of medical practitioners. This kind of thinking is also popular in Chinese medical institutions.

Osler mentioned more than a century ago that "no class of men needs friction so much as physicians and the daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is not antidote. The mistakes are often buried, and then years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered. To this mental attitude the medical society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms" (Cushing, 1925). Here we can say that daily narrative review thinking and activities among medical staff can be an antidote to this ego-centrism tendency and the discussions and criticism among colleagues without castigation is the best way to enhance their ability facing failures and enhancing their workplace narrating self.

Therefore, changing the bad cognition that errors and mistakes cannot be mentioned and analyzed from the organizational level, and actively building the growth mindset of narrative review is in dire need. When medical staff lack narrative thinking, they will continue to repeat low-level mistakes. There are many reasons for medical errors, including the medical system, the shortage of medical resources, the uncertainty of diseases. However, the lack of narrative review thinking after the occurrence of medical errors, and the fundamental reason for allowing avoidable mistakes to happen repeatedly instead of learning from mistakes, lies in the industry thinking set of self-protection. To deceive themselves and cover up the truth, doctors are unable to organize the parties to openly review and talk about the events that have happened, which seriously affects the clinical thinking of doctors for a long time and misses the formation of good narrative thinking.

Narrative review can prevent us from falling into “cognitive dissonance.” “Cognitive dissonance” refers to a situation in which people rationalize results due to wrong guidance or self-psychological factors. If practitioners in the medical field do not have a correct understanding of medical errors and mistakes and cannot respond and handle them correctly, then we are likely to fall into “cognitive dissonance.” In other words, doctors all regard themselves as people who “cannot make mistakes”, so that they fall into an endless loop or thinking trap and suffer from the “non-admittance of mistakes syndrome”.

The thinking of narrative review is more a kind of critical thinking than accusing thinking. Critical thinking is conducive to changes, and especially when the medical staff are led to use the tool of critical thinking in the framework of “narrative critical thinking” that generates self-understanding, self-reflection and self-realization, they are more likely yielded to inner growth and innovation. As said in *The governing principles of ancient China* (《群书治要》), “子唯不推心以况人，故视用人如用草芥。使用人如用己，恶有不得其性者乎”, which means, “the noble man who can govern people should regard them as the same kind of human as he is from the bottom of his heart and the people will become more and more loyal to the governor whereas the man who sees the governed as worthless as dirt and grass and never concern them from the heart, then people will become mindless as the governor does to them”. In the atmosphere of narrative review, medical staff realize that the leaders are empathetic with us and what they are doing is try to help us to grow instead of castigating and calling to account.

When a medical practitioner has to face the castigation from the leaders immediately after such contingencies as medical errors or negligence, the medical staff will be involuntarily involved in “intrusive rumination” (W. Xu et al., 2019). Reflection is generally a good thing in medical education and clinical practice. However, invasive ruminations, is not a good thing, because it can lead to chronic self-doubt and long-term sense of shame, resulting in repeated lapses into workplace anxiety and burnout. Some young doctors who encounter such adverse situations will deny their career choice, and even turn over or give up their medical profession. Most medical staff, especially young doctors, when they are condemned and castigated by patients, patients’ families, and simultaneously by managers or tutors, they need someone willing to listen to and care for them, and most importantly, help them conducting narrative review of the whole process and using narrative critical thinking from different perspectives to understand different standpoints of different stakeholders so that they could see the essence of the problem and carry out follow-up narrative integration and adjustment, and eventually achieve career growth.

For practitioners in the healthcare industry, when we start the review activity, it may be difficult to adapt at first, and for some medical individuals with immature narrative selves, it may also suffer from “Alexithymia". Alexithymia is a condition in which the body feels strong emotions but is unable to express them verbally. The tolerant attitude of leaders and the good narrative atmosphere of the department can help doctors break through this barrier and get out of the narrative foreclosure and burnout. The head of the department can use the effect of narrative projection, such as narrative prescription to guide doctors with alexithymia to see themselves from other people’s stories and activate their “sleeping” “narrating self” after being touched.

In the process of reassessment, leaders and doctors will gradually break the blind spot of thinking and see what was originally invisible. Narrative review is not to investigate who is right and who is wrong in the past events, but to explore what details we can pay attention to in this event to avoid the story going negative, and which people can grow rapidly in the future after being cared for and responded to. The behavior of narrative recovery can create an open environment and reduce individual cognitive dissonance and collective burnout of departments by changing the attitude of organizations or groups to deal with mistakes.

3.3.2.3 Narrative creative writing activities of the PNCCH

The PNCCH also guides managers and doctors to carry out the narrative adjustment of individual doctors and the construction of hospital narrative ecology by writing stories. Through various policies and documents, leaders can encourage doctors to develop narrative creation from three levels, one is to write a diary narrative for themselves; Second, parallel medical record narratives or other relationship narratives in the medical context are used for daily sharing; The third is the parallel medical record story collection, health science popularization narrative, doctors’ education and growth narrative, doctors’ metapathographical narrative and medical institution history narrative. The first level refers to the dialogue between medical staff and themselves, the second level refers to the dialogue between medical staff and patients and other medical staff, and the third level refers to the dialogue of multi-dimensional relationships to influence the level of the relationship between medical staff and society to a greater extent.

Narrative reflective writing and narrative sharing can reduce the isolation of individual doctors. Writing is a very effective medium for reducing stress after a long and intense day at work, especially for medical staff who have experienced traumatic events. In the process of creating these stories, doctors can give meaning to the changing and uncertain world and restore their work status from disorder to order. Only by being both detached and caring can medical

staff not be involved in the emotional vortex of patients and fall into a state of emotional exhaustion or compassion fatigue and will not see themselves as objective and calm experts, and fall into the quagmire of professional burnout.

Encouraging medical staff to create narratives can also give them the opportunity to develop deep self-narrative connections with themselves, thus lead to the maturity of their narrating self. The ability to integrate one's own life narrative or workplace narrative when being alone is one of the important indicators of the improvement of his or her narrative competence. British pediatrician and psychoanalyst Donald Winnicott believes that the capacity of the individual to be alone, in other words, being alone in the presence of someone else, is one of the most important signs of maturity in his or her emotional development (Winnicott, 1958)

. When the medical staff are busy on clinical routines all the time without self-narrative integration and adjustment, they will be vulnerable to lose themselves and their sense of life meaning. Developing narrative creative writing when the staff are alone is the best way to heal themselves; developing narrative dialogue with themselves when they are alone is the best weapon against the fatigue of experiencing the world and the uncertainty of the unknown world.

The adjustment power of narrative creative writing can make the novice doctors quickly form a positive medical professional identity. The internship period, which is so important for the growth of medical education, is a time when the narrator is anxious about his identity as a doctor. Because the individual case is at odds with the prevailing system of medical theory, the intern is often unfamiliar with his/herself during his/her residency. At the same time, in the process of contact with patients, this sense of strangeness will also appear. The patient's recognition of the doctor's expert status is a prerequisite for receiving treatment from the doctor, and the young doctor who is a novice/trainee feels anxious about not being able to fulfill the expert role at present. Through narrative creation, interns can sort out and record the confusion at the beginning of their career and discover their own growth in the gradual narrative diary, so as to gain professional identity and sense of accomplishment.

Chinese hospitals that have launched narrative center projects have compiled the narrative works of doctors into volumes and published them, which has played a role in encouraging more doctors to share stories and creating a better atmosphere for multi-dimensional narrative interaction. For example, the narrative hospital histories of the First Affiliated Hospital of Xi'an Medical College are "Inheritance 1951-2021" (2022) and "The Medical Journey" (2022), and the Women and Children's Hospital Affiliated to Guangdong Medical University is "Shunde Heart, Maternal and Child Love" (2021), "My Family is a Medical Professional" (2022) and "The Beauty of Life" (2023), "Narrative Medicine Story Collection" by Southern Medical

University Nanfang Hospital. These stories are witnesses of the hospital's history and the inheritance of its culture, giving doctors a sense of belonging. A good hospital narrative ecology is the "warm environment" and "family culture" for the high-quality development of hospitals/departments.

3.3.2.4 The main characteristics of a good hospital narrative ecology

A good hospital narrative ecology is not necessarily marked by whether there is a physical narrative center, but managers must create a good multi-dimensional narrative interaction atmosphere and carry out rich narrative communication activities. Adverse events and medical errors are important causes of physician burnout. A good hospital and department narrative ecology can reduce the occurrence of error incidents through close narrative connections among peers. For the healthcare industry, teamwork is critical. When doctors cannot carry out effective narrative communication, patient safety will be seriously threatened for a variety of reasons, such as missing critical information for diagnosis, misunderstanding of information, unclear instructions, and communication that ignores subtle changes in the patient's status. The famous Huang-Lao Taoist classic "Liu Tao·Wen Tao·Wenshi" from the ancient pre-Qin period of China mentioned that "if you have the same feelings, you will cooperate closely; if you cooperate closely, your career will be successful." On the one hand, narrative competence allows us to view and solve problems from the perspective of other colleagues, and on the other hand, it can enhance trust and the possibility of close cooperation among peers.

The narrative hospital management philosophy in terms of colleague communication encourages open dialogue, implementation of narrative briefings for pre- and post-operative teams, and the creation of interdisciplinary narrative committees or narrative working groups to develop plans to prevent "disruptive events" from occurring. When a destructive event does occur, the problem can be solved in real time by initiating strategies such as "time-out" and emergency damage treatment (code white) to prevent the situation from deteriorating further.

The narrative hospital management concept creates more opportunities for doctor-patient narrative interaction, and the narrative communication between doctors and patients can effectively reduce professional burnout.

Good hospital narrative ecology has the following characteristics:

1. Leaders actively plan good narrative interaction activities between doctors and patients.

2. Leaders create opportunities for new and old employees to share narratives and enhance the sense of professional value inheritance of young doctors.

3. Leaders create opportunities to share, read and create biographies of older doctors to

form a professional identity of doctors.

4. Leaders create diversified narrative communication space, so that doctors have the opportunity to share their own stories.

5. Leaders actively pay attention to the narrative connection status of new employees.

6. Leaders create narrative opportunities for retired employees to repair family narrative connections and help them return to their families smoothly.

7. For mistakes or adverse events, Leaders jump out of the right and wrong dilemma, and are willing to explore the reasons behind them together with employees, and improve accordingly.

8. Leaders and employees work together to create stories of the organization's future vision.

9. Leaders and doctors have high bio-health narrative competence, good connection with family narrative, and less fall in professional narrative foreclosure.

10. Leaders are good at using narrative strategies to form the unified actions of organizations.

When a hospital/department is in a multi-dimensional narrative community, then the workplace can be called an "Open Society". The term "open society" was coined by the French life philosopher and Nobel laureate Henri Bergson (1859-1941) as a state of democracy that embraces "narrative empowerment." The workplace with stable interpersonal narrative connection in all dimensions is an "organization with high enabling scene". Excellent individuals flood into the organization, are willing to nourish and grow together with existing members of the organization, and the job burnout rate is reduced. Workplaces with weak interpersonal narrative connections are "organizations with low enabling scenarios" and high burnout rates.

It can be predicted that when the concept of narrative medicine is truly integrated into the daily management work of major medical institutions across the country, when the hospital leaders really have narrative intelligence, actively create a warm and harmonious hospital narrative ecology, and make full use of narrative leadership to infect and influence the medical staff, who are equipped with good comprehensive narrative competence and narrative mediation ability. When the backbone of the hospital knows how to use the narrative concept to build the overall harmonious relationship between the various departments of the hospital, the interpersonal narrative crisis events will be greatly reduced, and the harmonious hospital, healthy hospital and humanistic hospital can be gradually realized.

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Chapter 4: Research Methods

4.1 Quantitative research: the correlation between medical narrative competence and professional burnout

4.1.1 General data survey questionnaire

The questionnaire covered 10 items including gender, age, income, professional title level, educational background, working years, marital status, living status, degree of exposure to narrative medicine, and whether the medical institution has set up a narrative center.

4.1.2 Measurement scales

4.1.2.1 Physician Narrative Competence Scale (CNCS-MP)

The scale of narrative competency of doctors was adopted in the scale of Narrative Competencies of Medical Practitioners compiled by X. L. Yang et al. (2023). This scale can be divided into two subscales. The narrative cognitive ability scale was used to measure the basic situation of narrative cognition of Chinese doctors (see table a.1). The narrative behavior ability scale is used to measure the narrative practice ability of Chinese doctors, (see table a.2). The narrative cognitive competence scale includes 2 dimensions and 23 items, bio-health narrative awareness (9 items) and career narrative thinking (14 items).

It adopts the Likert 4-level scoring method, with "1~4" indicating a range from "completely disagree" ~ "completely agree". The total score of the scale ranges from 23 to 92. The higher the score, the stronger the doctor's narrative cognitive ability. The narrative behavioral competence scale includes 5 dimensions and 38 items, including life and health (8 items), family connection (8 items), career development (9 items), peer communication (4 items), and doctor-patient interaction (9 items). Using the Likert 4-level scoring method, "1~4" means ranging from "completely inconsistent" to "completely consistent". The total score of the scale ranges from 38 to 152. The higher the score, the stronger the doctor's narrative behavior ability.

The results of confirmatory factor analysis showed that the two scale models fit well. In terms of reliability, it is generally considered that when the Cronbach's alpha >0.5 represents acceptable, 0.6~0.8 is good, and >0.9 is considered very good. After testing, the results of this study show that the reliability of each scale used in the survey is good, see table 4.1.

Table 4.1 The internal reliability of scale

	Dimension	Cronbach's alpha	Items
Narrative cognitive abilities	Overall coefficient	0.984	23
	Bio-health narrative consciousness	0.956	9
	Professional narrative behaviors	0.986	14
Narrative behavior ability	overall coefficient	0.989	38
	Bio-health narrative behavior	0.964	8
	Professional narrative behaviors	0.965	8
	Career development narrative behavior	0.972	9
	Peer narrative interaction behavior	0.961	4
	Doctor-patient narrative connection behavior	0.979	9

Validity refers to the ability of a measurement tool to measure what it is supposed to measure. The questionnaire in this study was designed with reference to established scales and literature. The CFA method was used to effectively reflect the latent variables and explain the relationship between the two in the model hypothesis, while testing the validity. It is generally believed that the KMO value should be greater than 0.7. and a KMO value of 0.9 or above indicates that the scale data are very suitable for factor analysis; CR>0.7 and AVE>0.5 indicate that the internal consistency and validity of the scale are good. Therefore, the questionnaire has good reliability and validity. The results of the model fit analysis are shown in Table 4.2, and the results of the structural validity analysis are shown in Table 4.3.

Table 4.2 Model fit analysis

CFI	Narrative cognitive abilities	Narrative behavior ability
χ^2/df	16.905	27.83
CFI	0.955	0.959
TLI	0.952	0.953
GFI	0.856	0.876
NFI	0.953	0.957
IFI	0.955	0.959
RMSEA	0.061	0.079

Note: χ2/df: Chi-square to degrees of freedom ratio (ideal value range 0~5, χ2/df is bigger due to the larger sample size in this study); CFI: Comparative Fit Index; TLI: Tucker-Lewis Index; GFI: Goodness of Fit Index; NFI: Normed Fit Index; IFI: Incremental Fit Index (value range 0.8~0.9 indicates a good fit and greater than 0.9 indicates a high fit); RMSEA: Root Mean Square Error of Approximation (values less than 0.08 indicate a good fit, values less than 0.05 indicate a high fit).

Table 4.3 Construct Validity

	Dimension	KMO	Bartlett's Test of Sphericity	CR	AVE
Narrative cognitive abilities	Overall coefficient	0.984	141948.122		
	Bio-health narrative consciousness	0.952	38866.852	0.957	0.713
	Professional narrative behaviors	0.977	232188.665	0.984	0.826

Narrative behavior ability	overall coefficient	0.990	141948.122		
	Bio-health narrative behavior	0.949	38708.378	0.964	0.767
	Professional narrative behaviors	0.951	38711.922	0.959	0.743
	Career development narrative behavior	0.959	49228.014	0.973	0.806
	Peer narrative interaction behavior	0.868	20052.379	0.958	0.847
	Doctor-patient narrative connection behavior	0.966	55454.660	0.971	0.857

4.1.2.2 Burnout Scale (MBI-GS)

This scale was translated and revised by Chinese scholar Li Chaoping (Li & Shi, 2003), including 15 items, emotion Exhaustion (5 items), depersonalization (4 items), low sense of achievement (6 items), each item adopts Likert 7-level scoring method, with 0 to 6 points indicating “never” to “every day”. Dimension score is the sum of all item scores in this dimension divided by the number of items. Total burnout score = emotional exhaustion × 0.4 + depersonalization × 0.3 + reduced sense of personal accomplishment × 0.3. If it is greater than 1.5, it is judged as occupational burnout. When 3.5 > burnout comprehensive A total score of ≥1.5 is considered mild to moderate burnout; a score of ≥3.5 is considered high burnout (W. B. Schaufeli et al., 2009).

4.1.2.3 General Self-efficacy Scale (GSES)

GSES was compiled by Professor Schwarzer and others in Germany. In 2001, C. K. Wang et al. (2001) translated and revised it. The Chinese version of the scale has a total of 10 items, using a 4-level Likert scoring method, ranging from “not at all correct” to “completely correct”, ranging from 1 to 4 points, with a total score of 10 to 40 points. The higher the score represents the stronger self-efficacy. The Cronbachs α coefficient of this scale in this study was 0.962, indicating the good reliability in this study.

4.1.3 Study subjects

This survey was conducted nationwide, and questionnaires began to be distributed in December 2023. As of April 15, 2024, a total of 4,516 questionnaires were collected from medical staff in 40 hospitals across the country. The same IP address can only be filled in once. After excluding invalid questionnaires, 4239 questionnaires remained. Among them, 606 are male and 3,633 are female; 332 are junior college or below, 3,384 are undergraduates, and 523 are graduate students; 334 have no professional title, 1,336 have junior professional titles, 2,018 have intermediate professional titles, 411 have deputy senior professional titles, and 140 have senior

professional titles. The researchers conducted a study on the correlation between medical narrative competence and professional burnout among all included subjects.

To explore the relationship between narrative competence and professional burnout using self-efficacy as a mediator, a convenience sampling method was adopted focusing on selected medical staff from four provinces, including Guangdong, Shandong, Shaanxi, and Hunan. The inclusion criteria for research subjects are: ① having obtained a practitioner certificate; ② engaging in clinic work for ≥1 year; ③ voluntarily participation in this survey. Exclusion criteria: ① Interns, trainees, and rehired personnel and ② having encountered major life events in the past three months. Finally, 1883 valid questionnaires were collected. Gorusch (1983)'s method requires that the sample size should be 5 to 10 times the number of items. This study has a total of 73 items. Considering the 20% inefficiency, the calculation requires the sample size to be at least 876 cases. The sample size of this study has met the requirements.

4.1.4 Data processing and analysis

The questionnaire was distributed online through the questionnaire star platform, and the content was composed of the general information, the narrative competence scale of doctors, the professional burnout scale and the self-efficacy scale.

SPSS27.0 software was used to conduct data analysis on 4239 questionnaires. The general information was described by frequency and percentage; for the information that met the normal distribution, the T- test was used for comparison between the two groups, and one-way ANOVA was used for three or more groups, with the scores expressed as X±S, and the correlation was tested using Pearson's test; for the information that didn't meet the normal distribution, rank sum test was used. The Mann-Whitney U was used for comparison between the two; the Kruskal-Wallis test was used for three or more groups with multiple independent samples, scores were expressed as M (P25, P75), and Spearman's test for correlation was used. $\alpha = 0.05$.

On the basis of the above data processing software, "Model4" of the PROCESS macro program in SPSS was adopted to test the mediating effect, and the mediating relationship between self-efficacy and narrative competence and professional burnout was tested. The data in this study are of large sample size and approximately normally distributed, so the analysis was performed using the method of analyzing normally distributed data.

4.2 Qualitative research

4.2.1 Narrative inquiry

Narrative inquiry is a qualitative research method proposed by Clandinin and Connolly in 1990. This method is to study human thinking, behavior and social interaction through narrative and exploration of stories (Clandinin, 2022). Start with a story and end with a story, which not only pays attention to the story itself, but also pays attention to the society, culture and psychology behind the story. Narrative inquiry obtains unique information about living subjects, evidence of temperature and soul, and data that cannot be obtained by simple experiments and questionnaire surveys. This study uses a narrative inquiry method to allow doctors to tell their true experiences and mental journeys at work. In the process, doctors are allowed to express their own voices, tell their own feelings about professional burnout and stories about how to alleviate burnout, and have a positive impact on them. Through interpretive understanding of their behavioral feelings, we can explore the deep-seated reasons behind their professional burnout and gain a glimpse into the actual situation of the entire medical group.

4.2.2 Study subjects

The interviews in this thesis were conducted with medical staff who are from the hospitals that are participating in the PNCCH. The selection of research subjects follows the following criteria: first, they must have worked continuously in a medical institution for more than four years, excluding interns and regular trainees; second, they must have a certain level of understanding of narrative medicine. Finally, a total of 983 narrative interview responses were collected. The research followed the sampling principle of saturation and selected samples for collection and coding until saturation, that is, no new categories appeared in the interview content. The research subjects were finally determined to be 52 people.

Purposive sampling was adopted and interviews were taken from the hospitals that had conducted teacher training in narrative medicine (see table 4.4 for details). This study conducted interviews in the form of face-to-face interviews from June 2022 to August 2023 and recorded them with permission. Interviews lasted a mean of 40 minutes per subject.

Table 4.4 Basic Information of the interviewees (The demographics and specialty of participant)

Participants' code	Sex	Area	Working years	Participants' code	Sex	Area	Working years
A01	man	Shenzhen	25	A27	man	Yanbian	15
A02	woman	Foshan	7	A28	woman	Yanbian	3

A03	woman	Foshan	31	A29	woman	Changchun	14
A04	woman	Dongguan	8	A30	woman	Zibo	17
A05	man	Zhanjiang	27	A31	woman	Zibo	24
A06	man	Shenzhen	8	A32	man	Zibo	30
A07	woman	Guangzhou	4	A33	man	Taiyuan	16
A08	man	Huizhou	13	A34	woman	Taiyuan	10
A09	woman	Yunfu	4	A35	man	Taiyuan	14
A10	woman	Guangzhou	20	A36	woman	Datong	16
A11	woman	Dongguan	7	A37	woman	Datong	21
A12	woman	Zhuhai	10	A38	woman	Changsha	4
A13	woman	Zhanjiang	30	A39	man	Hengyang	1
A14	woman	Shenzhen	12	A40	man	Chenzhou	9
A15	man	Foshan	20	A41	woman	Changsah	5
A16	woman	Guangzhou	10	A42	woman	Hengyang	7
A17	man	Lanzhou	16	A43	man	Changsha	10
A18	woman	Lanzhou	10	A44	woman	Changsha	9
A19	man	Lanzhou	20	A45	woman	Chenzhou	6
A20	man	Chengdu	31	A46	woman	Hengyang	10
A21	man	Chengdu	14	A47	woman	Hengyang	5
A22	woman	Chengdu	31	A48	woman	Wenzhou	20
A23	woman	Changchun	12	A49	man	Wenzhou	10
A24	woman	Yanbian	12	A50	woman	Wenzhou	17
A25	woman	Changchun	14	A51	woman	Shi Jiazhuang	9
A26	woman	Changchun	9	A52	woman	Shi Jiazhuang	12

4.2.3 Research ideas

First, this thesis uses the narrative inquiry method to conduct narrative interviews around the interviewees. Before the interview, the interview outline is determined, the basic information of the interviewees is collected, and the interviewees are explained to the interviewees what burnout is and what the symptoms of burnout are.

The theme of “Physician burnout in the context of narrative medicine” is divided into three levels: first, whether the interviewee himself or anyone around him has experienced burnout; second, what are the causes of professional burnout; third, how to empower through narrative

relieve your own professional burnout. The interview outlines included:

1. Please introduce your medical (or professional) background, training and practices.

2. Under what circumstances or occasions were you exposed to narrative medicine (NM)? What is your relevant training, education, and research experiences regarding NM?

3. What is your viewpoint and concept of NM?

4. What is your understanding and opinions about the concept of narrative competence (NC) of medical personnel?

5-1. What are the most significant factors or things in your recent life that made you fall into the mire of professional burnout?

5-2. How the conception of Chinese NM help you go out of the mire professional burnout?

5-3. How do you use the conception of NM to help the medical colleagues to go out of the mire of professional burnout?

6. Do you think you not only fall into the mire of professional burnout, and also into the trap of professional narrative foreclosure? What details make you think so?

7. What do you expect the differences in your future clinical or medical practice as well as your family life will be after receiving Chinese narrative medicine coaching and participating the Project of Narrative Sharing?

8. What are your suggestions to the leaders of your hospital for the resolution of the problem of professional burnout?

9. Could you please describe a scene, episode, or moment in your professional life that stands out as an especially positive experience? This might be the high point scene, or an especially joyous, happy or wonderful story in your professional life (McAdams, 1995).

10. Any other stories or comments you want to tell or give on the topic of Chinese NM and the prevention of professional burnout among medical staff.

The author initially drafted a narrative interview protocol, as based on the research purpose and literature review in the study plan. Narratives were audiotaped and transcribed.

Secondly, sort out the audio recording files of the interviews and organize them into text to form the text content of the interviews. Import them into NVivo11.0 software one by one and code them according to the three-level coding sequence. Finally, the causes of physician burnout are summarized, and the relief method of narrative medicine is used to construct a theoretical model.

4.2.4 Data wrangling

Rooted theory employs a bottom-up inductive logic that emphasizes an iterative process of

theory generation and data collection to ensure that theoretical constructs are deeply rooted in primary sources. This study used NVivo11.0 qualitative analysis software to conduct bottom-up layer-by-layer coding of the interview text. Through comparative induction, the corpus is continually refined from the surface upwards, making connections to form theoretical models. First, open coding, read and familiarize yourself with the original materials with an open mind, discover information points that are repeated frequently, extract content related to the topic of this research, establish free nodes, and form first-level coding. Secondly, main axis coding finds mutual connections among different conceptual categories, refines key generic concepts, establishes tree nodes, and forms secondary coding. Finally, selective coding refines the second-level coding, summarizes the core categories, establishes a complete theoretical framework, and forms a third-level coding.

Chapter 5: Study Findings

5.1 Findings of the quantitative study

The study on the correlation between doctors' narrative competency and professional burnout used SPSS27.0 software to conduct data analysis on 4239 questionnaires. The count data used descriptive statistics, independent-sample t test, one-way ANOVA and Pearson correlation analysis. The 1,883 questionnaires included in the study on the mediation of self-efficacy in the relationship between clinical staffs' professional narrative competence and burnout were analyzed on the basis of the above data-processing software, and the mediation effect test was conducted using "Model4" of the PROCESS macro program in SPSS to test mediating relationship between self-efficacy and narrative competence and burnout. This section mainly presents the results of scale measurements and related data.

5.1.1 Research results of the correlation between doctors' narrative competency and professional burnout

5.1.1.1 One-way Analysis results of the Medical Narrative Competency Scale

Results Analysis: there are statistically significant differences in whether the medical institution where the doctor works has a narrative center, the degree of familiarity with narrative medicine, and the scores of narrative cognitive ability and narrative behavioral ability ($p<0.001$), see table 5.1.

Table 5.5 Comparison of the narrative competency scores of medical staff with different characteristics

item	Category	Narrative cognitive ability			Narrative behavioral ability		
		score	t/f	p	score	t/f	p
Whether to set up a narrative center	Yes	81.15±13.31	8.696	<0.001	126.45±22.81	13.798	<0.001
	No	77.17±12.75			115.96±21.60		
Familiarity with narrative medicine	Have participated in systematic narrative medicine/narrative nursing coaching courses	83.69±13.07	74.598	<0.001	130.14±22.61	76.151	<0.001

Participated in relevant conferences or continuing education projects	80.65±12.81	123.56±22.19
Heard of it but do not understand it	78.03±12.80	121.11±22.00
Never heard of it	73.19±13.45	110.62±23.35

5.1.1.2 Regression analysis of the influencing factors of narrative cognitive ability

Independent variable assignment: whether the medical institution has a narrative center (1=yes, 2=no); familiarity with narrative medicine (1=have participated in systematic narrative medicine/narrative nursing team courses; 2=participated in relevant conferences 3=heard of it but do not understand it; 4=never heard of it).

Results Analysis: whether the hospital participates in the narrative center project and the degree of familiarity with narrative medicine are factors that influence doctors' narrative cognitive ability. Through comparison, it was found that the narrative cognitive ability of doctors with a narrative center is higher than that without (B = -1.797, <0.001); the deeper the exposure to narrative medicine and the more familiar the medical staff were with narrative medicine, the higher the narrative cognitive ability of the medical staff would be (B = -2.024, P <0.001), see table 5.2.

Table 5.6 Regression analysis of the influencing factors the narrative cognitive ability

variable	B	SE	Beta	t	p
(constant)	92.214	1.787		51.593	<0.001
Whether your hospital or medical institution is involved in the PNCCH	-1.797	0.471	-0.06	-3.814	<0.001
Familiarity with narrative medicine	-2.024	0.219	-0.145	-9.247	<0.001
R^2	0.055				
Adjusted R^2	0.054				
F	122.826				

Results analysis: whether to set up a narrative center and the degree of familiarity with narrative medicine are factors that influence the doctor's narrative behavior ability. Through comparison, it was found that the narrative cognitive ability of doctors who have set up a narrative center in their medical institutions will be higher than that of doctors who have not set up a narrative center (B=-6.052, P<0.001); the deeper the exposure to narrative medicine, the more familiar doctors are with narrative medicine. The higher their narrative behavior ability (B=-3.27, P<0.001), see table 5.3.

Table 5.7 Regression analysis of the influencing factors the narrative behavior ability

variable	B	SE	Beta	t	p
(constant)	173.146	2.576		67.224	<0.001

Whether your hospital or medical institution is involved in the PNCCH	-6.052	0.801	-0.116	-7.552	<0.001
Familiarity with narrative medicine	-3.27	0.371	-0.136	-8.821	<0.001
R^2	0.068				
Adjusted R^2	0.068				
F	155.218				

To sum up, it shows that the establishment of narrative medicine centers in medical institutions and the training and courses related to narrative medicine for medical staff have significant effects, and the more relevant knowledge they have and the more familiar they are with narrative medicine, the higher their narrative competencies will be. Therefore, it is suggested that medical institutions set up narrative centers to provide physical space for doctors to learn narrative medicine; in addition, can also be carried out, such as narrative story sharing contest, doctor-patient narrative communication activities in disease day, narrative reading salon, narrative health communication, narrative photography exhibition. We will focus on improving the narrative competence of medical staff, cultivating talents with "narrative competence + medical competence", and promoting the high-quality development of medical institutions.

5.1.1.3 Correlation analysis of doctors' narrative competency and professional burnout

Results analysis: narrative cognitive ability was negatively correlated with professional burnout ($r= -0.311$, $p <0.01$), indicating that the higher the narrative cognitive ability of medical staff, the lower their level of professional burnout; narrative behavioral ability is negatively correlated with professional burnout ($r= -0.314$, $p<0.01$), indicating that the higher the narrative behavioral ability, the lower the level of professional burnout; there is a positive correlation between narrative cognitive ability and narrative behavioral ability ($r=0.691$, $p<0.01$), indicating that the higher the doctors' narrative cognitive ability, the higher their narrative behavioral ability, see table 5.4.

Table 5.8 Correlation between medical narrative competency and professional burnout (r value)

	Narrative cognitive ability	Narrative behavior ability	Professional burnout
Narrative cognitive ability	1		
Narrative behavior ability	0.691**	1	
Professional burnout	-0.311**	-0.314**	1

Note: * P <0.05, * * P <0.01, and * * * P <0.001

The enhancement of the medical staff' narrative cognitive level can promote their narrative behaviors. Therefore, hospital administrators and medical educators should carry out NM courses, trainings and practices, starting from changing the cognition of medical practitioners to enhance narrative awareness; and then changing their narrative behaviors to cultivate narrative wisdom, so as to make them become medical staff with high narrative competency,

thus changing the phenomenon of their burnout in general, and empowering the development of medical and health undertakings in China.

5.1.2 Results of the mediation effect of medical staffs' self-efficacy in professional narrative competence and professional burnout

The incidence of burnout among nurses in China is high, with detection rates ranging from 59.1% to 69.1% (Mao et al., 2021). From the nurses' perspective, nurses' burnout level is directly related to higher rates of patient mortality (Aiken et al., 2002) and the occurrence of hospital-transmitted infections (Patrick & Pryor, 2023). That is to say, nurse burnout seriously affects patient safety and medical quality and has also become a factor hindering the high-quality development of hospitals and departments. Many studies have found that medical staff's self-efficacy is negatively related to professional burnout (C. Xu et al., 2022).

Throughout the existing literature, the relationship between nurses' self-efficacy and burnout is relatively clear. However, no scholars have yet studied the interaction mechanism between clinical nurses' narrative competence, self-efficacy, and professional burnout. Therefore, this dimensional study uses the Chinese narrative hospital management theory as the framework, aiming to explore the mediating effect of self-efficacy between narrative competence and burnout, and provide scientific management basis for preventing and improving nurses' burnout.

5.1.2.1 Basic information results on narrative competence, burnout and self-efficacy in different demographic groups

A total of 1883 medical staffs were included in this study, including 102 males and 1781 females. Comparing the narrative competence scores of medical staffs with different gender, age, rank level, income, marital status, working years, degree of familiarity with narrative medicine and whether the medical institution has a narrative center, the differences are statistically significant ($P<0.05$); Comparing the burnout scores of medical staffs with different ages, rank level, income, living situation, marital status, working years and degree of familiarity with narrative medicine, the differences were statistically significant ($P<0.05$). See table 4.4 and table 5.5 for details.

Table 5.9 Basic information on narrative competence, burnout and self-efficacy in different demographic groups

Item	Class	Constituent ratio	Narrative competence		Professional burnout		Self-efficacy	
			t/F	p	t/F	p	t/F	p

Sex	Male	102 (5.4%)	2.287	0.022	1.278	0.204	1.794	0.076
	Female	1781 (94.6%)						
Age	≤25	198 (10.5%)	3.459	0.008	5.519	<0.001	1.298	0.268
	26~30	414 (22.0%)						
	31~40	941 (50.0%)						
	41~45	191 (10.1%)						
	>45	139 (7.4%)						
Rank	Not have	144 (7.6%)	5.890	<0.001	2.820	0.024	0.931	0.445
	Primary title	644 (34.2%)						
	Middle title	908 (48.2%)						
	associate professor	154 (8.2%)						
	Professor	33 (1.8%)						
Educational level	Below college	5 (0.3%)	1.784	0.148	1.865	0.134	0.546	0.651
	College degree	91 (4.8%)						
	Bachelor degree	1738 (92.3%)						
	Master's degree or above	49 (2.6%)						
Monthly income	≤3500	12 (0.6%)	4.464	0.001	8.956	<0.001	3.187	0.013
	3500~5000	188 (10.0%)						
	5000~10000	1361 (72.3%)						
	10000~15000	256 (13.6%)						
	≥15000	66 (3.5%)						
Living situation	living alone	174 (9.2%)	1.063	0.364	3.269	0.020	1.683	0.169
	Live with friends	115 (6.1%)						
	Live with your family	1580 (83.9%)						
	Other situations	14 (0.7%)						
Marital status	married	1445 (76.7%)	4.165	0.006	5.401	0.001	0.804	0.492
	unmarried	406 (21.6%)						
	divorce	32 (1.7%)						
Working years	1~5	413 (21.9%)	3.089	0.015	3.820	0.004	0.297	0.880
	6~10	455 (24.2%)						
	11~20	753 (40.0%)						
	>20	262 (13.9%)						
Degree of familiarity with narrative medicine	Participate in systematic learning	720 (38.2%)	17.290	<0.001	10.223	<0.001	10.894	<0.001
	Have attended the relevant meetings	658 (34.9%)						
	Heard of it, but did not understand	469 (24.9%)						

	Never heard of	36 (1.9%)						
Whether to set up a narrative center	Yes	1609 (85.4%)	7.725	<0.001	-1.480	0.140	5.502	<0.001
	No	274 (14.6%)						

5.1.2.2 Correlation analysis of narrative competence, professional burnout, general self-efficacy, and demographic characteristics

Correlation analyses were conducted for narrative competence, burnout, general self-efficacy, and demographic characteristics, with gender, age, income, title level, educational level, working years, marital status, living situation and familiarity with narrative medicine, and whether or not a narrative center was established in the medical institution where they were working as covariates to be controlled. The results showed that clinical staffs' narrative competence was positively correlated with self-efficacy ($r=0.542$, $p<0.001$); narrative competence and burnout were negatively correlated ($r=-0.285$, $p<0.001$); and burnout and self-efficacy were negatively correlated ($r=-0.313$, $p<0.001$), see table 5.6.

Table 5.10 Correlation analysis of medical staffs' narrative competence, self-efficacy and burnout (n =1883, r)

Item	Total score of narrative competence	Total score of self-efficacy	Total score of burnout
Total score of narrative competence	1		
Total score of self-efficacy	0.542***	1	
Total score of burnout	-0.285***	=-0.313***	1

Note: * * * P <0.001

5.1.2.3 Results of the mediation model of self-efficacy between narrative competence and burnout

Gender, age, income, rank level, educational level, working years, marital status, living situation and familiarity with narrative medicine, and whether the medical institutions have established narrative centers were used as control variables, narrative competence was used as the independent variable, and professional burnout is used as the dependent variable, self-efficacy as a mediating variable. The mediating effects in this study are divided into three types of models: (1) regression model constructed between medical staffs' narrative competence and professional burnout; (2) medical staffs' narrative competence and self-efficacy constructed a regression model; (3) medical staffs' narrative competence, self-efficacy and burnout jointly constructed a regression model.

The results showed that the narrative competence of medical staffs could negatively predict burnout, and the difference was statistically significant (P <0.001); the narrative competence

and self-efficacy entered the regression model together, the direct effect of narrative competence on burnout was significant, and the difference was statistically significant (P <0.001), and the self-efficacy of medical staffs could negatively predict burnout. See table 5.7, the direct effect of narrative competence on the path of professional burnout is -0.008 (95%CI -0.011~-0.006), and the interval does not include 0, accounting for 53.3% of the total effect; the indirect effect on the path of professional burnout through self-efficacy is -0.006 (95%CI-0.008~-0.005), the interval does not include 0, accounting for 40% of the total effect.

It shows that narrative competence can not only predict burnout directly, but also indirectly predict burnout through the mediating effect of self-efficacy. In summary, self-efficacy plays a partial mediating effect between narrative competence and burnout. The mediation model is shown in Figure 5.1.

Table 5.11 Results of the mediation model of subjects' self-efficacy between narrative competence and professional burnout

Variable	Professional burnout		Self-efficacy		Professional burnout	
	β	t	β	t	β	t
Constant	4.637***	10.811	16.439***	8.151	5.326***	12.442
Sex	-0.113	-0.989	-0.78	-1.451	-0.146	-1.299
Age	-0.018*	-2.229	0.03	0.795	-0.017*	-2.113
Rank level	0.013	0.259	0.09	0.383	0.017	0.341
Educational level	-0.081	-0.948	-0.37	-0.924	-0.096	-1.152
Marital status	0.144*	2.171	-0.281	-0.901	0.132*	2.032
Income	-0.118**	-2.576	-0.304	-1.416	-0.131**	-2.91
Working years	0.085	1.466	0.284	1.039	0.097	1.703
Living condition	0.027	0.562	-0.508*	-2.216	0.006	0.128
Degree of familiarity with Narrative medicine	0.089**	2.966	-0.194	-1.385	0.08**	2.745
Whether to set up a narrative center	-0.034	-0.485	-0.329	-0.991	-0.048	-0.693
Narrative competence	-0.015***	-12.85	0.149***	27.871	-0.008***	-6.309
Self-efficacy					-0.042***	-8.689
R^2	0.327		0.565		0.376	
The adjusted R^2	0.107		0.319		0.142	
F	20.385***		79.662***		25.722***	

Note: * P <0.05, * * P <0.01, * * * P <0.001; it was tested that there was no problem of multicollinearity among the variables, and the coefficients of variance inflation were all <5

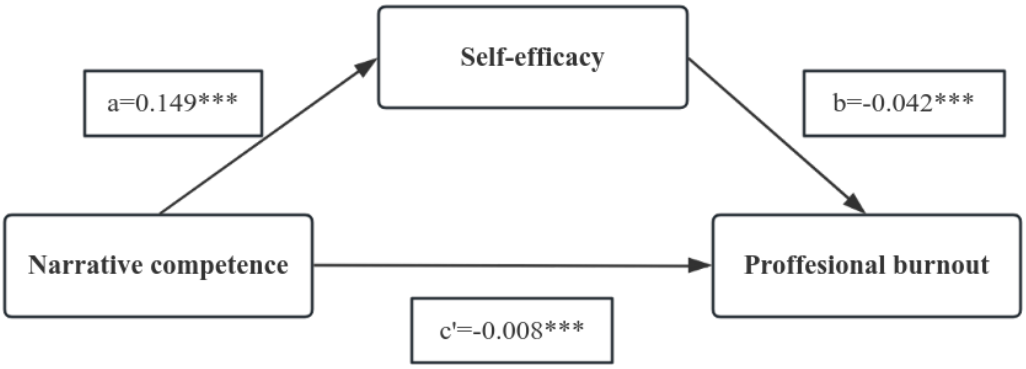

Figure 5.14 Mediation model of self-efficacy between narrative competence and burnout

Source: Developed by the author

5.2 Findings of qualitative study

The qualitative research part adopted the life narrative inquiry method and used Chinese narrative hospital management as the theoretical framework. We collected a total of 983 narrative interview responses. The research team used NVivo11.0 software to analyze the life narrative interview corpus of 52 randomly selected medical staff and constructed a theoretical model of medical professional burnout.

Based on the NVivo11 software, the word frequency analysis of the medical text interview material was performed, and the meaningless numbers and single words were removed to form a word cloud, see Figure b.1. In the word cloud map, the size of the font size indicates the frequency of occurrence of the relevant word in the text material. From the figure, we can see that the main focus of the interview materials is “叙事” (narrative), “医学” (medicine), “患者” (patient), “故事” (story), “职业” (occupation), “健康” (health), which is matches the research theme of “Burnout in the context of Narrative Medicine”. However, the word cloud could not reflect the specific causes of burnout and the specific details and distributional characteristics of the suggestions for using narrative medicine to alleviate burnout, which need to be further analyzed in relation to the reference points and coding content.

5.2.1 Node analysis of the causes of medical professional burnout

Through NVivo 11 software analysis, the factors that cause burnout among medical staff can be summarized into 4 parent nodes and 10 first-level child nodes, see Figure 5.2 and table 5.8. They are: (a) professional factors (including: working pressure, family pressure, mechanical

work); (b) personal factors (including: psychosomatic Status, lack of ability, being satisfied with the status quo); (c) hospital environment (including: lack of medical resources, tense relationships with colleagues and leaders); (d) patient factors (including: patient complaints, medical disputes). Among the causes of burnout among medical staff, the second-level sub-node of work pressure among professional factors has the largest number of references, which mainly includes heavy workload due to the professional features, frequent overtime work, scientific research pressure, examination pressure, promotion pressure; followed by complaints from patients and tense relationships with colleagues and leaders.

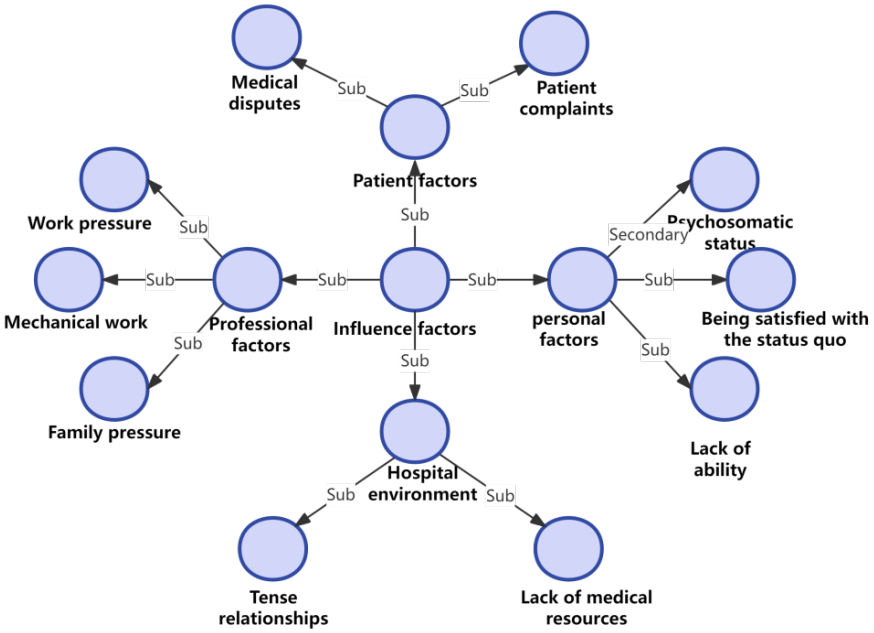

Figure 5.15 Influencing factors of burnout

Figure developed by the author

Table 5.12 Coding node structure of the causes of professional burnout

Parent node (4)	Level 1 child node (10)	Secondary child nodes (20)	Number of reference points
Professional factor	Working pressure	Large work load, long working hours, frequent night shifts	23
		Scientific research pressure	
		Examination stress	
		Promotion pressure	
	Family pressure	The Family requires him to make progress	9
		Wanting family companionship	
		Boring work affects family companionship	
	Mechanical work	Repeating the same work day after day	8
Personal factors	Psychosomatic condition	Sub-health	6
		It is difficult to come out of the patient's death	

		Feeling frustrated and guilty about not doing a good job	
	Lack of ability	Lack of clinical experience	5
	Be satisfied with status quo	Material conditions have been met and there is no goal	3
Hospital factors	Tension relationship	Leader's veto Post transfer Job competition is suppressed by colleagues	11
	Medical resource	Human resources are tight, salaries are not high, and equipment is insufficient	5
Patient factors	Patients' complaints	The patient did not understand and felt wronged Patient dissatisfaction and intentional provocation	12
	Medical disputes	Frequent patient complaints	4

5.2.2 Node analysis on suggestions for alleviating burnout

Through NVivo 11.0 software analysis, the suggestions given by the interviewees to alleviate medical professional burnout can be summarized into 4 parent nodes and 10 first-level child nodes, see table 5.9. They are: professional aspects (including: changing thinking, reconstructing the target); personal aspects (including: narrative integration, narrative reading, narrative writing, narrative sharing); hospital aspects (including: physical environment, narrative ecology); patient aspects (including: narrative listening, empathetic response), see Figure 5.3.

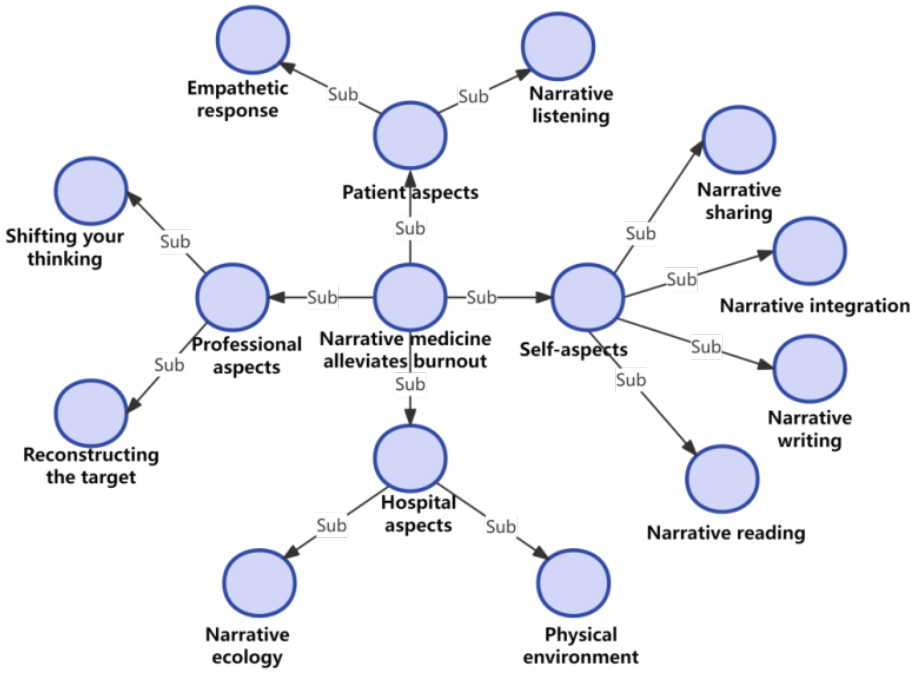

Figure 5.16 Narrative medicine alleviates burnout

Table 5.13 Coding node structure to alleviate medical burnout

Parent node (4)	Level 1 child node (10)	Secondary child nodes (17)	Number of reference points
Professional aspects	Shifting your thinking	Look at problems from different perspectives and changing perceptions. Medical work is not only a profession, but also a mission; avoid falling into professional narrative foreclosure.	5
	Reconstructing the target	Recall the original intention of choosing the profession, reshape the awe of the medical industry, and establish a professional idol.	21
Self-aspects	Narrative integration	Reflect on the patient's situation. Reflect on your own clinical practice. Review your own success experience.	18
	Narrative reading	Read the narrative works, and the stories of others.	11
	Narrative writing	Write parallel narrative cases and record personal stories.	5
	Narrative sharing	Share your stories with your family, your leaders, and your colleagues	18
Hospital aspects	physical environment	Provide narrative platforms offline, such as setting up narrative sharing centers, narrative sharing meetings, narrative speech contests, narrative reading clubs. Utilize new media online, such as live broadcasts and short video sharing. Construct a soft cultural environment of the hospital: mascot, hospital emblem, hospital song, hospital history museum.	22
	Narrative ecology	Adopt encouraging language and give encouraging education Managers pay attention to every employee's story. Managers use accumulated narrative capital to engage in narrative intervention.	24
Patient aspects	Narrative listening	Pay attention to patients' needs and feelings, listen to patients' helplessness, and set up a "speak freely" book Communicate and analyze the patients' bad emotions, and actively communicate with the family members	7
	Empathetic response	Understand the patient's story, respond appropriately, and share your story with the patient	8

Among the measures to use narrative medicine to alleviate medical professional burnout, medical staff themselves have the most nodes, including the four basic adjustment tools, namely, narrative integration, narrative reading, narrative writing, narrative sharing, which are used in the process of sharing stories through constant reviews and reflection, reading fictional or realistic stories in biographies, novels or other forms of texts, and at its highest level, creating their own reflective narratives. Secondly, in terms of hospitals or medical institutions at the organizational level, a good narrative ecological environment should be built and the "narrative management thinking" of the administrators and leaders should be promoted.

5.2.3 Narrative improvement story of job burnout in the context of narrative hospital management

The research team received a total of 983 narrative interviews. We selected one dean, three department directors, two head nurses, two young doctors and nurses under the age of 30, and presented their burnout-related self-reports as follows.

5.2.3.1 The dean's story

Dean A's story: Dean A used to be the director of obstetrics and gynecology. After switching from the head of the clinical department to administrative management, she became uncomfortable Dean A mentioned that after participating in the training of the narrative medicine team, she realized that there were three main reasons for her burnout:

First, she spent too much energy on the management of middle-level cadres; second, she lost himself in the repetitive and tedious daily clinical work and was objectified into a work machine. She regretted her choice after being transferred to a management position, because she believed that clinical work did not need to involve complex interpersonal communication and was simpler; third, she had a professional narrative foreclosure and lacked intimate narrative connections with family members, and was estranged from her husband and her daughter, whose growth was a headache for her.

After systematically participating in the workshop of the Chinese Narrative Medicine team, she has applied the narrative concept to management and daily family life, and her work state has changed greatly. The following is the story of her using narrative mediation to resolve internal contradictions in the department and help young management cadres achieve growth:

Qin is a 29-year-old head nurse with a master's degree and strong personal professional and research ability, who has been recognized at the provincial and municipal levels for many times. Qin stood out in the 2020 selection of the hospital's middle management cadres and became the head nurse of the gastroenterology department of our hospital. However, less than half a year after she took office, Qin was very depressed and told me that she was not suitable for the gastroenterology department, and she learned that the head nurse of the nephrology department was going to retire soon, so she wanted to take this opportunity to change departments and go to the nephrology department. As a matter of fact, I had already heard other nursing staff in the gastroenterology department reacting to the fact that Ms. Qin, the head nurse, was too young, had no management experience and did not know how to communicate. At that time, I happened to have studied the concept of narrative medicine, and I was also planning to use the narrative concept to have a chat with Tan, but I did not expect it to work well.

Instead of just saying yes or no to her request, I shared a story with her after spending almost an hour listening to her talk about the resistance and problems she had encountered in her gastroenterology department.

There was a traveler who, while traveling from village to village, met an old man sitting on the side of the road.

The traveler asked the old man, “Do you know how the people in the next village are?”

“Well,” asked the old man, “how were the people in the last village you went to?”

The traveler replied, “They were unfriendly, short-tempered, selfish and insatiable.”

The old man said, “Yeah, then you will find that all the people in the next village are similar to the people in the last village.”

A little while later, another traveler going along the same road also encountered the old man on the side of the road and asked the same question.

The old man also continued to ask the traveler the same question in turn, “What kind of people were in the last village you went to?”

The traveler replied, “They were friendly, cheerful, cooperative, joyful and generous.”

The old man said, “Uh-huh, then you’ll find that all the people in the next village are similar to the people in the last village.”

Qin was silent for a long time after hearing my story. I told her to go back and reconsider and come back to me if she still wanted to change positions. I remembered that in the Narrative Medicine workshop, the teacher said that a small story can be a light that illuminates the listener and makes her realize something about herself. Narrative sharing became a “thinking springboard” for me to communicate with Qin efficiently. One of my stories made Qin realize that if she did not change her thinking, she would still encounter the same situation and problems in the next department, because the key to solving the problem did not lie in changing departments and environments, but in Qin’s self-reflection and positive adjustment. As a result, a few days later, Qin found me again and said that she had not adjusted herself well in the process of changing from a nurse to a nurse manager and asked me to believe that she would be able to do a good job.

I also took this opportunity to share my own professional growth experience, encouraging Qin, who was entering the management position for the first time, to do a good job of serving the staff in the Gastroenterology Department and to know a famous quotes in ancient China “定其交而后求”, which means “making friendships with others before asking them to do anything”. Later, as one of the youngest head nurses in the hospital, Qin got along well with

her colleagues in the department and her work was widely recognized by everyone and the leadership. On the International Nurses' Day in 2023, she was also awarded the "the outstanding Head Nurse" and "the Outstanding Communist Youth League cadre". In the past few years of management, I have often used similar methods to resolve communication crises among middle-level management cadres. I use the concept of narrative community to always consciously bring the interpersonal relationships with middle management cadres and other hospital leaders in the direction of horizontal relationships, and thus felt the charm of management, and when I was able to let them grow, I was enthusiastic about my management career.

Not only that, in the past few years, I have increased the time for narrative interaction with my family. My daughter, who used to be very rebellious, got into the university of her choice this year after I changed the way I communicated with her and was willing to listen to her growing up problems. The whole family is getting closer and closer, and my work efficiency is getting higher and higher, and I no longer spend inefficiently in the office all day.

5.2.3.2 The story of the director of the clinical and functional departments

(1) Director B's story:

Director B is a female and non-clinical department director. She shared the story of meeting a dean with narrative management wisdom during her career transition, and then encountering a new concept of narrative medicine, managing the department with narrative conception:

At that time, the hospital moved from the old campus to the new campus, the hospital had just changed from a district-level hospital to an affiliated hospital of a medical university. The hospital implemented many changes, and I was interviewed by the dean and transferred from the Party and government office to the newly established Health management center to be the deputy director. However, because the director of the department was not yet in place at that time, I had to be fully responsible for the daily management and development planning of the department. For me, who had never been in contact with the field of health management, the new position was full of challenges, and thus, at a loss for words, I approached the dean and expressed my doubts about this arrangement and my confusion about how to carry out work in the future. The dean told me that he happened to have a book for me and asked me to read the story in this book carefully and then talk about some of my thoughts and plans. This book is Elbert Green Hubbard's *A Message to Garcia*.

A Message to Garcia tells the story of the brave Captain Rowan who entered Cuba alone in 1898 to deliver letters to General Garcia. The story tells people that what a person really needs

is a kind of professionalism, to be a loyal doer —— this is the true meaning of A Message to Garcia. General Rowan accomplished himself while serving others. After reading this book, I realized that a real leader does not have to be talented or have a lot of experience. As long as he can take root in daily life, with "delivering the letter" as the core goal, starting with respect and consideration for others, they will be successful. From then on, I was no longer confused. I immediately took the initiative to go out for research and study, took the initiative to form a team, and dedicated myself to completing the "letter delivery" task assigned to me by the dean.

I learned a lot of management wisdom from the dean. Soon, the hospital introduced the PNCCH and set up the first bio-health narrative sharing center in China, of which I became a beneficiary, and I realized that I had met a good leader with a high narrative management quotient. In recent years, I have applied the narrative concept to the health management practice of customers, which has been welcomed by customers. In the process of the management team, I continued to learn the narrative concept, set up a "bio-health narrative bench" in the health management center, as well as obtaining the approval of the Guangdong Provincial Federation of Social Sciences' Narrative Health Management Research and Practice Base to carry out related work. In recent years, the performance of the department has continued to rise, and the health management center has expanded its business from one floor to two floors. Many clients have changed their working methods and the way they get along with their families through narrative concepts, and their health conditions have improved significantly.

(2) The story of director C:

Director C is a gastroenterologist and hospital administrator who puts science and rational thinking first. After graduating with a doctorate in 2012, he worked in a university-affiliated tertiary hospital. In 2015, he was transferred to hospital management by chance. Since 2021, she has become a member of the narrative medicine team. She believes that the main reasons that caused her to suffer from professional burnout for a period of time are: too rational and absolutely scientific thinking, not knowing how to maintain good narrative connections in the hospital; narrative connections also became weak under the pressure of dual administrative and clinical work, and even broke completely for a period of time.

Here's her story:

Before and after I came into contact with narrative medicine, my thinking, work and lifestyle have almost undergone subversive changes, and I have benefited profoundly. I started teaching courses such as "Introduction to Clinical Medicine" at my university in 2013, and at the end of my lectures, I would always mention that the two most important words to be a doctor are logic and calmness. At that time, I believed that clear logic is the cornerstone of synthesizing

diagnostic clues and giving correct medical decisions. At the same time, it cannot be affected by the situation of patients and their families as well as emergencies. Therefore, we should try to keep a distance from patients and their families to ensure that we can always remain calm. I have also adhered to this concept in my clinical work in the gastroenterology department for many years.

After switching to the hospital management industry in 2015, I found that unlike clinical medicine, many hospital managers did not have a scientific knowledge system of management, and it is easier for them to give free rein to project management, Six Sigma, and other management methodologies that are constantly being simplified and applied in the hospital management industry, But it was soon discovered that managers seemed to pay more attention to relationship building, resource integration. While I strive to practice scientific management theory and achieve certain results, I often wondered in a confused way why hospital management was in such a state. Is it because the management research method I think is not what hospital management needs.

Over the years, my road to hospital management has been very hard. Not only is the work hard, but also because of the heavy workload, I am often exhausted when I go home, thinking about work, and thus have no interest in communicating with my family, let alone quality companionship with my family, in which case my relationship with my husband has become increasingly tense, and I have neglected to accompany my son as he grows up. My son was always criticized by his teachers at school, but I did not give him a timely response. Later, my husband and I had even written divorce papers. But even at this point, I still do not know how to adjust.

After coming into contact with narrative medicine, I gradually realized that that an overly rational way of thinking may be the root cause of various unsatisfactory experiences in my work and life. I am indeed too obsessed with the “technical” aspect. When encountering problems, I habitually use rational research method to solve problems. If I can not solve them, I will look for new methodologies. While the world is made up of people, except for “technique”, the success or failure of a thing depends more on the harmony of “Tao”, which is the “value symbiosis” mentioned in narrative medicine. At the same time, through the scale self-assessment, I found an important problem, that is, I had a weak narrative connection with my family, and due to the lack of narrative connection with my family in my daily life, I had accumulated a lot of negative emotions. During the epidemic prevention and control period, because my family was in my hometown and I was working alone in the hospital, my busy

work coupled with narrative blockage, I fell into severe job burnout during that period, and even developed stress-induced peptic tract ulcers.

After coming into contact with the concept of narrative medicine, I took the initiative to adjust my own state according to the narrative concept, focusing on repairing the narrative connection with my family, and gradually restoring the intimate narrative connection with my husband and son. After years of spending time with my son, I tried with the narrative connection with the nine-year-old. When my son came home from school, I asked him if anything fun had happened at school. The first few times, he did not pay much attention to me.

Maybe it was because I hadn't looked into his eyes and talked to him seriously for a long time, and he was not used to it, so this kind of behavior made him particularly wary. However, after I asked him seriously for a few days, he began to tell me some stories about the school. He was not able to explain clearly at first. Gradually, he was able to not only explain what happened clearly but also took the initiative to share his views. Slowly, he and I re-established the narrative interaction that a mother and son should have. I would often take the initiative to read some stories to guide him to regulate his emotions. In this way, his narrative competence improved day by day, and his narrating self and my professional narrating self-grew together.

At work, I adjusted my way of thinking and working rhythm. In the gastroenterology clinic, I used to write checklists and give diagnosis and treatment plans according to the test results against the guidelines and standards, running like a machine now I will apply the narrative theory to actively listen to the patient's story before and after the illness, and use the narrative concept to carry out narrative patient education, which has improved the efficiency of my work and gained the recognition of more patients. Once, in the busy and tense outpatient service, I was able to identify an acute heart attack patient with hidden symptoms by quickly grasping the main points of the patient's story, and my sense of professional identity was immediately enhanced.

In management, I have focused on creating a harmonious environment for my team, enhancing narrative connections with team members, and improving my management effectiveness. I sincerely said to Prof. Yang, "Narrative medicine is playing a huge role and producing immeasurable effects in both clinical work and hospital management. Narrative medicine guides the harmonious development between doctors and patients, workmates, and between people and society, to pursue and even reach the ultimate goal of value symbiosis." I was also involved between July and October 2023 in the writing of the book *Narrative Hospital Management* led by Prof. Xiaolin Yang.

(3) The story of nursing director D:

Director D of the Nursing Department is a woman born in the 1970s. After a major infection incident in the hospital, she was dismissed due to joint management responsibility. Suddenly withdrawn from the management work of nearly 2,000 people, she could not get out for a long time. It was during this time that she checked herself and found that she was suffering from burnout and depression. Because of her poor mental and physical condition, she was emotionally alienated from her husband, and her body even showed signs of tumors. But after being exposed to narrative medicine, her situation changed dramatically in all aspects, and she became a core teacher of narrative nursing across the country. Here is her story:

I love my nursing management position very much, but due to changes in my career, it is difficult for me to adjust my mentality. I was transferred to the Nursing teaching and research section and was responsible for teaching, but my condition was not very good every day. When I go home, I either get sulky or lose my temper with my husband. At that time, my husband had recently retired and was emotionally unstable. As a result, both of us encountered emotional and health crises. After the hospital introduced the PNCCH, I seemed to have found a new purpose. I integrate the concept of narrative nursing into the training of interns and nursing students, and also lead them to conduct narrative rounds to learn how to establish narrative connections with patients.

At that time, the hospital encountered a difficult matter. The patient's family members threatened the hospital every day to complain to the higher-level authorities. This caused headaches for both hospital leaders and the medical department. Using the concept of narrative mediation, I not only resolved the crisis, but also helped the patient's family understand how to become better family caregivers, which also improved the physical condition of the patient hospitalized in the ICU. The 67-year-old patient in the ICU ward is a retired leader of the local health bureau, and his wife who takes care of him is a retired employee of the hospital. The doctor gave this patient 26 diagnoses. In the ICU ward, the patient was irritable and his condition never improved.

Family members always go online or consult different doctors in other hospitals on how to treat certain diseases. They constantly question the hospital's treatment plans and medications, and constantly have disputes with the doctors in charge. The patient's family members express their extreme dissatisfaction with the hospital's medical level and management, and has complained repeatedly, resulting in a very tense doctor-patient relationship. Family members rarely actually go to the patient's side to be with him.

I invited this family member to the Narrative Center and shared with her stories from *The Death of Ivan Ilyich* and *Psychology of The Sickbed* by J. H. van den Berg, guiding her to see

it from the patient's perspective. The disease made her understand that although the patient was lying there, sometimes awake and sometimes asleep, he needed to communicate with the outside world, especially looking forward to hearing the voices of his family. We told her that there is nothing most desperate for someone who is ill than the loss of narrative connection with their family. Instead of constantly searching for treatment options and arguing with doctors, she could spend more time with her husband.

We went to the intensive care unit with the family, held her husband's hand while he was awake, talked to him, asked him if he missed his family, and he shed tears. We recommend that the patient's family record some videos of the grandchild and other family members' daily life scenes and play them for the patient every day during visiting hours. Slowly, the patient's overall condition miraculously improved. Now he has been transferred to the general nephrology ward of the hospital, and his family members have completely changed their original attitude.

Later, this family member also came to the narrative sharing center to explain his understanding of care to other patients' families. She said that with the advancement of modern medicine, every family member rarely gets sick. Once they do, it becomes a serious illness. Most of us do not know how to be caregivers. Even if she was a medical staff, she doesn't necessarily understand what her family needs most. of care. Through the narrative works I recommended, she understood that family members should, like Gerasim, form a closer narrative connection with the sick family member. The company and care of family members can achieve effects that drugs cannot. Only by teaching patients' families how to become better caregivers can we better improve the patient's life quality.

Although the patient passed away in the end, I became good friends with the patient's family. In the final stages of this patient's life, I recommended that the family take him home. I applied the concept of palliative care to help him reconcile with himself, his family, and his colleagues, and pass away peacefully. After that, I used narrative medicine to resolve many doctor-patient disputes, and I often traveled to various places to give lectures on narrative nursing and narrative management. The concept of narrative prescription in the narrative medicine made me realize the importance of watching more films related to life, aging, illness and death to improve my own narrative competency. I invited my husband to watch all the films recommended in the PNCCH and comment on the films together. Unexpectedly, the relationship between my husband and I was also repaired.

Many colleagues believe that after the hospital infection incident, my condition was actually better than before. In fact, it was not the hospital-related incidents that made me grow,

but narrative medicine. The concept of narrative medicine has allowed me to grow, and although I am approaching retirement age, I feel that this growth is very important to my health. I will continue to regard narrative medicine and narrative nursing as a lifelong career rather than a mere career.

5.2.3.3 The story of the head nurse

(1) The story of the head nurse E:

Head nurse E, 36 years old, is from Jiangxi, but has been working in a hospital in Shenzhen since graduation. In recent years, she has been the head nurse of the endocrinology department. When she was filling in the burnout scale organized by the Nursing Association during the epidemic, she was measured as having burnout. This situation continued until she participated in the teacher team training activities of the hospital's PNCCH. Before, she often suffered from insomnia and was easily irritable. She felt very tired during work and could not focus on her work. She could not spend time with her family when she got home and was absent-minded. Here's what she said:

During the two-day team training activity of the hospital PNCCH that I participated in, the head nurse of the oncology department, Chen, shared the story of how her nursing team gave a dying elderly patient the final dignity of life. Due to the epidemic, a dying elderly patient was hospitalized alone in the hospital, and his children who were far away from home were unable to arrive at the hospital to accompany and say goodbye to their mother before she died. Nurse Chen described what the girls in their department did when the old man passed away - they patiently helped her comb her hair and put on clean clothes. While they were doing these things, they were talking to the deceased old man, telling the old man that her children had been missing and caring about her in the distance, as if the old man had just fallen asleep and passed away peacefully.

When I was listening to Nurse Chen described this detail, I felt a tightness in my chest and discomfort at first when I heard about the elderly people who were alone in the hospital, because it was during the epidemic that my housemother passed away alone while hospitalized in her hometown hospital in Jiangxi. And this is the root cause of my depression and burnout over the past six months. However, after I listened to Nurse Chen's story, the image that had been bothering me - the scene of my mother-in-law dying alone in despair and darkness, was suddenly replaced by the warm and loving farewell described by Nurse Chen. I shed tears with excitement and started sobbing unconsciously.

After the cry was heard, I told the story of my wife in front of my colleagues:

I lost my mom when I was little. After marrying my husband, I became very close to my mother-in-law. My husband is the only son of my mother-in-law, and my father-in-law has passed away. My mother-in-law has been taking care of my children in Shenzhen for many years. One Spring Festival during the epidemic, my mother-in-law went back to her hometown to visit her family. Unexpectedly, she suddenly felt unwell in her hometown and was hospitalized in a hospital in her hometown, where she was diagnosed with stage III cancer.

Since a large number of nursing staff were needed during the epidemic to support nucleic acid tests in various communities, and if I take leave to return to my hometown, I need to be quarantined in the two places for 14 days. For me, my wish to accompany my mother-in-law is completely unfulfilled. My husband and I have agreed to take my mother-in-law back to Shenzhen for treatment when the epidemic subsides. However, what I didn't expect was that my mother-in-law's condition took a turn for the worse and she suddenly died in the hospital shortly after the Chinese New Year. I was not able to say goodbye to my mother-in-law, nor did I have the opportunity to attend her funeral.

Since my mother-in-law passed away, I have been unable to accept the reality that my mother-in-law has passed away. I have been unable to concentrate on the work in front of me and integrate into the current life. I am lost, insomnia, and anxious. The agonizingly bleak scene of my grandmother passing away alone in the hospital often came to mind, and my husband is also in a very bad state. After studying narrative medicine, I know that we are deprived of grief, and no one among us dares to mention it, causing a break in the narrative connection on the matter of the housemother, and that we were all stuck in the traumatic narrative foreclosure of bereavement.

Today I heard a story shared by the colleague in the oncology department. I can imagine that my mother-in-law also received concern and narrative care from nursing sisters far away in her hometown when she was dying. After telling my story, I hugged with colleagues whom I was not familiar... That night, I went home and shared this with my husband. My husband and I reminisced about my mother-in-law's past together and also listened to my husband's story about how his mother loved and cared for him when he was a child. Finally, after holding our hands and crying, we came out of the narrative foreclosure of losing our mother-in-law and returned to the present moment. After that, I got closer to my nursing sisters and my work efficiency improved. In the subsequent burnout test, I found that I was no longer within the burnout score range.

Colleagues shared their stories of caring for terminally ill elderly patients, which alleviated head nurse E's sense of guilt toward her mother-in-law and soothed her heart, which was deeply

mired in moral condemnation and emotional distress. Each of us has very powerful abilities of self-repair, self-healing, self-adaptation, self-awakening, and self-redemption. In a good narrative ecology, these powers can burst out. Normalized narrative sharing among colleagues is an essential element of a good narrative ecology, and is of great help in harmonizing interpersonal relationships among colleagues and preventing one's own career crises.

(2) The story of the head nurse F:

Head nurse F is a 31-year-old young head nurse. The following is her career growth story:

Shortly after starting my career at the age of 22, I made a mistake in nursing and was reprimanded and complained about by a patient's family. The director of the cardiovascular unit I was in at the time and the nurse practitioner were furious and scolded me severely. I was unable to concentrate on my work for many days afterward and even questioned my career choice. Later, the head nurse of our department took a leave of absence due to a diagnosis of breast cancer. Fortunately, the new nurse practitioner saw something was wrong with me. She took the initiative to talk to me, put herself in the shoes of a young caregiver, and listened to my account of the whole incident. Under her guidance, I told all the doubts and grievances I had in my mind. Miraculously, after telling this story, which I had hidden in my heart and had not been asked about by anyone, my mood immediately became soothed.

The matron also told me what she had seen and heard during her further studies in Hong Kong. She told me that no one is perfect, and that not repeating the same mistakes was progress. After receiving the nursing supervisor's narrative response and reassurance, I quickly came out of the giddy state that had lasted for two months and devoted myself to nursing. I felt the power of narrative from that time onwards and would emulate the nurse manager's way of listening to the patient's heart. Under the influence of the nurse practitioner, the head of the department and several young doctors have also changed a lot.

In my cardiovascular department, within a few years, a number of young health care workers have been promoted, most of the staff in the department have achieved academic upgrading and title promotion, and the department has a very high level of patient satisfaction and a very harmonious doctor-patient relationship. I also grew up to be a chief nursing officer last year, and I think that experience was very beneficial to my own growth. However, it was not until I recently participated in the "PNCCH" that I learned that this nurse manager used the concept of narrative management. Instead of managing us with authority, she established a more balanced horizontal narrative connection to stimulate the growth power of narrating self of the young people and foster teamwork.

After systematic study of narrative department management concepts, I realized that the

narrative leadership of the director and nurse can change the narrative ecology of a department, so I began to actively learn narrative knowledge, read more various stories, and exercise my narrative thinking. When I encounter colleagues making mistakes again, I also know how to accompany them like the former head nurse, listen to them review the story from their perspective, find out the problem together, and face it together, and not just to criticize. In this way, she gets along well with the little sisters, and the efficiency of completing tasks after decomposition is also very high, and the department where she works is more cohesive.

The narrative competency of departmental managers can play a decisive role in the creation of a departmental narrative ecology and the reduction of the overall burnout rate. The narrative leadership of department management has warmed young doctors. When young doctors grow into department managers, they will also pass on such a good narrative ecology to the next generation of young doctors. Hospital managers should be “tolerant and generous” when dealing with adverse events. The harmonious relationship between people must be maintained by “the way of forgiveness". In Chinese, “Ru (如)” plus “Xin (心)” constitutes the character “Shu (恕)”, which means to be compassionate and to be able to stand in the position of others for the sake of others. In “Shuowen·Xinbu” (《说文•心部》), “恕” means “Forgiveness is benevolence.” The word “Ru (如)” also means if. Think more about ifs and what-ifs in your mind, think in other people’s shoes, and use your own heart to infer the hearts of others. In this way, you can be more tolerant and forgive more. “Forgiveness (恕)” means to put oneself in the shoes of others, to love others from one’s own heart. In another interview, because there was no such narrative connection between the director and department staff, many staff in his department had become depressed, resigned, or had their jobs transferred.

5.2.3.4 The stories of the young doctors

The story of young doctor G: 29 years old, ICU doctor, officially practiced medicine in three public hospitals in Xi’an for 4 years. Before contacting the narrative medicine team training, she had submitted her resignation report to the hospital. At that time, the self-reported depression scale was severe depression, and the occupational burnout scale was also high burnout. Here is her story:

I consider myself a very careful doctor, and I have always had a good relationship with patients. However, one night some time ago, when I was on duty, a young patient named A Biao was finally stabilized after two days of intensive resuscitation of all signs. The patient’s mother, Aunt Wu, had been waiting in the hospital for two days and two nights, looking exhausted and

with bloodshot eyes. Xiaojie went over and explained to her about the situation of A Biao, and suggested that she should go back and have a good rest, and leave the care to us, so that she could go to the hospital the next day and have more energy to take care of A Biao. Aunt Wu repeatedly asked about her son A Biao's condition and decided to go back to rest.

However, never thought of is that with no warning, in the first sign of vital signs in the morning, after emergency rescue, finally failed to save back. When A Biao's mother Aunt Wu arrived, A Biao had no vital signs. When Aunt Wu saw me, she pointed at me extremely violently and scolded me. She blamed me for letting her go back, and also suspected that I had a mistake in the treatment process, which delayed the treatment. Aunt Wu has been saying to Sue the hospital, but also to sue me. And the colleagues in the department think I committed, even tired them, to me. My director asked me to write an objective description of the situation, but I was not satisfied once or twice. In the end, I was asked to repeatedly write more than 20 situation descriptions.

In those days, I couldn't fall asleep. When I fell asleep, I always woke up suddenly. I do not know where I was wrong. Do not understand why the patient's family questioned themselves, even their own colleagues also questioned themselves. Every day at 1:30 in the morning, which I repeatedly mentioned in the situation description, I would suddenly wake up, with heart palpitations, dizziness, vomiting, and I could not sleep for a night. After ten days, I felt like I would have collapsed soon. The next day, I was in a trance and could not concentrate on doing good things, so I was always scolded and rejected by my colleagues and the director again. I felt chest tightness and deep tiredness in the department. When I returned to the dormitory, I couldn't get a rest. In this vicious circle, I had no choice but to resign and leave my medical job.

Fortunately, I once made a popular science video and met the head of the publicity department of the hospital. She heard about me, but she didn't know how to help me. At that time, the hospital just introduced the "Narrative Medical Center Project" and was training a team. The section chief helped me to apply for an opportunity to audit, let me must go to listen to it. This is the first time I've heard of the word narrative medicine, but as soon as I heard the section chief say it, it felt like lifting me out of my days of confusion.

I went to this event. After I listened to the narrative medicine teacher tell the story of the surgeon Paul in the movie "Nights in Rodanthe", and heard the story of "Nurse Xiufang and the driver" in real life, my story jumped out in my heart. Unexpectedly, the teacher observed me and let me get up to share my own story. I shivered as I told my story, and I saw a young nurse at the nearby table crying with me. The teacher came over and hugged me, let me

gradually calm down. Then the teacher told the story of how the young Osler used a letter to resolve the possible family medical crisis after the death of a young patient.

After listening to Osler's story, I realized that if family members are not present at the scene of a patient's death and have not witnessed the death, they may feel a strong sense of denial and resistance, and they have an urgent need to "find out the truth", and are often filled with anger, suspicion, and blame for the "unjustifiable death". Often, they are filled with anger, doubt, and blame, and are eager to find someone to blame. And because it is difficult to bear the consequences alone, the tone of voice often carries a strong sense of skepticism and distrust of what the other person says. The physician's response should not be to rush to clear his or her name, but to use "narrative mediation" to establish an internal narrative connection with the patient's family. Purely objective explanations and fact sheets cannot truly touch the family's heart. More important than writing a fact sheet is to establish an interpersonal narrative relationship with the patient, listen to their story, and defuse the crisis. This story enabled me to understand, from the perspective of the patient's family, why Aunt Wu was so angry at the time and what the death of her loved one meant to her.

I love clinical medicine very much, but after the death of a young patient and the incident of medical malpractice, I felt that I was unable to fulfill my role as a doctor. After listening to the stories of various doctors and patients in the training of the narrative medicine team, I understood the demands of the patient's family, and also turned these stories into nutrients for my own professional narrative self-growth, and realized that this incident was a test and an experience for me. After that story sharing, I gradually regained my freedom from guilt, and my colleagues in the hospital also changed their attitudes towards me during the narrative medicine study. I was no longer plagued by the nightmare of the 1:30 am, and I was able to rediscover myself by entering the clinical work with a growing attitude.

Later, I also found Aunt Wu and had a long talk with her, despite her previous medical communication methods. At that time, Aunt Wu had not come out of the pain of losing her son, and my initiative made her very surprised. But this time, I put down the identity of a doctor, with a mark of peers and Wu mother launched a life touch life narrative. From Aunt Wu, I learned that A Biao's father died in an accident when he was 9 years old. From then on, I do not know because of the loss of his father, or because the family income suddenly decreased, A Biao nutrition did not keep up, A Biao's health had been not very good.

However, Aunt Wu said that the two of them depended on each other and had a very good relationship. A Biao is Aunt Wu's only spiritual sustenance, but now she is the only one left... I cried as I listened to Aunt Wu tell her story. Previously, I did not understand these stories, only

know that the only person who has been in the hospital to accompany Biao is Aunt Wu. At that time, when Aunt Wu broke down and cried, pointing and cursing at me, I felt very aggrieved. Now, I understand why Aunt Wu was so agitated…. Now, I also send Aunt Wu WeChat messages every week. After that exchange, Aunt Wu gradually came out of the traumatic narrative foreclosure of losing her son. Through my own experience, I understand why narrative medicine advocates the establishment of narrative connections between doctors and patients. This connection can not only help patients and their families, but also allow us to regain professional value and alleviate burnout.

The young doctor G has not yet come out from the traumatic event because of the accidental death of the patient on duty, and then encountered the plight of the multi-layer managers who asked to write the situation statement repeatedly, which led to serious problems of the mind and body, and then affected the efficiency of the daily work, and was also scolded and criticized by the leadership. After comprehensive consideration, Xiaojie had no choice but to submit a resignation application to the leader.

Fortunately, the hospital-level leaders of Xiaojie's hospital began to pay attention to narrative medicine at that time and set up a narrative center in the hospital to carry out narrative medicine-related activities. Through this incident, hospital administrators also realized the peer narrative care that young doctors need when encountering adverse events. Narrative is a collection of wisdom and essential tips that reflect managers' responsibility. While managers at all levels of the hospital bear important responsibilities for the business development of the hospital and departments, they should also be responsible for the physical and mental health of their employees and their career development.

5.2.3.5 The stories of the young nurses

The story of a young nurse H: Nurse H was diagnosed with thyroid cancer before the epidemic. As a nurse in the thyroid and breast department, she contracted the disease, which made her feel scared and self-denial. Before that, she had suffered from job burnout, and after giving birth to her second child, she had been planning to switch to an administrative position. After being diagnosed with cancer, she decided to resign. At that time, hospital administrators had just introduced PNCCH and narrative medicine team-cultivating activities in the hospital. The director of the nursing department and the director of the department of thyroid breast surgery happened to be the first batch of narrative medicine teachers in the hospital. They want to try to use narrative medicine to help Nurse H get out of the darkest moment in her life. The following is Nurse H's self-report:

My daily work is very busy like other medical staff, and I am constantly spinning like a gyroscope in my daily routine. When I come home, I want a quiet environment where I can get the best relaxation and rest. However, my mother-in-law was a busy person, always arranging for her grandsons and granddaughters, and even her brother's grandchildren to stay at the house, where they went to a nearby school, making the house even busier than a food market every day. I prefer to be quiet, originally, I was married to one person, but now it is like I am married to a family, which makes me I am very painful inside, how can I not figure it out, so when I come home, I close the door of my room, basically do not talk to them. I also rarely interact with my own children when I get home because my children are always arguing with them.

The two directors allowed me to attend a number of hospital-sponsored events at the Narrative Center during my sabbatical treatment, one of which was on the aspect of children's narrative connection. From the sharing of many parents, I saw that the root cause of crises such as anorexia, depression, self-harm, and even suicide in many only children was the lack of narrative interaction between parent and child, as well as peers. This made me reevaluate my own situation, and I came to realize that my children are fortunate to have grown up with so many siblings of similar ages, and that conversations with them can unintentionally provide my children with the interpersonal wisdom necessary for a healthy existence.

The other activity was on the elderly. Many elderly people have fallen into a state of mental and physical ill-health after experiencing a break in their occupational narratives, a break in their social narratives and a break in their family narratives. This makes me think that when I get old, my children may work in other places. As long as I treat these children who grow up in my own home a little better, communicate more and build relationships, they will be able to work when I get old. There will be no lack of long-term and stable narrative connections. They will care for me and take care of me so that I can have a healthier and less lonely old age life.

Before I was introduced to narrative medicine, my concern was that there were too many children, too noisy, and I thought it was not worth spending time to take care of other people's children. And during these few narrative events, I changed my original fixed perspective and thinking. I imagined the extension line of my own life process, my children gained life wisdom because they had a partner to grow together, the growth of my narrating self was in an open and healthy state, their future was brighter, and when I got older, I had more connections. I became instantly enlightened, and with treatment, I recovered quickly from my thyroid cancer illness.

Instead of quitting, I couldn't wait to move the window that opened in front of me to my department and my ward. I returned to my nursing job. When I came home every day, I happily accepted the noisy children of the past. I regarded the children's laughter as a pastime outside

of work and established a harmonious family narrative relationship with them; the benign family narrative ecology in turn soothed the burnout after a busy work life, and helped me recover my physical and mental health, and my return to work was also praised by my colleagues.

Through this disease, I realized that many thyroid cancer patients, including myself, were in a long-term state of anger and worry, narrating self-consolidation, did not grow, and did not gain the ability of narrative regulation to cause the disease. Therefore, in my subsequent clinical care, in addition to my previous professional nursing work, I would often talk to my patients about the concept of narrative regulation and guide them to adjust their relationships with their families in a timely manner. Through this illness, I was blessed with good narrative competency and recognized the true nature of life, establishing intimate narrative connections with my family, colleagues and patients. Every day, I feel energized because I am touching and nourishing each other with different lives.

It can be seen from the above narrative interview content that:

(1) Most of the respondents have self-assessed the occupational burnout scale within 5 years. Among the 983 interviews, 617 people believed that they had suffered from occupational burnout, and the burnout rate was approximately 62.7%. Most of the interviewees who were suffering from burnout also believed that they were also trapped in a state of professional narrative foreclosure.

(2) Before contact with the narrative medicine, the vast majority of medical staff were alienated from their family members, unable to spend quality time with their families, and did not have good narrative connections with their colleagues.

(3) Managers have no awareness of narrative management and mainly use evidence-based management concepts to carry out daily work and are prone to burnout.

(4) After systematically receiving training in narrative medicine and narrative hospital management concepts, they all know how to use the keywords of narrative medicine theory to describe and reflect on their own conditions.

(5) By improving their bio-health narrative competency and career narrative competence, they have overcome professional burnout and professional narrative foreclosure, changed their attitude towards life, changed the way they treat their families, changed their perspective on viewing and dealing with problems, and change their perspectives of understanding and interpreting life, inspiring unprecedented vitality and creativity.

(6) They have gradually internalized the narrative competency into a conscious action in hospital / department management and life.

Chinese hospital managers generally work under great pressure. They have to face difficult problems every day, such as shortage of medical resources, staff burnout, difficulty in management, and increasing number of patient complaints. However, managers are often trapped in the biomedical model of evidence-based medical thinking and the numerical domination model of evidence-based management thinking and seldom think about the root causes of staff burnout, the frequent occurrence of doctor-patient conflicts and adverse events.

We selected 59 representative stories from 983 narrative interview cases to further serve as model cases for the cultivation of the management ability of narrative hospitals and narrative departments. In the past, managers mostly studied management-related theories and cases of overall hospital management, mostly focusing on evidence-based cases, lean and process management cases, and lacking review and reflection from a narrative perspective. These vivid daily cases can fundamentally change the management thinking of hospital managers, truly break through the bottleneck problems encountered in hospital management and help hospitals and departments to achieve sustainable and high-quality development.

5.2.4 Construction of the model of medical professional burnout in the context of narrative hospital management

It can be seen from the above node analysis that the influencing factors of medical professional burnout can be categorized into four types: professional factors, personal factors, hospital factors and patients' factors. From the perspective of narrative medicine, the measures of using narrative medicine to alleviate burnout can also be summarized into four aspects: professional aspect, personal aspect, hospital aspect and patients' aspect. Relevant suggestions are put forward from these four aspects, as shown in Figure 5.4. Professional characteristics of medical staff are determined by the social environment. China's large population, high demand for medical services, and the mismatch between the demand for medical services and the supply of medical services have led to heavy workloads and long overtime work hours for medical practitioners, who thus do not have the time to spend with their families. At the same time, they are also faced with various scientific research pressure and promotion pressure. Professional characteristics are the objective factors of burnout among medical staff, which need the participation of government leaders and the whole society to deal with.

Hospital administrators, doctors themselves and patients are the three main subjects of the hospital, which are closely related to the causes of burnout and the direct factors leading to burnout among medical staff. The alleviation of burnout should first focus on these three subjects. For hospitals, hospital administrators are the leading core of hospitals, and their

narrative competency, narrative quotient and narrative adjustment ability will have a direct influence on medical staff and indirectly affect patients. Medical staff are the main group of burnouts, and their personality traits and psychosomatic condition are also the direct causes of burnout; patients are the objects of doctors' daily work contact, and patient's tone, attitude and medical disputes arising in the process of medical treatment will bring medical staff adverse emotions and pressure, making them feel empathy fatigue or even emotional exhaustion.

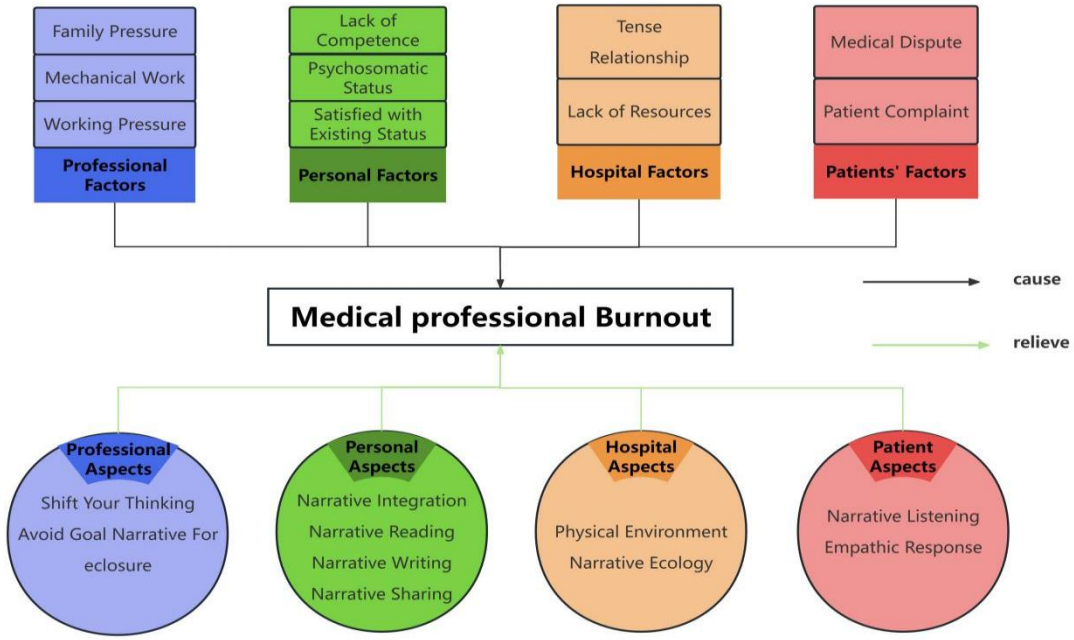

Figure 5.17 The model of medical professional burnout

Source: Developed by the author

In addition to individual autonomous interventions for burnout, interventions from the management level of the hospital as an organization are also very important. Hospital administrators, doctors and patients are closely linked. In the context of narrative medicine, the interpersonal narrative connection among the three has a direct impact on the degree of burnout. Within the framework of narrative medicine, the humanity of all people is respected in all aspects. The hospital administrators use narrative wisdom to build a good hospital narrative ecology, treating doctors as the real "human beings" rather than "robots" or "machines"； peer narrative interactions can reduce medical errors, and the reduction of medical errors can alleviate burnout; the personality of the doctors in the organization is respected, which means that they can better establish empathetic connections between doctors and patients when facing patients; meanwhile, the patient is respected, and the feedback to the doctor will be warmth and gratitude, thus injecting inexhaustible motivation for the doctor's work.

Hospital leaders should view their management as a career rather than a temporary add-on to their professional medical work. An old quote in a classical literature says that "举而措之天

下之民谓之事业”, which means “try to take actions and measurements for all the people in your governance is an eternal career and cause for leaders". After cultivating the narrative quotient, the ability of multi-dimensional narrative connections and narrative community construction of managers, the most important thing is for them is to utilize narrative management in their management practice to widely empower their employees. The results of this study show that medical professional burnout mainly attributed to four aspects: professional factors, personal factors, hospital factors and patients’ factors. Measures to alleviate burnout through the active use of narrative medicine by medical staff include the autonomous development of narrative integration, narrative reading, narrative creation by medical staff, and the creation of narrative ecology led by hospitals, the narrative sharing in different dimensions, and the enhancement of narrative leadership by administrators. Through attribution analysis, the thesis aims to provide theoretical basis and solutions to the alleviation of medical burnout in the future.

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Chapter 6: Discussion and Conclusions

This section analyzes and discusses the results of the data from three aspects: the study on the correlation between doctors' narrative competency and burnout, the study on the mediation of self-efficacy in doctors' professional narrative competence and burnout, and the construction of a burnout model based on the narrative exploration of medical professional burnout. It also conducts attribution analysis at the individual and organizational levels, and proposes countermeasures for alleviating occupational burnout through the concept of narrative hospital management.

6.1 Discussion

6.1.1 Correlation analysis of medical staff' narrative competency and burnout

Narrative behavior ability was negatively correlated with burnout ($r= -0.314$, $p <0.01$), indicating that the higher the narrative behavior ability, the lower the level of burnout. After realizing that they were caught in burnout, doctors with strong narrative behavioral ability were able to take action in the following ways. First, doctors will conduct self-narrative regulation, have deep inner dialogue with themselves, and achieve growth in narrative integration. Second, they will establish narrative connection with family members, share experiences and stories with family members to gain their support and alleviate the state of emotional exhaustion when encountering difficulties at work. Third, doctors will engage in narrative communication with colleagues and listen to their stories, establishing emotional connections with colleagues to reduce individual loneliness and get out of the state of depersonalization. Finally, they will have narrative interaction with patients to enter into the patients' life stories, respond to the patients' stories, and get the patients' recognition, so as to gain a sense of accomplishment, enhance professional identity, and get out of the state of low achievement. Therefore, improving the narrative competency of doctors can reduce their burnout level.

Narrative cognitive ability was positively correlated with narrative behavior ability ($r=0.691$, $p <0.01$), indicating that the higher the narrative cognitive ability of doctors, the higher their narrative behavior ability, and the improvement of doctors' narrative cognitive ability can promote the change of their narrative behavior. Narrative cognitive ability is

positively correlated with the growth of medical narrating self and workplace narrating self. The more and more systematic the bio-health narrative concepts and narrative medicine concepts that doctors master, the more they can be applied to clinical narrative practice. Therefore, hospital administrators and medical educators should carry out training for narrative medicine teachers and talents, improve their narrative cognition as a whole, systematically develop the narrative practice, enhance the narrative adjustment ability and their control over holistic health; and then change their narrative behavior, cultivate narrative wisdom, finally change the phenomenon of burnout of doctors in general, and empower the development of China's healthcare industry.

6.1.2 Analysis of the intermediary role of self-efficacy in in the relationship between medical professional narrative competence and burnout

6.1.2.1 Current analysis of narrative competence, self-efficacy and burnout among medical staff

In this study, the narrative competence of medical staff was scored as (128.35 ± 21.96), which was at a relatively good level compared with the total scale score of 152 on the scale. The reason for this was analyzed as 81% of the subjects included in this study understood narrative medicine. Most of the study subjects have heard of narrative medicine, and even 73% of medical staff have attended relevant courses and systematic training, so the narrative competence of the subjects in this group was in the middle to upper level. The burnout score of medical staff was (2.03 ± 1.10), which was at the middle level according to the judgment criteria of burnout. The detection rate of burnout in this group was 66.3%, which was generally consistent with the research results of domestic scholars (Nie & Li, 2019). In this study group, the self-efficacy score of medical staff was (31.71 ± 5.93), which was slightly higher than that of domestic research scholars (T. Wang et al., 2022). and was at a good level. One important reason for this is that some of the survey respondents had received systematic training in narrative medicine, and they were able to use their narrative adjustment ability to adjust themselves more quickly.

6.1.2.2 Correlation analysis of medical staff's narrative competence, self-efficacy and burnout

The results of this study showed that medical staffs' narrative competence was positively correlated with self-efficacy ($p < 0.001$), indicating that medical staffs with greater narrative competence would have higher self-efficacy. Medical staffs with high narrative competence can

establish a good narrative connection with self, family members, colleagues and patients. They can quickly obtain useful information from communication with others, discover patients' narrative demands, get expected responses, improve their work ability, and then enhance their self-confidence.

Narrative competence was negatively correlated with burnout ($p < 0.001$), that is, medical staffs with higher narrative competence were less likely to suffer from burnout. In the context of narrative medicine, the only antidote to burnout is to establish a horizontal interpersonal narrative relationship with family members, colleagues and patients (X. L. Yang, 2023). Medical staffs with high narrative competence are a life subject with intimate narrative connection. They enjoy the communication, communication and cooperation with others. They will not regard patients as "tasks" or themselves as "robots" or "machines" that can only work on an on, and are not easily trapped in a professional narrative foreclosure (X. L. Yang et al., 2021). They can be empowered in narrative interaction and enhance professional identity, thus alleviating burnout.

Self-efficacy was negatively correlated with burnout ($p < 0.001$), that is, the higher self-efficacy, the less likely to develop burnout, which is consistent with the findings of C. Xu et al. (2022), Yu et al. (2021). Medical staffs with high self-efficacy believe that they can well handle various emergencies encountered at work, set higher goals for themselves, and maintain a more positive attitude to do things. Therefore, medical staff with high self-efficacy can find self-value in their work, reduce emotional exhaustion and low sense of achievement, so their burnout level is low.

6.1.2.3 Self-efficacy plays a partially mediating role between medical staffs' narrative competence and burnout

Research shows that clinical staffs narrative competence had a direct negative predictive effect on burnout ($P < 0.001$), and self-efficacy partially mediated the relationship between narrative competence and burnout, with the mediating effect accounting for 40.00% of the total effect ($P<0.001$), indicating that narrative competence not only directly predicts the level of burnout, but also indirectly influences medical staffs' burnout through self-efficacy level. When staffs have a high level of narrative competence, in trouble or emergencies, they can quickly use their abilities of attention, representation, affiliation and reflection to cope with difficulties and make decisions ,In this way, they can obtain positive feedback and a sense of accomplishment, make them have a more positive perception of work, have a sense of professional mission, reduce the occurrence of emotional exhaustion and dehumanization, thereby reducing their level of

professional burnout.

This study showed that the improvement of clinical staffs' narrative competence could prevent the occurrence of burnout, and self-efficacy played a partial mediating role between narrative competence and burnout. Based on this, it is suggested that nursing managers should take the theory of Chinese narrative medical system as the framework to strengthen the training of clinical staff's narrative competence and create a harmonious narrative ecological environment. Clinical staffs should use others' positive or successful life stories as the carrier to project others' beliefs onto themselves, enhance self-confidence, and at the same time establish multi-dimensional interpersonal narrative connection with family members, medical seniors or peers, patients and their families and even hospital leaders. Only in this way can clinical staffs gain a sense of professional identity, maintain physical and mental health, and empower individuals to get out of the crisis of burnout, thus promoting the development of China's health industry.

6.1.2.4 Personal and organizational attribution analysis of medical professional burnout

First, professional characteristics are the fundamental factor of burnout among medical staff. Under the national conditions that China's medical services are in short supply relative to the vast number of patients, patients place high expectations on doctors, and the special nature of their occupation and environment make medical staff a high-risk group for burnout (Zhou et al., 2020). In the coding analysis, it was found that 78% of the respondents explicitly mentioned that their work was stressful, and that scientific research, promotion, and appraisal were pushing medical staff into the abyss of burnout. As some interviewees said, "the pressure of work is particularly high; there is only work all day long, but no life, and the work is mechanized every day." In essence, it is caused by the particularity of the medical profession. in which doctors treat themselves as a "tool" for completing their work, in other words, depersonalization, that is, the "objectification" of the subject.

Second, their own factors are the internal factors of medical professional burnout. During the interview, it was found that medical staff was satisfied with the status quo (falling into goal-oriented narrative foreclosure), psychosomatic condition (unable to develop self-narrative regulation after experiencing trauma and falling into trauma narrative foreclosure; experiencing frustration at work and having deep doubts about their own abilities and career choices, falling into doubt narrative foreclosure), their own ability (weak self-narrative regulation of daily stress), family relationship (weak family narrative connection resulting in relationship tension or chronic distress from difficulty helping family members out of difficult situations) are all the

causes of job burnout. People have different personality traits, and some interviewees reported that they felt “psychologically exhausted after facing pain and death for a long time” and “a sense of powerlessness and frustration when encountering patients with very serious conditions”.

Thirdly, hospital factors and patient factors are the direct factors of medical professional burnout. Hospital factors are divided into hospital hardware conditions and hospital soft power. The lack of human, financial and material resources in the hospital will directly affect the work experience and work efficiency of doctors. In this interview, some interviewees suggested that due to the lack of human resources, the secondment of the department staff would lead to an increase in the workload of the doctors in the seconded department, but these do not seem to be the most important factors. More interviewees mentioned the situation of disconnected interpersonal narratives in the workplace. where managers only emphasize effectiveness and do not care about the process, and do not respect the stories of their staff, and the uncoordinated atmosphere of narratives within the department and the difficulty of sharing their stories with their colleagues, all of which can lead to a state of isolation and becoming isolated individuals of life.

Finally, patient factors also occupy a very important proportion. In this interview, 32% of the interviewees said that they felt even more physically and mentally exhausted when facing patients’ dissatisfaction, complaints, and medical disputes. For example, “I feel frustrated and do not want to continue”, “I have paid a lot but not only received no reward, but received bad words”, “I have encountered family members of patients who are deliberately provoking” ... When dealing with these adverse emotions and pressures, doctors need to expend emotional energy. If energy is continuously consumed without rest, they will encounter emotional exhaustion.

6.1.3 A study of the countermeasures of using the narrative hospital management concept to alleviate burnout

6.1.3.1 The organizational level

Many studies have shown that individuals are less likely to experience burnout if they are part of an organization that provides ongoing humanistic and existential support to the individual. In other words, in addition to the autonomous interventions of the individual, organizational intervention at the management level is also very important to intervene in job burnout.

At the organizational level, we can:

(1) Build a narrative sharing platform and create a tangible physical environment

The construction of hospital narrative ecology requires two aspects of supportive environment: tangible physical environment and intangible psychological environment. The physical environment is the narrative sharing platform built by the hospital to create a good narrative atmosphere. A hospital with a good narrative ecology should set up physical spaces such as narrative sharing center, narrative mind harbor, narrative warming bar, narrative coffee house, to provide a physical space for the narratives of the medical staff, so that their emotions, pressures, and doubts can be expressed, released, and solved in it.

In addition, hospitals should actively promote the concept of narrative medicine by carrying out many form-rich peer narrative sharing sessions, narrative speech contests, doctor-patient narrative reading club and other activities to form a bond that drives all medical staff to participate in narrative. At the same time, hospitals should take the advantage of the development of new media to shoot short videos and conduct live broadcasts, so that more people can see the stories of doctors and provide a platform for them to display their narratives. Many interviewees said they could explore the pressure of work, family, children's education and other aspects in their narratives. Hospitals cultivate medical staff's bio-health narrative competency (the foundation of doctors' narrative competency) from the organizational level, and enhance the ability to prevent professional narrative foreclosure, which in itself can help employees actively integrate into their families and society and alleviate burnout.

(2) Improve the narrative leadership of administrators, and build a good narrative ecology

Hospital narrative ecology is a metaphor of the soft environment in the medical context. In order to create a good narrative ecology, it needs to be led by the management of hospitals and departments with good narrative management awareness, with top-down support and promotion, and all doctors participating in narrative interaction and narrative communication to form a complete narrative ecology (X. L. Yang et al., 2024). Hospital administrators are the "leaders" in the construction of hospital narrative ecology, and improving the narrative quotient and narrative leadership of administrators is a key part of alleviating the job burnout of doctors.

During the interview, some interviewees mentioned that the director would share their stories and experiences through regular meetings or private conversations, and the care and attention of the leaders could release their emotions. Hospital administrators should use daily accumulated narrative wisdom and narrative capital to gain insights into the causes behind burnout, and make positive narrative interventions to regulate it. For example, conduct warm narrative care and sharing activities for new employees, retired employees and employees in

important transition period; conduct one-on-one talk, focus on the interest demands and value positions of doctors, and guide doctors with different personalities out of job burnout.

The narrative empowerment relationship is established between hospital managers with narrative management thinking and young doctors. Millennial young medical staff or "Generation Z" were born and raised in an era when the Internet is popularized and electronic products are rampant. The objective environment makes them lack the ability to self-narrative adjustment. They are prone to strained relationships with their leaders after being criticized, blamed and lectured to, becoming more reluctant to follow orders from their supervisors, and even experiencing narrative foreclosure or burnout, which can ultimately either lead to more serious consequences for the organization or to leaving or resigning from the job, In turn, when a manager can show narrative humility and horizontal tolerance, giving young people a chance to reflect on themselves, it can empower their long-term development.

In the context of narrative hospital management, hospitals as an organization, the first key for the hospital managers to carry out organizational value reconstruction is to make the management "shift from control to narrative empowerment". As Bill Gates said, "As we look ahead into the next century (the 21st century), great leaders will be those who empower others" (Taricani, 2021). Empowering employees or people under management to be self-driven and self-growth is the trend of the times. The narrative empowerment of hospital managers covers three aspects: first, the self-narrative empowerment of hospital managers; second, hospital managers' narrative empowerment for hospital employees to realize the endogenous tension of the organization; third, the hospital administrators empower the narrative ecology of the hospital to attract more external excellent personnel to join, enrich the roots of narrative ecology and realize the virtuous cycle of narrative ecology.

6.1.3.2 The Personal and interpersonal level

On a personal level, we can:

(1) Cultivate the narrative competence, and improve the built-in narrative competency of the doctors

The professional narrative competence of medical staff is a soft indicator of whether they have the spirit of humanistic care and whether the profession can achieve sustainable development. Doctors' narrative competency is directly related to the maturity of their narrating self. The stagnation in the growth of the narrating self leads doctors to life burnout, and the stagnation in the development of the professional narrating self leads doctors to professional burnout. Life burnout and professional burnout are positively correlated, and for the healthcare

industry, which deals with human life and health, the growth of both the narrating self and the professional narrating self is related to the life safety and health quality of oneself and the service object. Combining narrative management concepts and interview results, we believe that medical staff' narrating self and professional narrating self must improve their maturity from the following aspects:

First of all, perform narrative integration adjustment. The doctor reviews his own life story and anticipates and looks forward to the future life story. For example, one of the respondents in this interview mentioned that "when individuals are suddenly faced with a large amount of urgent, unstructured, and important work during their return home from an epidemic, they will rebuild a sense of satisfaction and fulfillment in their careers through self-composition." By reviewing the meaningful and valuable stories of one's career, one can value your professional value and goals.

Secondly, narrative reading adjustment should be made. Doctors should read books containing stories which describe situations similar to their own life or work. Read the growth stories of professional idols or medical predecessors, so as to gain the motivation for career development and stimulate the enthusiasm for the medical career. Reading narratives of the other contemporary clinician authors can enhance the maturity of their workplace narrating self. As William Olser (Fletcher & Fletcher, 1997) says, "Books are tools, doctors are craftsmen, and so truly as one can measure the development of any particular handicraft by the variety and complexity of its tools, so have we no better means of judging the intelligence of a profession than by its general collection of books. A physician who does not read soon sinks to the level of the cross-counter prescriber, and not alone in practice, but in those mercenary feelings and habits which characterize a trade". Narrative reading adjustment can help clinicians conduct in-depth examinations to find the causes and mechanisms of professional burnout, and finally achieve enlightenment, make self-adjustments, and release stress.

Then, conduct the narrative writing adjustment. The medical staff's narrative writing can truly go into the heart and gain internal drive. We transform our experiences into visible and readable material texts in the form of diaries, poems, paintings and parallel narrative medical charts. Writing is an effective medium to reduce stress after a long and intensive day's work. Especially for doctors who have experienced traumatic events, narrative writing is the most effective way to regulate. During the writing process, doctors reflect on their own behavior, organize their thinking, listen to their inner voices, and build a close relationship with themselves, thereby resolving stress and confusion and achieving reconciliation with themselves.

Finally, make narrative sharing. In the context of narrative medicine, doctors should establish narrative connections with managers, colleagues, and family members to share what they encounter and feel, so as to gain opportunities to understand and express themselves, and to gain opportunities to connect with others. Narrative sharing can reduce the isolation of individual physicians. In this analysis, some doctors said: "Share their own experiences with colleagues", "Narrate stories about work encounters to arouse the resonance of other colleagues. At the same time, listen to what others share and find ways to solve difficulties." Not everyone has good self-narrative adjustment ability. Doctors with low self-narrative adjustment ability need to turn to people with high narrative competency to obtain "narrative prescriptions" in narrative interactions, so as to get out of the professional dilemma.

(2) Conduct narrative communication and establish narrative connection with patients

Patients are important life subjects in the doctor-patient narrative community. A healthy narrative relationship requires a good narrative connection with the patient.

First, learn to listen to narrative. When listening to patients' stories, doctors assume the responsibility of the listener and can use their narrative imagination according to their own rhythm to imagine the patient's situation, and find stories that can respond to the patient from their own narrative capital., so that the patient's prescription for treatment is also a "narrative prescription". Medical institutions can set up positions similar to "listening directors." At present, the Affiliated Hospital of Southern Medical University and some other domestic hospitals have launched "narrative directors", who have doctors with good narrative competency to carry out "narrative rounds" and supervise doctors to listen to patients' stories (X. L. Yang et al., 2024).

Secondly, make narrative empathetic response. For doctors, narrative listening is standard and empathetic response is high standard (X. L. Yang, 2023). The doctor responds after patiently listening and guides the patient to tell his traumatic experience so that the patient's story can be understood, accepted, and empathized with. When communicating with patients and their families, transform the obscure and difficult terminology into heart-warm and easy-to-understandable language, transforms indifference into enthusiasm, and pay attention to the situation of the patient. When initiating conversations, start with everyday conversations, such as asking if the patient has had dinner or talking about the weather today. Instead of treating the patient as a machine with a broken part, they include it in the relationship network of the doctor-patient narrative community.

Thirdly, in this interview, some interviewees mentioned that he would share the success

stories of other patients with patients to give them hope, or share the written parallel narrative cases and reflections with patients, so that he himself could be understood by patients while caring for them. Reduce the contradiction between doctors and patients, ease the tense doctor-patient relationship, and frees doctors from quarrels and complaints, so they no longer have to feel exhausted and mentally exhausted.

6.1.4 Response to research questions

For question 1, this article systematically revealed the internal and external attribution mechanisms of burnout in medical practitioners through comprehensive analyses of quantitative and qualitative data within the framework of Narrative hospital management. The intrinsic root cause is reflected in the lack of narrative competency among medical practitioners. The results of data analysis showed that both the narrative cognitive competence and narrative behavioral ability of medical practitioners were significantly negatively correlated with the level of burnout, and that medical practitioners with higher narrative competency were better able to establish a positive sense of professional meaning and belonging through the enhancement of bio-health narrative literacy and clinical narrative thinking, as well as the establishment of multiple narrative community through narrative interconnectedness among doctors and patients, peers and families, which led to a lower incidence of burnout.

The external underlying cause stems from the lack of a narrative ecology in hospitals. Studies have shown that burnout rates are significantly higher ($p<0.001$) in medical institution that do not have a narrative centre. The root cause of this is that hospitals over-emphasize process standardization under evidence-based management models, neglecting the intersubjective narrative needs of employees, leading to a breakdown in interpersonal connections and a weakened sense of belonging to the organization. For example, 78% of the 52 interviewees mentioned that “managers only focus on performance indicators, not employee’s personal stories”, confirming that the lack of narrative ecology exacerbates the vicious circle of burnout. Therefore, the concept of narrative provides a theoretical framework with both depth and breadth to explain burnout in healthcare professionals, and reveals the mechanism of the two dimensions of “competency-ecology”.

For question 2, this article verifies the feasibility of intervening in burnout at both the organizational and individual levels through the practical application of narrative hospital management theory. At the organizational level, through the construction of the “Narrative Centre Project”, the improvement of the narrative sharing mechanism, and the cultivation of a narrative organizational culture, hospitals can effectively create a safe, supportive, and

symbiotic narrative ecosystem, enhance the sense of belonging and professional identity of medical staff, and alleviate the pressure of medical staff in the areas of colleague relations and doctor-patient interactions. At the individual level, through systematic narrative medicine training, narrative writing and narrative sharing, doctors are able to improve their professional narrative competence, and then establish positive professional identity and enhance self-efficacy (e.g., Nurse H reconstructed her family relationship through narrative reading). In this article, it was verified that the enhancement of narrative competency not only directly reduced the level of burnout, but also further buffered the occurrence of burnout through the mediation of self-efficacy. Thus, narrative hospital management demonstrates effective burnout governance potential in a multidimensional, cross-level intervention design.

For question 3, based on the systematic analysis of empirical data from the implementation of the narrative center project and narrative interviews to construct the four-factor model of professional burnout (professional, personal, hospital, and patient) and the dual-path model of narrative empowerment (organizational narrative ecology and personal narrative competency), which provide empirical support and expansion direction for narrative hospital management theory.

This model provides empirical support and expansion direction for the theory of narrative hospital management. First, the model reveals the “leverage effect” of narrative ecology: hospital narrative centre is not only a physical space, but also a medium of value symbiosis, which directly reduces burnout rate (β=-0.116, $p<0.001$) and indirectly improves the quality of medical service (e.g., director of nursing E reduces disputes through narrative mediation), and indirectly improves the quality of medical service (e.g., director of nursing E reduces disputes through narrative mediation). E reduces disputes through narrative mediation).

Secondly, the 52 typical stories in the qualitative cases (such as young doctor G resolved doctor-patient conflicts through narrative communication) provided contextualized explanations for the theory. This demonstrates the ability of narrative management to integrate “objectivity in evidence-based medicine” with “subjectivity in narrative medicine”, facilitating the transformation of hospitals from “technology-first” to “humanistic empathy”. Ultimately, this theoretical framework provides a new paradigm for hospitals’ high-quality development: cultivating “soft power” through narrative ecology, and taking staff’s physical and mental health as the cornerstone, realizing the dual enhancement of medical service efficiency and humanistic care, and responding to the strategic needs of “Healthy China 2030”.

6.2 Conclusion

Medical professional burnout is related to the collapse of hospital culture or organizational management's perception of "intersubjectivity". In the era of evidence-based medicine, which emphasizes objective evidence and quantitative data, hospitals, as management institutions, attach too much importance to instrumental and productivity management of their employees, but lack the subjective, intrinsic and spiritual humanistic nutrients and existence support and supportive management of their being. The doctor regard himself as a technical being and a service-oriented superhuman or materialized being, and ignore the important value of multi-dimensional narrative connection in the medical context. As Epstein (2017) mentioned in *Attending: Medicine, Mindfulness, and Humanity*, without the internal scaffolding of mature narrating self and mental stability, and the external scaffolding of peer and institutional narrative support, no one can be expected to respond humanely to the experiences of illness and life tragedies of others. In this process, the doctor alienated from his patients as well as from himself. Narrative is the most effective "antidote" for the emotional indifference and numbness of doctors, and it is a bridge connecting humanity (X. L. Yang & Wang, 2023).

One of the most important purposes of the construction of Chinese narrative hospital management theory is to create a good hospital narrative ecology, enhance the professional identity of doctors, improve the medical environment, and alleviate job burnout. As a potential subject under the background of the new medical, the narrative hospital management is injecting inexhaustible impetus into the sustainable development of medical professional, either tangibly or intangibly. This study explores medical professional burnout from a new dimension, aiming to make individual doctors and hospital organizations realize that the tension and contradiction between doctors' subjective needs and objective reality are the deep-rooted causes of professional burnout and advocates hospital management actively create a harmonious and heart-warming hospital narrative ecology. At the same time, inspire doctors to take the initiative to improve their family narrative connection, doctor-patient narrative communication skills, and peer narrative interaction awareness, and actively use narrative to empower organizations and empower individuals to surmount and get out of the organizational and personal crisis caused by burnout.

Hospital managers with narrative leadership consciousness are like the White Knight in *Good Luck: Creating the Conditions for Success in Life and Business*, dedicated to patiently creating an environment suitable for clover to grow. However, most hospital managers lack

narrative leadership or narrative wisdom. They are more like the Black Knight, who manage the day-to-day work like a doctor, taking stopgap measures, and do not have a holistic sense of whole-person management. They blindly build hospital buildings, buy advanced medical equipment everywhere, and spend a lot of money to introduce medical talents. However, high-level medical talents are often lost due to "not acclimatized". The spacious hospital building and expensive medical instruments and testing equipment did not lead to improved patient satisfaction and improved medical service standards. The hospital did not usher in high-quality development. On the contrary, the hospital leadership ultimately missed the golden opportunity for high-quality development of the hospital.

If a good hospital narrative ecology cannot be established and the whole hospital is desolate and lifeless, the development of every individual in the hospital will become water without a source and a tree without roots. In the context of narrative hospital management, hospital leaders should first focus on the internal and external environment required for the high-quality development of the hospital, so that every leader and employee who works silently on this environment has the magical power of narrative, and everyone can make the best use of their talents and materials, thrive in the best hospital narrative ecology, nourish each other, contribute ideas and put in practice and efforts for the high-quality development of the hospital. As long as the hospital leaders are willing to take actions and efforts to actively create a good and harmonious hospital narrative ecology, they will obtain or construct the best hospital narrative ecology necessary for the high-quality development of the hospital, which is also the most direct embodiment of the "soft power" and "warm power" of the hospital.

Narrative leadership can be regarded as a kind of "meta-leadership", which is an important foundation for leaders to develop all other leadership qualities; narrative management is a practical path for leaders to show their narrative wisdom. If the hospital narrative ecology is harmonious and healthy, leaders at all levels of the hospital can give full play to their flexible narrative leadership and narrative management. On the contrary, every employee in the hospital is bound to develop a decadent or negative mentality. In the context of big health, the relationship of all dimensions is bound to lead to poor communication due to the weak narrative connection, and various contradictions emerge one after another. When clinical front-line doctors work in a state of fear, patients' medical experience is bound to be very poor, and it is difficult to ensure the improvement of patient satisfaction. Finally, the improvement of medical service level has become an empty talk.

Whether the hospital narrative ecology is healthy and harmonious depends on the narrative consciousness, narrative competency and narrative wisdom of the hospital leadership. If every

manager of the hospital becomes a respected and beloved “white knight”, then the lucky grass will take root and sprout everywhere in the hospital, and it will be full of vitality. It is foreseeable that if hospital managers, employees, patients and patients’ families can grow up healthily in a harmonious hospital narrative ecology like clover, then every hospital employee, patient and patient’s family will be empowered by the narrative wisdom of the hospital management, which in turn will stimulate unlimited enthusiasm and creativity of the staff. At the same time, patients’ compliance and cure rate will be greatly improved, the doctor-patient relationship will be more harmonious.

Management is no small matter, especially the hospital management. Through the publication and distribution of the first *Narrative Hospital Management: From Lean Management to Value symbiosis*, hospital managers around the country will be able to learn the essence of narrative hospital management from this book and develop and improve it in practice by combining it with the specific realities of different regions, cultures and hospitals; through the event of narrative hospital management, more hospital leaders can cultivate more lucky grasses and pass luck and warmth to more hospitals, more medical staff, more patients, and more people, so as to provide a steady stream of motivation and wisdom support for the high-quality development of hospitals. The author sincerely looks forward to working hand in hand with hospital managers across the country to improve hospital management to a new height, consolidate the humanistic foundation for high-quality development, promote the progress of medicine and social harmony, and realize the grand goal of “Healthy China 2030 Plan” as soon as possible.

6.3 Contributions

Focusing on the core issue of ‘Healing the healer’, this study pioneered the construction of the theoretical system of narrative hospital management and systematically explored the issue of burnout in medical practitioners, which provides a new perspective for the development of the discipline of medical management.

In terms of theoretical contributions, this study fills the research gap of narrative medicine in the field of hospital management, breaks through the traditional hospital management model focusing on technology improvement and efficiency enhancement, puts forward the concept of ‘narrative hospital management’, and constructs a set of systematic frameworks to optimize the professional environment of medical staff and improve the quality of healthcare services through narrative strategies and narrative ecology. This theoretical innovation not only deepens

the research dimension of narrative medicine but also provides theoretical support for the interdisciplinary integration of medical management disciplines.

For the practical application, based on the complexity of China's healthcare system, this study provides an in-depth analysis of the causes of burnout among healthcare workers through research data from several hospitals, and proposes a hospital management optimization strategy centered on narrative medicine. The study found that establishing a narrative culture in hospitals, optimizing the communication mechanism between doctors and patients, and constructing a support system for healthcare workers can effectively alleviate burnout, improve the sense of professional identity and well-being of medical staff, and ultimately promote the quality of healthcare services. This result provides operable practice guidelines for hospital managers and helps to promote domestic healthcare organizations to move towards a more humane and sustainable development.

This study not only opens up a new research direction for the deep integration of narrative medicine and hospital management but also provides a solid foundation for subsequent in-depth research. Subsequent research should break through and go deeper into medical institutions at different levels to explore more universal management strategies. At the same time, it should combine artificial intelligence technology to build an intelligent narrative management system to achieve accurate assessment and intervention of physician burnout. In addition, the research results can also provide a scientific basis for policy optimization and promote the promotion and application of the narrative hospital model nationwide. Ultimately, through the deep integration of narrative medicine, hospital management can be promoted to develop in a warmer and more humane direction, so that every medical staff can provide patients with better health care services in a good narrative ecology.

However, narrative medicine is still in its infancy in China, and research in related fields is not yet extensive and in-depth. Sustained efforts are still needed to achieve a comprehensive improvement in narrative medicine literacy and to strengthen the awareness of the importance of narrative medicine among society and medical personnel. In such a grand context, this study can be considered as a solid start and an important contribution to the development of narrative medicine. By introducing narrative medicine into hospital management, especially exploring the issue of burnout among medical practitioners, this study provides a new theoretical framework for hospital management, promotes the integration of narrative medicine thinking and management models, and demonstrates the important potential of narrative medicine in enhancing the work experience of medical staff and the quality of medical services.

Therefore, this study is not the end point, but the starting point for an in-depth exploration

of narrative hospital management models. Chinese medical institutions have unique complexities in terms of their institutions and management, and future research should further break through the current framework to explore in depth the application of narrative medicine in different levels and types of healthcare organizations, and to search for laws and strategies with broad applicability. As the scope of research continues to expand, the concept of narrative medicine will continue to inject new impetus into the development of hospital management in China, and provide theoretical support and practical guidance for the construction of a more humane and warmer healthcare environment so that every medical staff can not only improve their professional competence, but also obtain a higher sense of occupational well-being in a good narrative ecology, thus promoting the whole healthcare industry towards a more humanistic direction.

Bibliography

Aboumatar, H. J., Weaver, S. J., Rees, D., Rosen, M. A., Sawyer, M. D., & Pronovost, P. J. (2017). Towards high-reliability organising in healthcare: A strategy for building organisational capacity. *BMJ Quality & Safety*, *26*(8), 663-670.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*, *288*(16), 1987-1993.

Alcauskas, M., & Charon, R. (2008). Right brain: Reading, writing, and reflecting: Making a case for narrative medicine in neurology. *Neurology*, *70*(11), 891-894.

Anderson, R., & Cissna, K. N. (1997). *The Martin Buber-Carl Rogers dialogue: A new transcript with commentary*. State University of New York Press.

Bagnall, A., Jones, R., Akter, H., & Woodall, J. (2016). *Interventions to prevent burnout in high risk individuals: Evidence review.* Public Health England.

Bajaj, N., Phelan, J., McConnell, E. E., & Reed, S. M. (2023). A narrative medicine intervention in pediatric residents led to sustained improvements in resident well-being. *Annals of Medicine*, *55*(1), 849-859.

Balch, C. M., Oreskovich, M. R., Dyrbye, L. N., Colaiano, J. M., Satele, D. V., Sloan, J. A., & Shanafelt, T. D. (2011). Personal consequences of malpractice lawsuits on American surgeons. *Journal of the American College of Surgeons*, *213*(5), 657-667.

Balch, C. M., & Shanafelt, T. D. (2018). The role of leaders, supervisors, and individual surgeons in reducing burnout and promoting physician wellness. In C. Scoggins, R. Pollock, & T. Pawlik (Eds.), *Surgical mentorship leadership: Building for success in academic surgery* (pp. 267-282). Springer.

Baldwin, C. (2013). Living narratively: From theory to experience (and back again). *Narrative Works*, *3*(1), 98-117.

Barello, S., Palamenghi, L., & Graffigna, G. (2020). Burnout and somatic symptoms among frontline healthcare professionals at the peak of the Italian COVID-19 pandemic. *Psychiatry Research*, *290*, 113129.

Barends, E., & Rousseau, D. M. (2018). *Evidence-based management: How to use evidence to make better organizational decisions*. Kogan Page Publishers.

Barker, R. T., & Gower, K. (2010). Strategic application of storytelling in organizations: Toward effective communication in a diverse world. *The Journal of Business Communication (1973)*, *47*(3), 295-312.

Becker, J., & Dickerman, M. (2021). 951: Impact of narrative medicine curriculum on burnout in pediatric critical care trainees. *Critical Care Medicine*, *49*(1), 473.

Benner, P. (1982). From novice to expert. *The American journal of nursing*, *82*(3), 402-407.

Birigwa, S. N., Khedagi, A. M., & Katz, C. J. (2017). Stop, look, listen, then breathe: The impact of a narrative medicine curriculum on pediatric residents (descriptive Abstract). *Academic Pediatrics*, *17*(5), e40-e41.

Blanch, A., & Aluja, A. (2012). Social support (family and supervisor), work–family conflict, and burnout: Sex differences. *Human Relations*, *65*(7), 811-833.

Blanchard, P., Truchot, D., Albiges-Sauvin, L., Dewas, S., Pointreau, Y., Rodrigues, M., Xhaard, A., Loriot, Y., Giraud, P., & Soria, J. (2010). Prevalence and causes of burnout amongst oncology residents: A comprehensive nationwide cross-sectional study. *European Journal of Cancer*, *46*(15), 2708-2715.

Boje, D. M. (2017). The storytelling organization: A study of story performance in an office-supply firm. In S. Minahan (Ed.), *The aesthetic turn in management* (pp. 211-231). Routledge.

Bostanli, L., & Habisch, A. (2023). Narratives as a tool for practically wise leadership: A comprehensive model. *Humanistic Management Journal*, *8*(1), 113-142.

Brady, K. J., Trockel, M. T., Khan, C. T., Raj, K. S., Murphy, M. L., Bohman, B., Frank, E., Louie, A. K., & Roberts, L. W. (2018). What do we mean by physician wellness? A systematic review of its definition and measurement. *Academic Psychiatry*, *42*(1), 94-108.

Briner, R. B., Denyer, D., & Rousseau, D. M. (2009). Evidence-based management: Concept cleanup time? *Academy of Management Perspectives*, *23*(4), 19-32.

Brockington, G., Gomes Moreira, A. P., Buso, M. S., Gomes da Silva, S., Altszyler, E., Fischer, R., & Moll, J. (2021). Storytelling increases oxytocin and positive emotions and decreases cortisol and pain in hospitalized children. *Proceedings of the National Academy of Sciences*, *118*(22), e2018409118.

Butcher, L. (2019). Neurologists find an antidote to burnout through narrative medicine. *Neurology Today*, *19*(8), 40-41.

Callahan, D. (1998). Managed care and the goals of medicine. *Journal of the American Geriatrics Society*, *46*(3), 385-388.

Carthon, J. M. B., Hatfield, L., Brom, H., Houton, M., Kelly-Hellyer, E., Schlak, A., & Aiken, L. H. (2021). System-level improvements in work environments lead to lower nurse burnout and higher patient satisfaction. *Journal of Nursing Care Quality*, *36*(1), 7-13.

Cassel, E. J. (1982). The nature of suffering and the goals of medicine. *New England Journal of Medicine*, *306*(11), 639-645.

Chambers, R., Gullone, E., & Allen, N. B. (2009). Mindful emotion regulation: An integrative review. *Clinical Psychology Review*, *29*(6), 560-572.

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. *Jama*, *286*(15), 1897-1902.

Charon, R. (2007). What to do with stories: The sciences of narrative medicine. *Canadian Family Physician*, *53*(8), 1265-1267.

Charon, R. (2015). *叙事医学：尊重疾病的故事* [Narrative medicine: Honoring the stories of illness] (L. P. Guo, Trans.). Peking University Medical Pres.

Charon, R., Hermann, N., & Devlin, M. J. (2016). Close reading and creative writing in clinical education: Teaching attention, representation, and affiliation. *Academic Medicine*, *91*(3), 345-350.

Cheng, X., Tang, C. M., Chen, L., Yang, L., Mei, J. H., & Wang, L. H. (2019). 湖北省三甲医院医生职业倦怠干预情况调查 [Investigation on the intervention of career burnout of physicians in Third-A-Grade hospitals of Hubei province]. *Medicine and Philosophy*, *40*(18), 55-58.

Chu, S. Y., Wen, C. C., & Lin, C. W. (2020). A qualitative study of clinical narrative competence of medical personnel. *BMC Medical Education*, *20*(1), 1-13.

Clandinin, D. J. (2022). *Engaging in narrative inquiry*. Routledge.

Clough, B. A., March, S., Chan, R. J., Casey, L. M., Phillips, R., & Ireland, M. J. (2017). Psychosocial interventions for managing occupational stress and burnout among medical doctors: A systematic review. *Systematic Reviews*, *6*(1), 144.

Cole, T. R., & Carlin, N. (2009). The suffering of physicians. *The Lancet*, *374*(9699), 1414-1415.

Cooren, F. (2001). Translation and articulation in the organization of coalitions: The great whale river case. *Communication Theory*, *11*(2), 178-200.

Cushing, H. (1925). *The life of sir William Osler* (Vol. 2). Clarendon Press.

Darzi, A. (2018). *Better health and care for all: A 10-point plan for the 2020s*. Institute for

Public Policy Research.
Daskal, L. (2017). *The leadership gap: What gets between you and your greatness*. Penguin.
Davis, M., & Henderson, B. M. (1929). Hospital administration: A career. *The American Journal of Nursing*, *29*(5), 627.
DeChant, P. F., Acs, A., Rhee, K. B., Boulanger, T. S., Snowdon, J. L., Tutty, M. A., Sinsky, C. A., & Craig, K. J. T. (2019). Effect of organization-directed workplace interventions on physician burnout: A systematic review. *Mayo Clinic Proceedings: Innovations, Quality Outcomes*, *3*(4), 384-408.
De Janasz, S. C., Crossman, J., Campbell, N., & Power, M. (2014). *Interpersonal skills in organizations*. McGraw-Hill.
Denning, S. (2006). Effective storytelling: Strategic business narrative techniques. *Strategy & Leadership*, *34*(1), 42-48.
Diorio, C., & Nowaczyk, M. (2019). Half as sad: A plea for narrative medicine in pediatric residency training. *Pediatrics*, *143*(1), e20183109.
Doolittle, B. R., Windish, D. M., & Seelig, C. B. (2013). Burnout, coping, and spirituality among internal medicine resident physicians. *Journal of Graduate Medical Education*, *5*(2), 257-261.
Drake, D. (2017, February). *Using attachment theory to develop coaching capabilities in managers and leaders*. Consulting Psychology Conference: The Next Wave of Leadership, Seattle, WA, America.
Dunbar, R. I. (2020). Structure and function in human and primate social networks: Implications for diffusion, network stability and health. *Proceedings of the Royal Society A*, *476*(2240), 20200446.
Dyrbye, L., & Shanafelt, T. (2016). A narrative review on burnout experienced by medical students and residents. *Medical Education*, *50*(1), 132-149.
Dyrbye, L. N., Harper, W., Durning, S. J., Moutier, C., Thomas, M. R., Massie Jr, F. S., Eacker, A., Power, D. V., Szydlo, D. W., & Sloan, J. A. (2011). Patterns of distress in US medical students. *Medical Teacher*, *33*(10), 834-839.
Egnew, T. R. (2018). A narrative approach to healing chronic illness. *The Annals of Family Medicine*, *16*(2), 160-165.
Epstein, R. (2017). *Attending: Medicine, mindfulness, and humanity*. Simon and Schuster.
Fadlallah, R., El-Jardali, F., Nomier, M., Hemadi, N., Arif, K., Langlois, E. V., & Akl, E. A. (2019). Using narratives to impact health policy-making: A systematic review. *Health Research Policy Systems*, *17*(1), 1-22.
Feng, S. Y., Li, Z. J., Chen, Y. X., Yuan, Y. C., Chen, J., Zhou, Q. X., & Long, J. P. (2017). 社会支持干预对感染科护士职业倦怠的影响 [A study of the effect of the intervention of social support on nurses burnout indepartment of infectious diseases]. *Jilin Medical Journal*, *38*(02), 390-391.
Fisher, W. R. (1989). Clarifying the narrative paradigm. *Communications Monographs*, *56*(1), 55-58.
Fisher, W. R. (1994). Narrative rationality and the logic of scientific discourse. *Argumentation*, *8*(1), 21-32.
Fisher, W. R. (2021). *Human communication as narration: Toward a philosophy of reason, value, and action*. Univ of South Carolina Press.
Fletcher, R. H., & Fletcher, S. W. (1997). Evidence-based approach to the medical literature. *Journal of General Internal Medicine*, *12* (Suppl. 2), S5-S14.
Foucault, M. (1990). Right of death and power over life. In T. C. Campbell, & A. Sitze (Eds.), *The history of sexuality* (Vol. 1, pp. 135-159). Vintage Books.
Frank, L. B., Murphy, S. T., Chatterjee, J. S., Moran, M. B., & Baezconde-Garbanati, L. (2015). Telling stories, saving lives: Creating narrative health messages. *Health Communication*,

30(2), 154-163.
Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues*, *30*(1), 159-165.
Gardner, H. (2011). *Leading minds: An anatomy of leadership*. Basic Books.
Gawande, A. (2010). *Checklist manifesto, the (HB)*. Penguin Books India.
Gill, R. (2011). Using storytelling to maintain employee loyalty during change. *International Journal of Business and Social Science*, *2*(15), 23-32.
Gorusch, R. L. (1983). *Factor analysis* (2nd ed.). Lawrence Erlbaum Associates.
Green, D. E., Walkey, F. H., & Taylor, A. J. (1991). The three-factor structure of the Maslach burnout inventory: A multicultural, multinational confirmatory study. *Journal of Social Behavior Personality*, *6*(3), 453-472.
Greenfield, G., Ignatowicz, A. M., Belsi, A., Pappas, Y., Car, J., Majeed, A., & Harris, M. (2014). Wake up, wake up! It's me! It's my life! patient narratives on person-centeredness in the integrated care context: A qualitative study. *BMC Health Services Research*, *14*, 1-11.
Greenhaus, J. H., & Powell, G. N. (2006). When work and family are allies: A theory of work-family enrichment. *Academy of Management Review*, *31*(1), 72-92.
Guo, L. P. (2020). 叙事医学在中国：现状与未来 [Narrative medicine in China: Present and future]. *Medicine & Philosophy*, *41*(10), 72-92.
Guyatt, G., Cairns, J., Churchill, D., Cook, D., Haynes, B., Hirsh, J., Irvine, J., Levine, M., Levine, M., & Nishikawa, J. (1992). Evidence-based medicine: A new approach to teaching the practice of medicine. *Jama*, *268*(17), 2420-2425.
Han, B. C. (2015). *The burnout society*. Stanford University Press.
Harari, Y. N. (2017). *Homo Deus: A brief history of tomorrow*. Harper.
Heffernan, M. (2011). *Willful blindness: Why we ignore the obvious at our peril*. Walker & Company.
Hester, O. R., Bridges, S. A., & Rollins, L. H. (2020). 'Overworked and underappreciated': Special education teachers describe stress and attrition. *Teacher Development*, *24*(3), 348-365.
Hewitt, D. B., Ellis, R. J., Hu, Y.-Y., Cheung, E. O., Moskowitz, J. T., Agarwal, G., & Bilimoria, K. Y. (2020). Evaluating the association of multiple burnout definitions and thresholds with prevalence and outcomes. *JAMA Surgery*, *155*(11), 1043-1049.
Hodkinson, A., Zhou, A., Johnson, J., Geraghty, K., Riley, R., Zhou, A., Panagopoulou, E., Chew-Graham, C. A., Peters, D., & Esmail, A. (2022). Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis. *BMJ*, 14(378), e070442.
Hu, D., Kong, Y., Li, W., Han, Q., Zhang, X., Zhu, L. X., Wan, S. W., Liu, Z., Shen, Q., & Yang, J. (2020). Frontline nurses' burnout, anxiety, depression, and fear statuses and their associated factors during the COVID-19 outbreak in Wuhan, China: A large-scale cross-sectional study. *EClinicalMedicine*, *24*, 100424.
Hu, Z., Wang, H., Xie, J., Zhang, J., Li, H., Liu, S., Li, Q., Yang, Y., & Huang, Y. (2021). Burnout in ICU doctors and nurses in mainland China–a national cross-sectional study. *Journal of Critical Care*, *62*, 265-270.
Huang, Y. H., Du, P. l., Chen, C. H., Yang, C. A., & Huang, I. C. (2011). Mediating effects of emotional exhaustion on the relationship between job demand–control model and mental health. *Stress Health*, *27*(2), e94-e109.
Hurwitz, B., & Bates, V. (2016). The roots and ramifications of narrative in modern medicine. In W. A. Whitehead (Ed.), *The edinburgh companion to the critical medical humanities* (pp. 559-576). Edinburgh University Press.
Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary Therapies in Clinical Practice*, *15*(2), 61-66.

Jiang, A. L. (2018). 叙事护理的发轫与探究 [The genesis and exploration of narrative nursing]. *Shanghai Nursing*, *18*(1), 5-7.

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing*, *27*(1), 20-32.

Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of Behavioral Medicine*, *8*(2), 163-190.

Kok, N., Van Gurp, J., Teerenstra, S., Van Der Hoeven, H., Fuchs, M., Hoedemaekers, C., & Zegers, M. (2021). Coronavirus disease 2019 immediately increases burnout symptoms in ICU professionals: A longitudinal cohort study. *Critical Care Medicine*, *49*(3), 419-427.

Kotter, J. P., & Cohen, D. S. (2012). *The heart of change: Real-life stories of how people change their organizations*. Harvard Business Press.

Lapierre, L. M., Li, Y., Kwan, H. K., Greenhaus, J. H., DiRenzo, M. S., & Shao, P. (2018). A meta-analysis of the antecedents of work–family enrichment. *Journal of Organizational Behavior*, *39*(4), 385-401.

LeNoble, C. A., Pegram, R., Shuffler, M. L., Fuqua, T., & Wiper III, D. W. (2020). To address burnout in oncology, we must look to teams: Reflections on an organizational science approach. *JCO Oncology Practice*, *16*(4), e377-e383.

Lewis, B. (2016). Mindfulness, mysticism, and narrative medicine. *Journal of Medical Humanities*, *37*(4), 401-417.

Lewis, J. F. (2024). People don't quit their jobs; They quit their bosses. *Journal of Veterans Studies*, *10*(3), 19–22.

Li, C. P., & Shi, K. (2003). 分配公平与程序公平对工作倦怠的影响 [Impact of distributional equity and procedural equity on job burnout]. *Psychologist*, *35*(5), 677-684.

Li, F., Ning, X. H., Wang, J. L., & He, Z. (2022). 叙事病历临床应用的可能路径 [Possible approaches to clinical application of narrative medical records]. *Medicine & Philosophy*, *43*(6), 46-51.

Li, P. L. (2021). *共生管理：重塑商业伦理和企业价值观* [Value symbiosis: Reshaping business ethics and corporate values]. China Economic Press.

Liao, H. C., & Wang, Y. H. (2023). Narrative medicine and humanities for health professions education: An experimental study. *Medical Education Online*, *28*(1), 2235749.

Lijoi, A. F., & Tovar, A. D. (2020). Narrative medicine: Re-engaging and re-energizing ourselves through story. *The International Journal of Psychiatry in Medicine*, *55*(5), 321-330.

Liu, Y., & Liu, G. X. (2020). 临床医生职业倦怠现状及相关因素研究 [Job burnout in clinicians: Current status and related factors]. *Journal of Third Military Medical University*, *42*(03), 288-293.

Locke, K. (2011). Field research practice in management and organization studies: Reclaiming its tradition of discovery. *The Academy of Management Annals*, *5*(1), 613-652.

Lu, D. W. (2023). Sleep and burnout among health care professionals—the role of the individual. *JAMA Network Open*, *6*(11), e2341882-e2341882.

Maitlis, S., & Christianson, M. (2014). Sensemaking in organizations: Taking stock and moving forward. *Academy of Management Annals*, *8*(1), 57-125.

Malik, Z., Ahn, J., Schwartz, A., Blackie, M. J. A. E., & Training. (2023). Narrative medicine workshops for emergency medicine residents: Effects on empathy and burnout. *AEM Education and Training*, *7*(4), e10895.

Mao, F. X., Sun, J. Y., Yang, B., Wang, Y., Wang, J., & Cao, F. L. (2021). 护士功能性躯体症状与职业倦怠的关系 [The relationship between functional somatic symptoms and job

burnout among nurses]. *Chinese Journal of Mental Health*, *35*(12), 1031-1037.
Marini, M. G. (2015). *Narrative medicine: Bridging the gap between evidence-based care and medical humanities*. Springer.
Maslach, C. (1993). Historical and conceptual development of burnout. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 1-16). Taylor & Francis.
Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99-113.
Maslach, C., & Leiter, M. P. (2000). *The truth about burnout: How organizations cause personal stress and what to do about it*. John Wiley & Sons.
Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103-111.
Maslach, C., & Leiter, M. P. (2022). *The burnout challenge: Managing people's relationships with their jobs*. Harvard University Press.
Mathieu, F. (2012). *The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization*. Routledge.
McAdams, D. P. (1995). *The life story interview*. Northwestern University.
McAdams, D. P. (2006). The problem of narrative coherence. *Journal of Constructivist Psychology*, *19*(2), 109-125.
McGregor, I., & Holmes, J. G. (1999). How storytelling shapes memory and impressions of relationship events over time. *Journal of Personality and Social Psychology*, *76*(3), 403-419.
McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M., & Aiken, L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs*, *30*(2), 202-210.
McLean, K. C., & Thorne, A. (2006). *Identity light: Entertainment stories as a vehicle for self-development*. American Psychological Association.
Melamed, S., Shirom, A., Toker, S., & Shapira, I. (2006). Burnout and risk of type 2 diabetes: A prospective study of apparently healthy employed persons. *Psychosomatic Medicine*, *68*(6), 863-869.
Menon, N. K., Shanafelt, T. D., Sinsky, C. A., Linzer, M., Carlasare, L., Brady, K. J., Stillman, M. J., & Trockel, M. T. (2020). Association of physician burnout with suicidal ideation and medical errors. *JAMA Network Open*, *3*(12), e2028780-e2028780.
Messmer, M. (2000). *Managing your career for dummies*. Wiley.
Milota, M. M., van Thiel, G. J., & van Delden, J. J. (2019). Narrative medicine as a medical education tool: A systematic review. *Medical Teacher*, *41*(7), 802-810.
Moniz, T., Lingard, L., & Watling, C. (2017). Stories doctors tell. *Jama*, *318*(2), 124-125.
Montgomery, A., Todorova, I., Baban, A., & Panagopoulou, E. (2013). Improving quality and safety in the hospital: The link between organizational culture, burnout, and quality of care. *British Journal of Health Psychology*, *18*(3), 656-662.
Moss, J. (2020). Rethinking burnout: When self care is not the cure. *American Journal of Health Promotion*, *34*(5), 565-568.
Mueller, R. A. (2018). Book Review: Muller, Jerry Z.(2018). The tyranny of metrics. *International Journal on Food System Dynamics*, *9*(3), 302-305.
Murphy, J. W., Franz, B. A., & Schlaerth, C. (2018). The role of reflection in narrative medicine. *Journal of Medical Education Curricular Development*, *5*, 2382120518785301.
Nadar, S. (2019). "Stories are data with soul" 1: Lessons from black 2 feminist epistemology. In T. G. Oren, & A. L. Press (Eds.), *The Routledge handbook of contemporary feminism* (pp. 34-45). Routledge.
Naldi, A., Vallelonga, F., Di Liberto, A., Cavallo, R., Agnesone, M., Gonella, M., Sauta, M. D.,

Lochner, P., Tondo, G., & Bragazzi, N. L. (2021). COVID-19 pandemic-related anxiety, distress and burnout: Prevalence and associated factors in healthcare workers of north-west Italy. *BJPsych Open*, *7*(1), e27.

Narva, A. M., & Marturano, E. T. (2023). Connecting through chaos: Stories of empathy and trust. *Narrative Inquiry in Bioethics*, *13*(1), 39-44.

Newell, J. M. (2017). *Cultivating professional resilience in direct practice: A guide for human service professionals*. Columbia University Press.

Nie, S. J., & Li, S. (2019). 哈尔滨市护士职业倦怠现状及其影响因素调查研究 [Analysis of the status and influencing factors of occupation burnout of nurses in Harbin city]. *Hospital Management in China*, *39*(07), 69-71.

Niu, M., Zhang, X., Du, X., Du, L. L., Wang, X. L., Zhang, H., Gao, J. X., & Zhang, C. X. (2023). 肿瘤科护士医学叙事能力与职业倦怠的相关性研究 [Correlation between medical narrative competence and job burnout ofoncology nurses]. *Chinese Genenral Practice Nursing*, *21*(12), 1589-1594.

Nolan, W. (1786). *An essay on humanity: Or a view of abuses in hospitals. With a plan for correcting them*. Author.

Nowaczyk, M. J. (2012). Narrative medicine in clinical genetics practice. *American Journal of Medical Genetics Part A*, *158*(8), 1941-1947.

Oakes, W. P., Lane, K. L., Jenkins, A., & Booker, B. B. (2013). Three-tiered models of prevention: Teacher efficacy and burnout. *Education Treatment of Children*, *36*(4), 95-126.

Osler, W. (1999). *Burrowings of a book-worm*. McGill University.

Pallai, E., & Tran, K. (2019). Narrative health: Using story to explore definitions of health and address bias in health care. *The Permanente Journal*, *23*(1), 18-52.

Panagioti, M., Geraghty, K., Johnson, J., Zhou, A., Panagopoulou, E., Chew-Graham, C., Peters, D., Hodkinson, A., Riley, R., & Esmail, A. (2018). Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *JAMA Internal Medicine*, *178*(10), 1317-1331.

Panagioti, M., Panagopoulou, E., Bower, P., Lewith, G., Kontopantelis, E., Chew-Graham, C., Dawson, S., Van Marwijk, H., Geraghty, K., & Esmail, A. (2017). Controlled interventions to reduce burnout in physicians: A systematic review and meta-analysis. *JAMA Internal Medicine*, *177*(2), 195-205.

Paton, A., & Kotzee, B. (2021). The fundamental role of storytelling and practical wisdom in facilitating the ethics education of junior doctors. *Health*, *25*(4), 417-433.

Patrick, A., & Pryor, R. (2023). COVID-19, burnout, and healthcare-associated infections: A focus on wellness as a top safety priority. *Antimicrobial Stewardship Healthcare Epidemiology*, *3*(1), e155.

Peabody, F. W. (1927). The care of the patient. *Journal of the American Medical Association*, *88*(12), 877-882.

Pedersen, A. R. (2016). The role of patient narratives in healthcare innovation: Supporting translation and meaning making. *Journal of Health Organization Management*, *30*(2), 244-257.

Pei, J., Wang, X., Chen, H., Zhang, H., Nan, R., Zhang, J., & Dou, X. (2021). Alexithymia, social support, depression, and burnout among emergency nurses in China: A structural equation model analysis. *BMC Nursing*, *20*(1), 1-10.

Perris, K. D., Donahue, E. J., Zytkoskee, A. M., & Adsit, J. (2023). Narrative medicine: An Interdisciplinary Approach to Address Burnout Among the Nursing Workforce. *Humboldt Journal of Social Relations*, *45*, 136-151.

Pfeffer, J. (2006). *Hard facts, dangerous half-truths and total nonsense: Profiting from evidence-based management*. Harvard Business School Press.

Pfeffer, J., & Sutton, R. I. (2006a). Evidence-based management. *Harvard Business Review*,

84(1), 62-133.
Pfeffer, J., & Sutton, R. I. (2006b). Management half-truths and nonsense: How to practice evidence-based management. *California Management Review*, *48*(3), 77-100.
Phelan, J. (2008). Narratives in contest; or, another twist in the narrative turn. *Publications of the Modern Language Association of America*, *123*(1), 166-175.
Phillips, W. R., Uygur, J. M., & Egnew, T. R. (2023). A comprehensive clinical model of suffering. *The Journal of the American Board of Family Medicine*, *36*(2), 344-355.
Pines, A. M. (2018). Burnout: An existential perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 33–51). Taylor & Francis.
Primerano, E., & Alampi, D. (2019). Narrative medicine in intensive care. *Journal of Anesthesia & Clinical Care*, *6*, 43.
Rego, A., Cunha, M. P., Gomes, J. F., Cunha, R. C., Cabral-Cardoso, C., & Marques, C. A. (2015). *Manual de gestão de pessoas e do capital humano*. Lisboa: Edições Sílabo.
Remein, C. D., Childs, E., Pasco, J. C., Trinquart, L., Flynn, D. B., Wingerter, S. L., Bhasin, R. M., Demers, L. B., & Benjamin, E. J. (2020). Content and outcomes of narrative medicine programmes: A systematic review of the literature through 2019. *BMJ Open*, *10*(1), e031568.
Rogers, E., Polonijo, A. N., & Carpiano, R. M. (2016). Getting by with a little help from friends and colleagues: Testing how residents' social support networks affect loneliness and burnout. *Canadian Family Physician*, *62*(11), e677-e683.
Rousseau, D. M. (2020). The realist rationality of evidence-based management. *Academy of Management Learning Education Treatment of Children*, *19*(3), 415-424.
Sackett, D. L., Rosenberg, W. M., Gray, J. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, *312*(7023), 71-72.
Saint-Louis, N. M. (2010). *A narrative intervention with oncology professionals: Stress and burnout reduction through an interdisciplinary group process* [Doctoral dissertation]. University of Pennsylvania.
Sands, S. A., Stanley, P., & Charon, R. (2008). Pediatric narrative oncology: Interprofessional training to promote empathy, build teams, and prevent burnout. *The Journal of Supportive Oncology*, *6*(7), 307-312.
Santen, S. A., Holt, D. B., Kemp, J. D., & Hemphill, R. R. (2010). Burnout in medical students: Examining the prevalence and associated factors. *Southern Medical Journal*, *103*(8), 758-763.
Sarbin, T. R. (1986). *Narrative psychology: The storied nature of human conduct*. Praeger.
Schaufeli, W., & Enzmann, D. (2020). *The burnout companion to study and practice: A critical analysis*. CRC press.
Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, *14*(3), 204-220.
Schlak, A. E., Aiken, L. H., Chittams, J., Poghosyan, L., & McHugh, M. (2021). Leveraging the work environment to minimize the negative impact of nurse burnout on patient outcomes. *International Journal of Environmental Research and Public Health*, *18*(2), 610.
Scholander, L. H., Boström, A. M., Josephsson, S., & Vikström, S. (2023). Engaging in narrative relations in everyday work on a geriatric ward: A qualitative study with healthcare professionals. *Journal of Clinical Nursing*, *32*(13-14), 3954-3966.
Shanafelt, T. D., & Dyrbye, L. (2012). Oncologist burnout: Causes, consequences, and responses. *Journal of Clinical Ocology*, *30*(11), 1235-1241.
Shanafelt, T. D., Gorringe, G., Menaker, R., Storz, K. A., Reeves, D., Buskirk, S. J., Sloan, J. A., & Swensen, S. J. (2015). Impact of organizational leadership on physician burnout and

satisfaction. *Mayo Clinic Proceedings*, *90*(4), 432-440.
Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic Proceedings*, *92*(1), 129-146.
Shaniuk, P. M. (2020). The spiritual works of mercy as a tool to prevent burnout in medical trainees. *The Linacre Quarterly*, *87*(4), 399-406.
Shapiro, J., Zhang, B., & Warm, E. J. (2015). Residency as a social network: Burnout, loneliness, and social network centrality. *Journal of Graduate Medical Education*, *7*(4), 617-623.
Siegel, B. (1990). *Love, medicine and miracles: Lessons learned about self-healing from a surgeon's experience with exceptional patients.* Harper Perennial.
Sinsky, C. A., Shanafelt, T. D., & Ristow, A. M. (2022). Radical reorientation of the US health care system around relationships: Rebalancing the transactional model. *Mayo Clinic Proceedings*, *97*(12), 2194-2205.
Taricani, E. (2021). Introduction: Considering the need for applied innovation in education. In E. Taricani (Ed.), *Design thinking and innovation in learning* (pp. 1-3). Emerald Publishing Limited.
Tetzlaff, E. D., Hylton, H. M., DeMora, L., Ruth, K., & Wong, Y. N. (2018). National study of burnout and career satisfaction among physician assistants in oncology: Implications for team-based care. *Journal of Oncology Practice*, *14*(1), e11-e22.
Thomas Craig, K. J., Willis, V. C., Gruen, D., Rhee, K., & Jackson, G. P. (2021). The burden of the digital environment: A systematic review on organization-directed workplace interventions to mitigate physician burnout. *Journal of the American Medical Informatics Association*, *28*(5), 985-997.
Thomas, J. T., & Otis, M. D. (2010). Intrapsychic correlates of professional quality of life: Mindfulness, empathy, and emotional separation. *Journal of the Society for Social Work Research*, *1*(2), 83-98.
Tian, L., Pu, J., Liu, Y., Zhong, X., Gui, S., Song, X., Xu, S., Zhou, X., Wang, H., & Zhou, W. (2019). Relationship between burnout and career choice regret among Chinese neurology postgraduates. *BMC Medical Education*, *19*(1), 1-10.
Topol, E. (2019). *Deep medicine: How artificial intelligence can make healthcare human again*. Hachette UK.
Vaara, E., Sonenshein, S., & Boje, D. (2016). Narratives as sources of stability and change in organizations: Approaches and directions for future research. *Academy of Management Annals*, *10*(1), 495-560.
Van de Vliet, P., Sprenger, T., Kampers, L. F., Makalowski, J., Schirrmacher, V., Stücker, W., & Van Gool, S. W. (2023). The application of evidence-based medicine in individualized medicine. *Biomedicines*, *11*(7), 1793.
Waddill-Goad, S. (2016). Overcoming stress in aesthetic nursing: A guide to avoiding burnout and fatigue. *Journal of Aesthetic Nursing*, *5*(3), 144-145.
Wang, C. K., Hu, Z., & Liu, Y. (2001). 一般自我效能感量表的信度和效度研究 [Reliability and validity study of the general self-efficacy scale]. *Applied Psychology*, *7*(1), 37-40.
Wang, T., Li, J. F., & Li, W. (2022). 自我效能感在护士感知的高绩效工作系统与工作幸福感间的中介作用 [Effect of perceived high-performance work system on nurses' job well-being: The mediating role of self-efficacy]. *Journal of Nursing*, *37*(14), 60-64.
Wang, W., & Da, R. (2022). 叙事医学在提高神经外科住培医师临床沟通能力中的作用 [Effect on the narrative medicine to improve clinical communication skills of standardized residency trainees in the department of neurosurgery]. *Continuing Medical Education*, *36*(7), 85-88.
Wang, Y. F. (2013). 临床医学人文:困境与出路:兼谈叙事医学对于临床医学人文的意义 [Trouble and sally of clinical medical humanities: Talk about the meaning of the narrative

medicine for clinical medical humanities]. *Medicine & Philosophy*, *34*(9a), 14-18.
West, C. P., Dyrbye, L. N., & Shanafelt, T. D. (2018). Physician burnout: Contributors, consequences and solutions. *Journal of Internal Medicine*, *283*(6), 516-529.
West, C. P., Dyrbye, L. N., Sloan, J. A., & Shanafelt, T. D. (2009). Single item measures of emotional exhaustion and depersonalization are useful for assessing burnout in medical professionals. *Journal of General Internal Medicine*, *24*(12), 1318-1321.
Wiederhold, B. K., Cipresso, P., Pizzioli, D., Wiederhold, M., & Riva, G. (2018). Intervention for physician burnout: A systematic review. *Open Medicine*, *13*(1), 253-263.
Williams, B., Lau, R., Thornton, E., & Olney, L. S. (2017). The relationship between empathy and burnout–lessons for paramedics: A scoping review. *Psychology Research Behavior Management*, *10*, 329-337.
Winkel, A. F., Feldman, N., Moss, H., Jakalow, H., Simon, J., & Blank, S. (2016). Narrative medicine workshops for obstetrics and gynecology residents and association with burnout measures. *Obstetrics Gynecology*, *128 Suppl 1*, 27S-33S.
Winnicott, D. W. (1958). The capacity to be alone. The International Journal of Psycho-Analysis, 39(5), 416-420.
Woods, A. (2014). Beyond the wounded storyteller: Rethinking narrativity, illness and embodied self-experience. In H. Carel, & R. Cooper (Eds.), *Health, illness and disease* (pp. 113-128). Routledge.
Xu, C., Liu, Y. Z., Chen, T., Xue, Z. C., Chen, Q., Wang, X. Y., & Li, W. (2022). 自我效能感在社区医护人员职业倦怠和主观幸福感之间的中介作用 [Mediating role of self-efficacy between job burnout and subjective well-being of medical staff in community health centers]. *Modern Preventive Medicine*, *49*(14), 2579-2584.
Xu, W., Jiang, H., Zhou, Y., Zhou, L., & Fu, H. (2019). Intrusive rumination, deliberate rumination, and posttraumatic growth among adolescents after a tornado: The role of social support. *The Journal of Nervous Mental Disease*, *207*(3), 152-156.
Yang, M., & Fry, L. (2018). The role of spiritual leadership in reducing healthcare worker burnout. *Journal of Management, Spirituality Religion*, *15*(4), 305-324.
Yang, X. L. (2011a). 医学和医学教育的叙事革命: 后现代"生命文化"视角 [Narrative turn in medical study and medical education: The postmodern biocultural perspective]. *Medicine & Philosophy*, *32*(9A), 64-65.
Yang, X. L. (2011b). 医学与叙事的互补: 完善当代医学的重要课题 [How medicine and stories need one another: An important project to complement modern medication]. *Medicine & Philosophy*, *33*(6A), 12-14.
Yang, X. L. (2022a). 生命健康叙事与中国传统中医智慧 [Bio-health narratives and the wisdom of traditional Chinese medicine]. *Chinese Medical Humanities*, *8*(4), 5-8.
Yang, X. L. (2022b). 叙事医学赋能医院管理与高质量发展 [The empowerment of narrative medicine on hospital management and high-quality development]. *Medicine & Philosophy*, *43*(21), 45-49+72.
Yang, X. L. (2023). *中国叙事医学与医者职业素养* [Chinese narrative medicine and medical professional competency]. Guangdong Higher Education Press.
Yang, X. L., Jia, Y. Z., Zhao, C. Y., Jin, H., & Lin, Z. H. (2023). 医者叙事素养量表的编制及信度效度检验 [Development and reliability/validity testing of the narrative competencies scale for medical practitioners]. *Medicine & Philosophy*, *44*(21), 39-44.
Yang, X. L., Li, X. J., & Li, Z. (2024). *叙事医院管理: 从精益管理到价值共生* [Narrative hospital management: From lean management to value symbiosis]. Guangdong Science and Technology Press.
Yang, X. L., Lin, Z. H., Li, L. Z., & Geng, M. (2021). 职业型叙事闭锁及其叙事赋能 [Professional narrative foreclosure and its narrative empowerment]. *Medicine and*

Philosophy, *42*(114), 49-52.

Yang, X. L., Tian, F., & Zhang, G. Q. (2020). 生命健康视野下的叙事闭锁 [Narrative foreclosure in the context of bio-health]. *Medicine & Philosophy*, *41*(23), 10-15+25.

Yang, X. L., & Wang, H. F. (2023). *医者叙事能力与职业发展* [Doctor's narrative ability and professional development]. Guangdong Higher Education Press.

Yost, P. R., Yoder, M. P., Chung, H. H., & Voetmann, K. R. (2015). Narratives at work: Story arcs, themes, voice, and lessons that shape organizational life. *Consulting Psychology Journal: Practice and Research*, *67*(3), 163-188.

Yu, X. M., Zhu, Y. Y., & Jiang, G. C. (2021). 自我效能感在肿瘤医院护士逆境商与职业倦怠间的中介效应 [Mediating effect of self-efficacy between adversity quotient and job burnout]. *Journal of Nursing*, *28*(20), 288-293.

Zaharias, G. J. (2018). What is narrative-based medicine?: Narrative-based medicine 1. *Canadian Family Physician*, *64*(3), 176-180.

Zak, P. J. (2015). Why inspiring stories make us react: The neuroscience of narrative. *Cerebrum: the Dana Forum on Brain Science*, *2*, 1-13.

Zhang, X. J. (2011). 叙事医学——医学人文新视角 [Narrative medicine: A new perspective on medical humanities]. *Medicine & Philosophy*, *32*(9A), 8-10.

Zhou, X. G., Li, Q., Ming, Z., Wei, A. Z., Ming, Z. Z., Shao, J., Wan, J., & Shi, K. (2020). 六盘水市医务人员工作压力及其对工作投入的影响 [Job stress of western region medical staff and the effects of jobengagement: A study of Liupanshui hospitals]. *Chinese Journal of Health Psychology*, *28*(6), 868-873.

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Webliography

Gawande, A. (2009, June 1). *The cost conundrum*. The New York Times. Retrieved May 25, 2009, from https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum

Joseph, R. (2018, February 24). *Doctors revolt*. The New York Times. Retrieved February 25, 2018, from https://www.nytimes.com/2018/02/24/opinion/sunday/doctors-revolt-bernard-lown.html

Lavrova, A. (2024, April 1). *Thriving and impacting story of someone's first year*. LinkedIn. Retrieved April 1, 2024, from https://www.linkedin.com/pulse/thriving-impacting-story-someones-first-year-anna-lavrova--nfhoe?trk=public_post_main-feed-card_feed-article-content

McKenna, J. (2024, January 26). *Medscape physician burnout & depression report 2024: "We have much work to do."*. Medscape. Retrieved January 26, 2024, from https://www.medscape.com/slideshow/2024-lifestyle-burnout-6016865

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Annex A

Table a.1 Rotated component matrix of narrative cognitive abilities

Clauses and sub-clauses	factor 1 Bio-health narrative consciousness	factor 2 Professional narrative behaviors
Frequent and deep narrative communication with people can sustain long-lasting wellness.	0.807	
I should reach out to friends and family for help during major life transitions, or when experiencing serious trauma and failure.	0.771	
The integration of life stories helps me to reduce my fear of death.	0.770	
Understanding self-story and others' stories from multiple perspectives can help me break out of difficult situations and prevent us from falling into a state of isolation.	0.761	
Narrative connections between people are as important to life and health as air, water and food.	0.758	
Regularly reading stories about life, aging, sickness and death enhances my awareness of physical and mental health.	0.752	
Reading and listening to other people's stories can help me get out of a difficult situation when I am frustrated in my studies or at work.	0.742	
Storytelling is more effective than reasoning in motivating me to make changes.	0.729	
Narrative is not the same as language/gossip.	0.680	
Harmonious and intimate narrative connections between healthcare professionals and administrators contribute to mutual trust, cohesion, and a sense of belonging to the hospital.		0.863
A strong narrative connection between doctors and nurses on a daily basis is conducive to better patient care.		0.846
Regularly organizing daily narrative communication activities in departments and hospitals is beneficial to the development of departments and hospitals.		0.836
Maintaining a stable narrative connection with colleagues is helpful for improving the clinical efficiency of the department.		0.830
Reading and listening to the stories of my peers' professional growth has been beneficial to my professional development.		0.827
When experiencing a complex medical event, it is important to reach out to colleagues to review and analyze the event from different perspectives.		0.815
Listening and responding to colleagues in major career transitions and crises.		0.812
Listening to stories of clinical practice from colleagues in the same department enhances the ability to cope with crises in the future.		0.800
Maintaining a stable narrative connection with the patient's family can enhance trust between the patient and the physician and promote a comprehensive understanding of the patient.		0.793
Providers with narrative skills are able to guide patients to tell comprehensive stories about their illnesses and extract useful details from them.		0.784

Establishing my own professional idols and familiarizing myself with their stories has helped me grow professionally.	0.779
It is important for providers to take the initiative to fully understand all aspects of a patient's family situation in order to make medical decisions.	0.775
Timely narrative communication with patients can identify shortcomings and advantages in one's own practice of medicine.	0.761
Over-specialized medical terms and expressions can be detrimental to doctor-patient communication.	0.747

Table a.2 Rotated component matrix of narrative behavior ability

Items	Factor 1 Bio-health narrative behavior	Factor 2 Family narrative behavior	Factor 3 Career development narrative behavior	Factor 4 Peer narrative interaction behavior	Factor 5 Doctor-patient narrative connection behavior
When I am sick, I will seriously reflect on my own living habits and psychological and emotional state, and take the initiative to make lasting adjustments.	0.783				
When encountering a failure, I reflect on the details of the entire incident and find possibilities for improvement to avoid similar incidents.	0.781				
When I encounter setbacks, I will think about the positive side of the setback story and get positive motivation from it.	0.765				
After important things happen, I will review the details of the story to achieve certain growth and change.	0.758				
When a decision or proposal is opposed by others, I will reflect on the reasons for the opposition or no cooperation from different perspectives and positions, and adjust my own practice.	0.723				
When discussing a historical event, I will explore and understand it from different perspectives and positions.	0.625				
I will take the initiative to interact with friends, relatives, classmates and colleagues.	0.573				
During every important life transition, I take the initiative to build narrative connections with friends, family or colleagues.	0.507				
When with my family members, I am willing to put down my phone to enjoy quality companionship, whether indoors or outdoors.		0.723			

In the family, I can actively and patiently listen to and respond to the ideas and opinions of my family members.	0.701	
My family often share their stories with me.	0.692	
When I have conflicts with my family, I will guide them to review the event, look forward to the possible direction of the story, and adjust their attitude and behavior.	0.664	
When my family faces important life transition events such as going to kindergarten, sleeping in separate beds, parents retiring, I know how to respond to their anxieties and tensions with stories.	0.661	
I share my experiences, reading or listening stories with family members.	0.654	
When a child makes a mistake or a family member encounters a difficult situation, I do not reason, but find the right story and find a way to touch him/her with the story to guide him/her to get out of the difficult situation consciously and proactively.	0.65	
In case of a traumatic event, I will actively talk to my relatives and friends and expect a positive response.	0.603	
I will keep a journal or narrative of my medical education growth and clinical practice experiences.		0.799
I have a habit of reading the biographical stories of my medical predecessors.		0.78
I usually actively read narrative works related to birth, aging, illness and death.		0.778
No matter how busy I am, I will find time to reflect on some stories I have encountered through writing.		0.711
I focus on listening to, recording, and sharing the humanistic stories in the history of medicine.		0.695
In my daily work, I pay attention to improving my ability to observe details by reading stories.		0.681
I have my own professional idols and am familiar with their stories.		0.647
I will actively read or share the career growth stories of my peers.		0.607
I have the habit of reading stories after class or work.		0.549

I will pay attention to the changes of colleagues and provide help when needed.	0.737	
When colleagues encounter career difficulties or career crisis, I will actively listen to and respond to them.	0.718	
I am able to maintain stable interpersonal narrative connections with my colleagues.	0.699	
When encountering problems and dilemmas, I will recall and refer to the experiences shared by colleagues or peers to deal with them.	0.619	
When communicating with patients, such as disease notification and treatment plan formulation, I avoid specialized language and use metaphorical language familiar to the patient in order to ensure that the patient understands better.		0.847
When facing patients, I will carefully observe and understand the relevant details of patients, and take the initiative to initiate a dialogue.		0.819
When conducting health education and disease popularization to patients, I will consider using stories as the media.		0.795
When facing dying patients, I will guide my family members and medical staff to accompany them and listen to his / her life stories.		0.746
I would search the patient's story for possible evidence of a correct diagnosis.		0.741
When dealing with emotional patients or their families, I will take the initiative to imagine the possible development direction of things, and actively adjust the communication mode to avoid crises.		0.734
When I meet a patient who is unwilling to open his/her heart, I will use stories to touch him/her.		0.714
When the patient tells a story of the illness experience, I will find the corresponding story to respond to the patient.		0.707
When making medical decisions, I will give suggestions based on the patient's social, psychological, cognitive, family and other aspects of the situation.		0.668

Annex B

Figure b.1 Word cloud chart of interviews with 52 doctors on the theme of “Professional Burnout in the Context of Narrative Medicine”

Source: Developed by the author