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Research Article

The Shift in the Narrative of Doctor-Patient Communication and the Cultivation of Medical Information Exchange Communication Based on the Information Technology Era

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Effective narrative turn of doctor-patient communication can strengthen the trust between doctors and patients, close the doctor-patient relationship, and reduce the contradiction between doctors and patients. Health humanities, as a more inclusive, open, and application-oriented discipline, has been gradually recognized by academic circles. Narrative medicine, as an interdisciplinary subject of humanities education and medicine, plays an important role in cultivating medical students' narrative ability. 30 medical staff in a general hospital were selected as the research object by questionnaire survey. General information questionnaire and medical narrative ability scale were used to investigate and multiple linear regression was used to analyze the influencing factors of medical students' medical narrative ability. The results show that the standardized regression coefficients of communication content, empathy, and communication results are 0.439, 0.367, and 0.138, respectively. The total score of medical narrative ability of medical students is 133, and the average score of items is 4.87, which is at a low level. In conclusion, the medical narrative ability of medical students is at a low level, and nursing managers should take targeted intervention measures to improve the medical narrative ability of medical students.

1. Introduction

Good narrative turn of doctor-patient communication can improve the degree of patients' cooperation in treatment and deepen doctors' understanding of patients' condition, bring more positive treatment awareness to patients, and help doctors to carry out medical work more pertinently [1]. The relationship between medicine and humanities is getting closer and closer. Some scholars say that they have actually merged, but the disconnection between them has always existed, especially when the doctor-patient relationship has become a social hot spot and focus, which presents the public with the lack of humanistic value in front of medical technology. Under the background of big health, big health, and big medicine, the relationship between medicine and humanities and health and humanities has attracted attention again. Health humanism not only discusses the humanistic value and social significance of diseases and ailments in clinical medicine, but also discusses the relationship between doctors and patients in different times and cultures. It also discusses nursing humanism, disability narrative, near-death experience and significance of death, physical and cultural identity, sex and gender identity, race, class and health equity, life and aging, health problems of mental patients, religious belief and spiritual education, etc. Scholars in the field of social sciences discuss the narrative turn of doctor-patient communication from a speculative point of view, put forward the dislocation between doctors and patients, the game of rights between doctors and patients, etc., and also study the conversation mode between doctors and patients from a linguistic point of view, which broadens the research scope of its subject field to a certain extent, but it still has little practical significance for clinicians.

Doctor-patient communication plays an important role in outpatient service. Doctors and patients (or family members) are the main participants in the narrative turn of doctor-patient communication. Zaharias believes that good communication between doctors and patients can lead to better behaviors of patients, such as quitting smoking,

increasing physical activity, changing eating habits, etc., thus producing better therapeutic effects [2]. Waal research indicates that 70% of medical malpractice lawsuits come from poor communication, and good communication between doctors and patients is the excellent guarantee to prevent medical lawsuits [3]. Han et al.' s survey results show that the proportion of patients' distrust of medical staff is 43.8%, and the proportion of medical staff who believe that both sides trust each other is only 25.9%. This distrust is gradually evolving into "collective distrust" [4]. Taher's survey results show that the lack of communication between doctors and patients accounts for 50.56% [5]. According to the statistics of the investigated hospitals, the Medical Ethics Office receives about 60 complaints from patients every year, 70% of which are caused by the communication between doctors and patients. According to the survey results of Adamson et al. [6], 43.8% of patients do not trust the medical staff, and only 25.9% of the medical staff believe that the mutual trust between the two sides is gradually evolving into "collective distrust." Therefore, how to guide both doctors and patients to a good development track and reconstruct the doctor-patient relationship of mutual respect, understanding, and cooperation is an urgent problem to be faced at present. In the daily work of doctors, it can also be easily found that doctor-patient communication is an indispensable part of medical activities. With reliable communication between doctors and patients, we can collect medical history and make a definite diagnosis more accurately and quickly, and we can also better implement disease treatment and health education, and at the same time promote emotional communication, doctor-patient trust, and doctor image.

The tense doctor-patient relationship not only damages the image of medical institutions and medical staff in patients' minds, but also affects the quality and order of medical and health services, hinders the healthy development of China's health undertakings, and then threatens the physical and mental health of the broad masses of people. In theory, based on the principles of constructivism and other nonpositivism, the health humanities advocate acknowledging the "multiple truths" of health cognition through dialogue and negotiation, rather than the single truth based on authority. This paper investigates the current situation of narrative turn of doctor-patient communication in hospitals, finds out the existing problems in narrative turn of doctor-patient communication, analyzes the main reasons, and puts forward suggestions and countermeasures for improvement. It also discusses the possibility of narrative turn in educational research from three aspects: the relationship between theory and facts, narrative experiments in educational field, and theoretical discourse to life discourse. Cultivating the narrative ability of medical students will be a new proposition of medical humanities education and a new dimension to measure the growth and development of medical students.

2. Related Work

2.1. Research on Health Humanities. Both health and medicine are the products of humanity, but with the development of science and technology and human society, the traces of these two concepts are more and more obvious, so that people regard them as a nonhumanistic concept more often. Great health humanities includes medical humanities and health humanities, and there is an intersection relationship between medical humanities and health humanities (see Figure 1). The three are not exclusive. The times keep pace with the times and the application is gradually expanded.

With the emergence of the concept of medical humanities, the rise of disciplines, and the rise of discipline groups, European and American countries regard medical humanities as the necessary content of medical education. Deliz et al. think that there is art participation in medical humanities, but it is too limited. The goal of healthy humanities is to infiltrate art and humanities into the education of all professionals in medical care, health, and happiness [7]. Lejano and others believe that medical humanities, as an interdisciplinary and multidisciplinary field, are becoming more and more complex, and humanities should be more involved in the construction of marginal disciplines involving medical and healthcare personnel, patients, and informal clinical nurses, etc., focusing on the practical consideration of community participation and public decision-making, and solving the current concerns about global health [8]. Ie et al. proposed to replace "medical humanities" with "healthy humanities," because the former only pays attention to humanities, doctors, medical students, and medical education, ignoring the experience of other medical and health related personnel and patients. The latter is more inclusive and applicable besides medicine [9]. Tumedei et al. defined health humanities as "recognition of people's values in the field of health services, attention to people's survival significance and quality of life," which is not inappropriate in itself, but lacks the consideration of function and strategy [10]; Liu et al. believe that conceptual interpretation usually leads to the conclusion that there are actually two or more concepts that must be distinguished, which leads to the divergence of interpretation [11]. Yu and others believe that it is necessary to emphasize the influence and role of all aspects of society and the whole world in the process of maintaining and recovering human health, and it is also necessary to attach importance to the traditional medical system outside the modern medical system [12].

2.2. Research on the Status Quo of Communication between Doctors and Patients. With the physiological-social-psychological medical model deeply rooted in the hearts of the people, it is necessary for schools and hospitals to advocate "patient-centered" and cultivate medical students with good character, humanistic quality, and communication skills. The core communication skills in the narrative turn of communication between doctors and patients are effective listening and empathy. Effective listening is a creative behavior that medical staff actively pay attention to through listening to eyes, asking about feelings, and thinking and understanding. This is also the highest level of narrative turn of doctor-patient communication, emphasizing that doctors need to integrate this skill into all aspects of medical activities and even extend it to life, work, and personal moral cultivation, so as to achieve three-dimensional and all-round development.

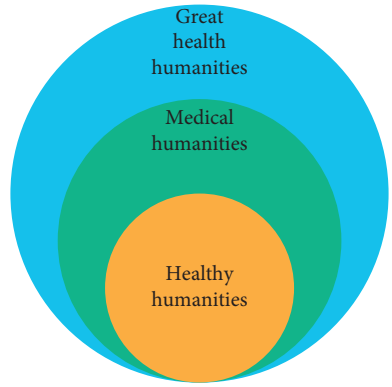

Figure 1: Schematic diagram of the relationship among health humanities and between health humanities and medical humanities.

In the research on doctor-patient communication from the perspective of patients, Zhang et al. found that less than 80% of patients and their families expressed "very satisfied or satisfied" with doctor-patient communication, while 92.8% of patients and their families thought "communication time was insufficient" and 32.0% thought of "lack of trust between doctors and patients" [13]. Macdorman's survey on medical students' understanding of doctor-patient communication in China shows that 86.9% of medical students are worried about the current situation of doctor-patient communication in China, and 76.8% of them choose "very bad" or "average doctor-patient relationship" in the evaluation of the current situation of doctor-patient communication, while only one-tenth of medical students choose "very harmonious doctor-patient relationship," and the current situation score of 74.1 points is obviously not convincing enough [14].

In the narrative turn of doctor-patient communication, medical staff's low humanistic quality, poor service attitude, and weak communication ability are often the primary reasons for the failure of doctor-patient communication. Arya et al.' s investigation shows that poor language, bad attitude, and bad medical ethics are the important causes of medical disputes, and even among senior doctors, there is a general lack of communication ability between doctors and patients [15]. Aleksei and others investigated 50 medical colleges and universities in China and found that only 40% of them offered communication teaching courses, and the teaching methods were mainly classroom lectures, mostly factual and conceptual knowledge. The design and arrangement of the courses were far from meeting the needs of medical students to deal with the complicated doctor-patient relationship after entering the clinic [16]. Akimoto's survey of medical students' attitudes shows that some medical students have a negative attitude, especially in studying the course of doctor-patient communication and the evaluation of doctor-patient communication [17]. Js et al. think of establishing a diversified teaching material system. Finally, the evaluation system of doctor-patient communication is the main means to reflect the level of doctor-patient communication ability and feedback and supervise the teaching quality, so it is necessary to choose a more objective and accurate evaluation system [18].

2.3. Research on the Cultivation of Medical Students' Narrative Ability. Since the second half of the 20th century, medical practitioners have gradually realized the significance of narrative in clinical treatment. In recent years, the explicit and implicit role of narrative ability in the treatment of diseases has been paid more and more attention and applied in the medical field, and narrative medicine has quietly emerged in China.

The value of narrative medicine lies in correcting the deviation that current medicine pays too much attention to money and machines and combining "finding evidence" with "telling stories" to find a new way out of medical humanistic care. Trinidad and others believe that medical education not only emphasizes the cultivation of professional knowledge and skills and scientific spirit, but also pays special attention to the cultivation of humanistic cultivation and sound personality [19]. Russell and others think that the medical humanistic spirit is the soul of medicine, which is the spiritual scene that people need to convey most when they are the weakest and most painful in life [20]. Bharti believes that the cultivation of narrative ability will have a positive transfer effect on the improvement of college students' oral expression ability, showing multiple ability changes of language expression microstructure, macrostructure, and content eventuality [21]. Therefore, starting with the cultivation of medical students' narrative ability, we can comprehensively exercise their expressive ability and finally improve the all-round development of narrative ability and humanistic quality.

3. Research Method

3.1. Analysis of Doctor-Patient Relationship Harmony. According to the main factors that affect the harmony of doctor-patient relationship, such as unsmooth narrative turn of doctor-patient communication due to information asymmetry, limitation of medical technology level, patients' higher requirements for medical service quality due to increasing medical expenses, patients' excessive rights protection in the face of medical disputes, and so on, this paper comprehensively evaluates the harmony of doctor-patient relationship from four levels: doctor-patient communication efficiency, patient treatment results, doctors' job satisfaction, and degree of doctor-patient disputes.

The research shows that the relationship between the harmony of doctor-patient relationship and its influencing factors can be expressed by the following function:

$$H(\mathrm{LR}) = f(A, B, C, D). \quad (1)$$

Among them, H is the harmony between doctors and patients;

A, communication efficiency between doctors and patients;

B, patient treatment results;

C, job satisfaction of doctors;

D, degree of disputes between doctors and patients.

According to the above conceptual model, we can find the key indicators that can best reflect the above four levels of doctor-patient relationship through the follow-up investigation of doctor-patient relationship, establish an index system to evaluate the harmony degree of doctor-patient relationship, and make a scientific and effective evaluation of doctor-patient relationship.

In order to accurately evaluate the harmonious degree of doctor-patient relationship, it is necessary to establish a comment set of the harmonious degree of doctor-patient relationship. According to the nature of the evaluation index of doctor-patient relationship harmony and the inherent demand of fuzzy comprehensive evaluation, this paper sets the number of evaluation grades of doctor-patient relationship harmony to five. The evaluation grades are as follows:

$$V = \{v_1, \ldots, v_5\}. \quad (2)$$

Among them, $v_1, \ldots, v_5$ means excellent, good, medium, poor, and very poor, respectively.

3.2. Investigation on the Status Quo of Doctor-Patient Communication

3.2.1. Questionnaire Design. Select 30 experts from hospital management, clinical medical staff, medical education, and medical statistics to discuss the first draft of the questionnaire, so as to revise and supplement it and form a presurvey questionnaire. Cluster sampling method selected clinical medical staff and inpatients from some departments of a general hospital as the investigation objects.

In order to reduce the interference and ensure the quality, before the investigation, the investigators explain the purpose of the investigation to the respondents in order to obtain their understanding and cooperation and at the same time explain the requirements for filling out the form. The patient questionnaire was distributed by full-time investigators in person and was required to be filled in on the spot, checked, and taken back on the spot. The quality control of medical staff's questionnaires is the responsibility of the head nurse of each department, and the incomplete questionnaires are filled in at that time and then taken back. The statistical results of the questionnaire are shown in Table 1.

From Table 1, it can be concluded that 200 patient questionnaires were distributed, and 160 valid questionnaires were recovered, with an effective rate of 80%. 300 questionnaires for medical staff were distributed, and 155 valid questionnaires were recovered, with an effective rate of 77.5%.

3.2.2. Research Tool. During the investigation, the author found that most patients can accurately understand the concepts of ideal service, appropriate service, and perceived performance in the three lists, but they cannot be quantitatively distinguished in the scoring process, and the same is true for the two lists. Based on this, the author adopts the evaluation method of SERVPERF to evaluate the service quality with perceived performance. The communication process scale includes survey items and three dimensions, namely, communication content, empathy, and communication results. See Table 2 for details of dimensions and items.

This table follows the positive 5-level balance scale of the original scale. Because some items involve laboratory tests, equipment inspection, etc., and some patients have not performed such inspection items, the "Not suitable" option is added after the 5-level scale. After the scale, add a comprehensive evaluation item "Comprehensive evaluation of this communication," which uses the percentile system.

Medical narrative ability scale is used to evaluate medical narrative ability of medical staff. The scale includes 27 items in three dimensions: attention listening (9 items), comprehension response (12 items), and reflection reproduction (6 items). According to Likert's grade 7 score, "completely non-conforming" to "completely conforming" were scored from 1 to 7, with a total score of 27 to 189. The higher the score, the stronger the medical narrative ability. Criteria: <145 points means low, 145~163 points means medium, and >163 points means high [13].

Cronbach's α coefficient of this scale is 0.950. The Cronbach α coefficient of the middle scale in this study is 0.954.

3.2.3. Statistical Method. After the completion of the research, the related data will be sorted out in detail, and the research data will be processed and analyzed by SPSS 20.0 statistical software. $(\overline{x} \pm s)$ is the measurement data, and t test is used after comparative analysis, and the difference is statistically significant ($P < 0.05$).

4. Result Analysis

4.1. Influence of Communication Process on Communication Quality. Calculate the arithmetic average of project scores in three dimensions as the comprehensive quality evaluation of each dimension, take the comprehensive evaluation of three dimensions as independent variables and "the comprehensive evaluation of the communication quality between doctors and patients this time" as dependent variables, and use the forced entry method to establish a regression model. The results are shown in Tables 3 and 4.

According to the data in Table 3, the model has statistical significance. The data in Table 4 shows that the three independent variables have significant influence on the comprehensive communication quality, and the three regression coefficients are all statistically significant. The standardized regression coefficients of communication content, empathy, and communication results are 0.439,

Table 1: Questionnaire statistical results.

Category	Questionnaire distribution	Recovery of valid questionnaires
Patient	200	160
Medical staff	200	155
Add up to	400	315

0.367, and 0.138, respectively. The larger the regression coefficient, the greater the influence degree.

Using the same method, the relationship between the item score and the comprehensive quality score of empathy in the dimension of "empathy" is discussed. The results are shown in Figure 2.

There are four related items: doctors explain patience to patients, answer questions patiently, listen patiently, and consult time, followed by patients' ability to bear medical expenses and the tone of doctors' speeches.

Using the same method, we explored the degree of influence between the project score of doctor-patient communication results and the comprehensive quality score of communication results, the learning of daily healthcare knowledge with the strongest correlation, and the knowledge about the drugs taken. The results are shown in Figure 3.

4.2. Medical Staff's Basic Understanding of Doctor-Patient Communication. Medical staff and patients have different views on the specific needs of patient communication, which is quite different. For patients' questions, only 55% of medical staff think that they should pay attention to and answer them, and 43% think that they should be answered selectively and pertinently (Figure 4).

The lack of understanding is also reflected in practical work. When patients ask questions about illness, diagnosis, and treatment, only 44% of medical staff can patiently explain them until the patients fully understand. This is also the reason why 32% of patients do not fully understand their own condition, diagnosis, and treatment plan (Figure 5).

In terms of communication content, apart from the patient's strong desire for illness and treatment plan, the medical staff also think that they should explain the relevant precautions and rehabilitation guidance to the patient, which also reflects that both sides have different understanding of medical knowledge and health concept.

As to how to address patients, 57.2% of medical staff can use cordial address according to the age of patients, but 39.1% of them call their names and bed numbers by first name. Proper appellation can make patients feel friendly, virtually close the distance between doctors and patients, and relieve patients' nervousness. Medical staff should avoid calling their name and bed number by first name and make patients feel the emotion and care of medical staff, rather than simply the relationship between treatment and being treated (Figure 6).

Nonverbal communication occupies a large proportion in the overall effect of communication, and eye contact and proper touch can get twice the result with half the effort. The survey results are shown in Figure 7.

Figure 7 shows that 92.1% of medical staff think that their external image, such as clothing, expression, tone, gesture and posture, has influence on patients, but only 57.7% of medical staff can always pay attention to proper eye contact, and 45.3% can always give elderly or pediatric patients proper touch. From the results, it can be seen that medical staff have a poor grasp of nonverbal communication skills.

Most medical personnel have not received the education of humanities knowledge. This situation is closely related to the current education system in China. China's higher medical education has long paid attention to the cultivation of medical students' professional skills but neglected the cultivation of humanistic quality and social practice ability. The proficiency of medical staff in the communication skills between doctors and patients affects the communication effect. In daily medical activities, the lack of communication skills among medical staff often leads to communication obstacles, and the lack of communication skills is the technical reason that affects the communication between doctors and patients. Through the investigation, we can see that the communication skills of medical staff in this hospital are relatively lacking.

4.3. Analysis of Medical Narrative Ability of Medical Students. The results of this study show (Table 5) that the medical narrative ability of medical students has a total score of 133, and the items are all scored 4.87, which is at a low level. Among the three dimensions, the dimension of paying attention to listening has the highest score, which indicates that medical students have a strong ability to listen to patients' voices. However, the reflection and representation dimension score is the lowest, which indicates that medical students' ability to reflect, absorb, and deconstruct patient narratives is low.

Higher empathic fatigue may weaken medical students' helping feelings, reduce their enthusiasm to reflect on cancer patients' stories and dilemmas, affect their ability to reflect, absorb, and deconstruct patients' narratives, and lead to their low medical narrative ability. It is suggested that improving medical narrative ability of medical students and meeting narrative nursing needs of patients are practical problems that managers must pay attention to.

The score of medical narrative ability was taken as the dependent variable, and the statistically significant items in the single factor analysis were taken as the independent variables for the multiple linear regression analysis. The results of multiple regression analysis are shown in Table 6.

The results of this study show that the lower the working years, the lower the scores of medical narrative ability of medical students, which is basically consistent with related research results [16, 17]. The higher the average monthly income, the stronger the medical narrative ability of medical students. According to the self-determination theory, under

Table 2: Dimensions and items of survey scale.

Communication process	Project
Communication content	Tell me the cause of illness Tell me the general result Tell me the reason for the inspection Tell me the advantages and disadvantages of the treatment plan Tell me the precautions in life Tell me the possible recovery time Tell me the next visit time Tell me the approximate cost
Empathy	Answer my question Listen to me patiently The tone of speech Consultation time
Communication result	How much do I know about my illness? How much do I learn about health care? How much do I learn about drugs? How much do I learn about a healthy lifestyle?

Table 3: Variance analysis.

	Sum of squares	Freedom	Mean square	F value	P value
Regression sum of squares	68321.307	5	23147.882	421.768	$P \leq 0.001$
Square sum of residuals	26014.281	401	55.123	—	—
Total sum of squares	96976.337	369	—	—	—

Table 4: Coefficient of regression.

	B	Std. error	Beta	t	P
Constant	12.103	1.608	—	7.724	$P \leq 0.001$
Communication result	2.017	0.412	0.138	4.363	$P \leq 0.001$
Communication content	10.816	0.663	0.439	10.217	$P \leq 0.001$
Empathy	4.247	0.517	0.367	9.248	$P \leq 0.001$

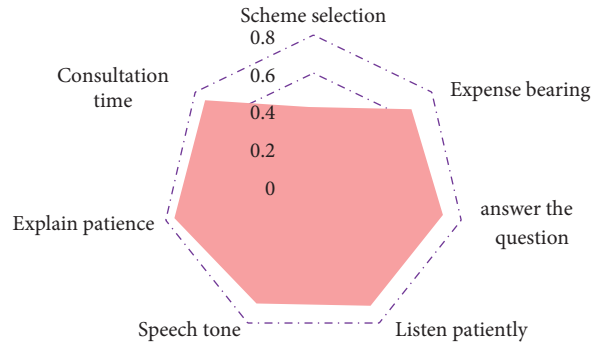

Figure 2: Correlation coefficient between empathy item score and empathy comprehensive quality score.

certain circumstances, external rewards can improve the intrinsic motivation of individuals to engage in certain activities or jobs [6]. Studies have found that the higher the monthly income, the higher the nurses' core competence score [7], which is consistent with the results of this study.

This study shows that narrative nursing knowledge reserve is the influencing factor of medical narrative ability of medical students, which is consistent with previous research results [18]. Medical students with high self-efficacy have higher self-confidence in work and stronger sense of professional mission and will study narrative nursing knowledge and skills harder, thus improving medical narrative ability. It is suggested that nursing managers should regularly carry out self-efficacy monitoring and psychological counseling activities for medical students, care for and guide medical students with low self-efficacy, and set up excellent nurse deeds display columns in departments to play the role of role models for medical students to help them improve their self-efficacy.

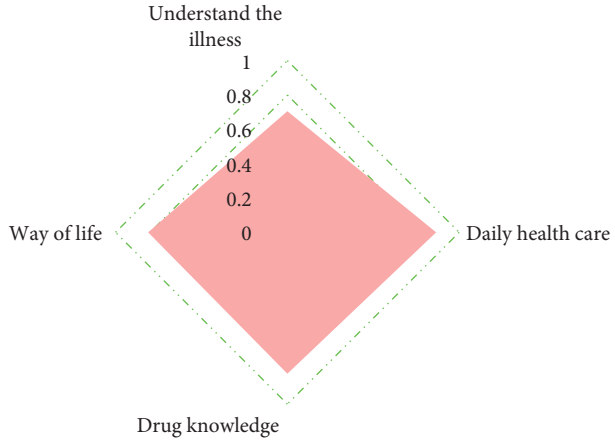

Figure 3: Correlation coefficient between communication result items and comprehensive quality score of communication results.

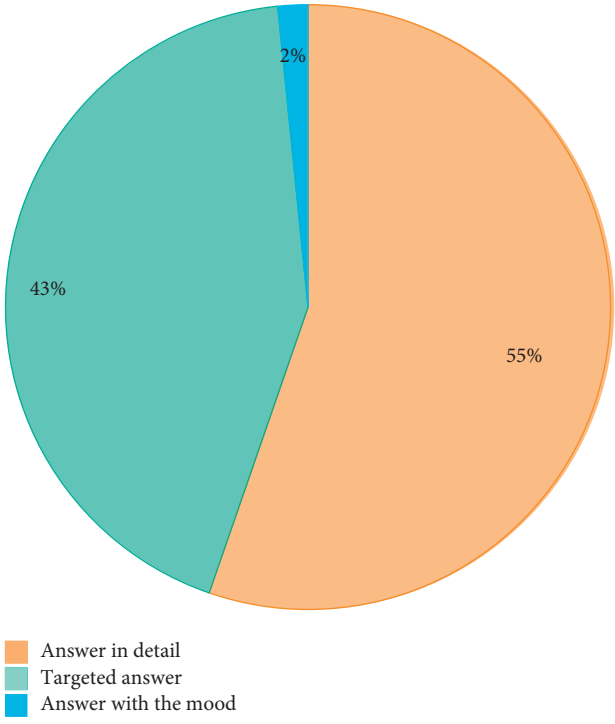

Figure 4: Medical staff's cognition of patients' questions.

5. Cultivation of Medical Narrative Ability of Medical Students

Narrative ability is also a basic skill. Narrative skills are based on effective communication. Modern medicine cannot solve all the problems. Facing patients' pain, doctors are more comforting. Modern medicine fails to pay attention to patients and their experiences as subjects, which leads to the lack of emotional communication and parallax displacement between doctors and patients, and narrative ability helps to supplement this [8].

In the process of diagnosis and treatment of diseases, doctors use all the information about diseases, combine their professional knowledge and clinical experience, analyze, synthesize, judge, make a diagnosis, and make a treatment plan. The thinking process is clinical thinking ability. This requires students to build common logic and knowledge with patients on the premise of mastering the existing theoretical knowledge and combining with the general experience of life, so that doctors and patients can communicate and understand on the basis of consensus, and the transformation of this knowledge needs to be realized through the narrative transformation of doctor-patient communication.

In this paper, we look at the process of patients' visits and doctors' visits from the perspectives of diagnosis, treatment, and communication and regard diagnosis, treatment, and communication as the three elements of the clinical diagnosis and treatment process (Figure 8) and propose that the perspective of communication should be reintroduced into the

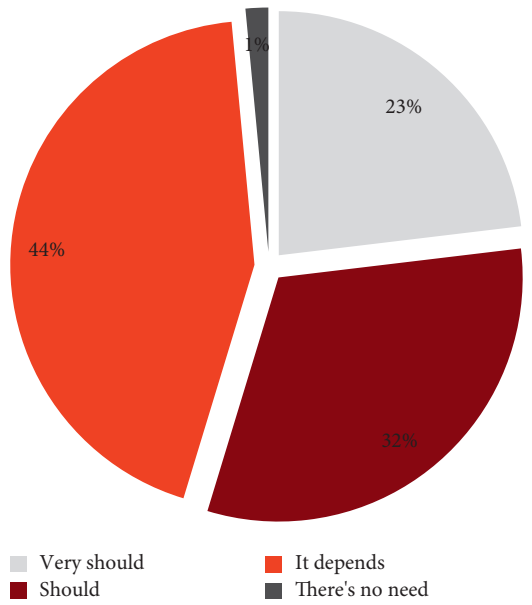

Figure 5: Medical staff's cognitive map of explaining illness to patients.

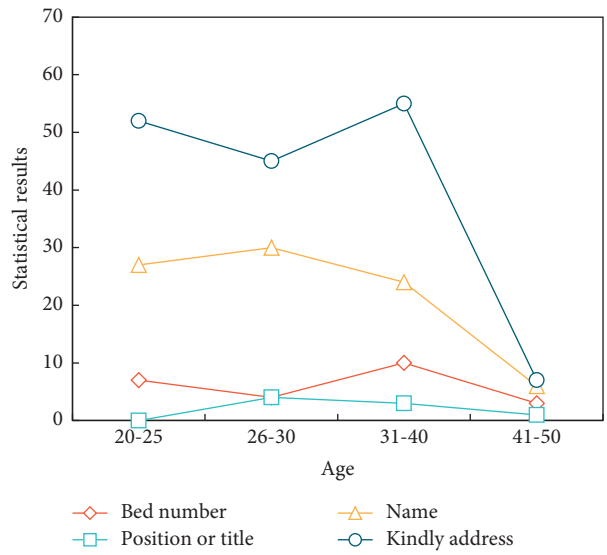

Figure 6: Statistics of medical staff's address to patients of different ages.

previous flat thinking mode. The new diagnosis and treatment thinking model constructed in this paper is shown in Figure 9.

Communication perspective includes two levels of communication effect and communication object, diagnosis perspective includes two levels of subjective impression and objective information, and treatment perspective includes two levels of patients' needs and treatment methods. Communication objects can be further divided into doctors, patients, patients' families, and other four dimensions. The communication effect can be further divided into three dimensions: treatment, help, and comfort, and there is an interactive relationship among these dimensions. Therefore, subjective impression includes two dimensions: visual and inquiry, while objective information includes four dimensions: physical examination, other information, imaging, and laboratory examination.

Patients' visiting purposes are different, which are based on the different needs of patients. Therefore, patients' needs require doctors to pay attention to and listen to patients' narratives and give corresponding reasonable responses through communication. This paper roughly divides it into three dimensions, that is, illness needs, psychological needs, and other needs. Based on the different needs of patients, treatment methods can be roughly divided into two dimensions: drug treatment and nondrug treatment. In the former, besides the treatment symptoms, the drug types, dosage, and side effects should be selected according to the needs of patients. The latter is a treatment other than drug therapy, such as physical therapy, psychotherapy, surgery, and so on (as shown in Figure 10).

The purpose of cultivating narrative ability is to strengthen doctors' responsibilities. The responsibility of

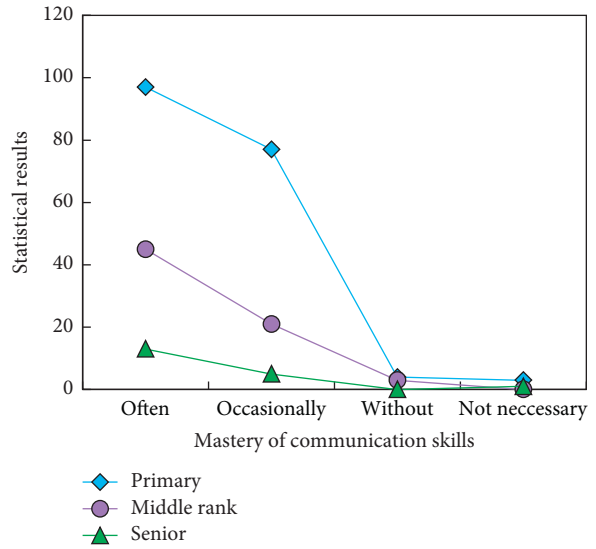

Figure 7: Analysis of eye contact skills of medical staff with different professional titles.

Table 5: Total score of medical narrative ability of medical students and scores of each dimension.

Project	Number of entries	Score	Item sharing
Pay attention to listening	10	48	5.51
Understanding response	11	63	5.01
Reflection reappearance	7	20	3.36
Aggregate score	30	133	4.87

Table 6: Multiple linear regression analysis results of influencing factors of medical narrative ability of medical students.

Project	B value	SE value	β value	T value	P value
Constant	68.33	6.67	—	11.71	$P \leq 0.001$
Working life	1.52	0.55	0.1	2.26	$P \leq 0.001$
Average monthly personal income	3.31	1.14	0.13	2.66	$P \leq 0.001$
Narrative nursing knowledge reserve	5.28	1.25	0.24	4.36	$P \leq 0.001$
Have you received narrative nursing training	17.42	1.89	0.41	9.33	$P \leq 0.001$
General self-efficacy	0.55	0.11	0.24	5.42	$P \leq 0.001$

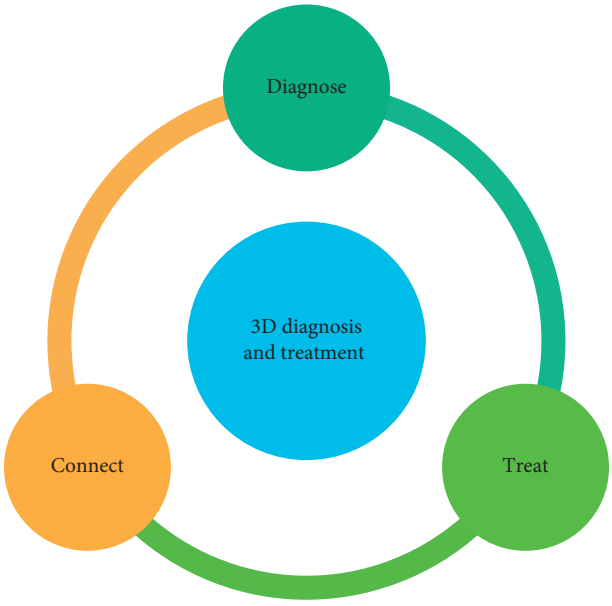

Figure 8: Three-dimensional diagnosis and treatment thinking.

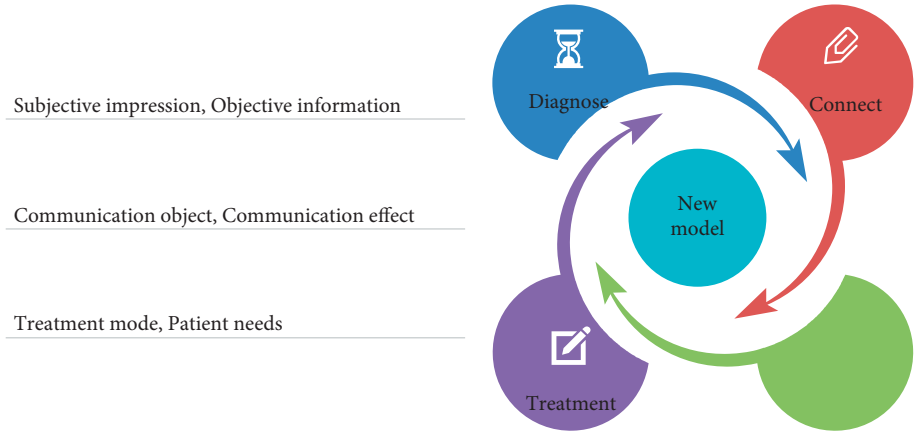

Figure 9: New diagnosis and treatment thinking model diagram.

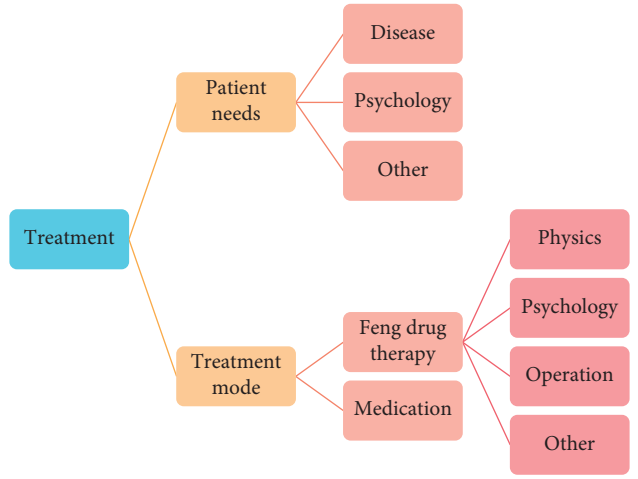

Figure 10: The level and dimension of therapeutic perspective.

narrative ability must be based on respect for patients. Respect the patient's life, respect the patient's life value, care for the patient, sympathize with the patient, and give the patient the humane love like a relative [13]. Humanistic care practice is the key link to understand and deepen the essence of nursing care, and it is the dominant behavior feature in concrete application. Through feeling, experiencing, expressing, and implementing care in practice, nurses' professional quality of actively caring for patients is gradually cultivated [15]. Great health humanities neither exclude medical humanities and narrow health humanities, nor are the end. On the contrary, it covers medical humanities and narrow sense of health humanities. As the idea of humanistic quality education in universities, healthy humanities can improve the realization of the ultimate value of university education [11].

Medical colleges and universities should establish a team of practitioners of narrative medicine specialty according to the characteristics of medical students, offer relevant narrative medicine courses for them, and establish a medical training system of narrative medicine, so as to help medical students master relevant narrative skills to the greatest extent in the most suitable training stage for shaping their personal professional ethics in stages. Through the standardized medical training system, we can provide scientific guidance for medical students, help them to establish narrative ability system with their own characteristics, improve their narrative ability, and help them master narrative skills.

6. Conclusion

In the current narrative shift of doctor-patient communication, apart from the necessary treatment and care for patients, we should give empathy to patients' families and communicate with their families in narrative way. Health humanities, as a discipline concept of "more inclusive, more open, and more application-oriented," has enriched the content of medical humanities. The cultivation of medical students' narrative ability is the product of the perfect combination of humanistic spirit and medical education. It influences medical students with the charm of literature, and medical students infect patients with humanistic knowledge, thus serving as an important supplementary part of evidence-based medicine, to treat patients equally, regardless of gender, old and young, especially those who have difficulties in communication, but also put themselves in the patient's

shoes, analyze and summarize communication methods, and apply them in clinic, so as to improve communication ability. There is a big gap between medical staff's understanding and practice of patients' communication needs and patients' expectations. Medical staff lack humanistic care and communication skills. Training medical students can enhance students' empathy ability in practical teaching and help students to improve their professional knowledge and ability, which is of great significance to enhance medical students' humanistic spirit.

Data Availability

The data used to support the findings of this study are included within the article.

Conflicts of Interest

The authors declare that no conflicts of interest exist concerning this study.

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