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Peer Review

Review of: "Narrative Medicine: A Way to Care More Than Cure"

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Overall Assessment

This timely commentary argues that narrative medicine should not be regarded as a luxury limited to well-resourced institutions, but as a potentially valuable component of clinical practice and medical education in Bangladesh and comparable settings. The manuscript has a clear thesis, a relevant contextual focus, a generally current bibliography, and appropriate declarations regarding funding, competing interests, and language-editing tools. Its attention to communication, empathy, reflective practice, patient experience, professional development, and clinician well-being is valuable.

The central argument is promising, but the manuscript requires substantial revision before publication. In particular, it should distinguish normative claims from demonstrated effects, explain how the literature was selected, engage seriously with counterarguments, define the limits of transferability, and present a feasible implementation pathway. These revisions would strengthen, rather than weaken, the authors' position.

Major Comments

1. Align efficacy claims with the evidence. Statements that narrative medicine "improves," "reduces," or "leads to" outcomes such as empathy, communication, adherence, satisfaction, academic performance, or well-being require studies that measured those outcomes. Conceptual or descriptive sources establish plausibility but not effectiveness. Please distinguish demonstrated effects, associations, preliminary findings, theoretical rationales, and expected but unproven benefits. Where evidence is heterogeneous, self-reported, or drawn mainly from high-resource settings, use appropriately cautious language such as

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"may support" or "has shown promise." Outcomes should not be treated as interchangeable, and each citation should support the precise claim to which it is attached.

2. Clarify the literature-selection approach. Although this is a commentary rather than a systematic review, readers should know how the supporting sources were chosen. Please add one concise sentence identifying databases, approximate period, principal terms, and broad selection priorities, or state explicitly that the references were selected narratively and are illustrative rather than comprehensive. Recent syntheses should be considered where they materially inform the argument, including DOI 10.1136/bmjopen-2019-031568, DOI 10.1186/s12913-024-11530-x, and PMIDs 38512594, 40329527, 40844184, and 42143141. Not every work must be cited; the goal is to represent the current balance and limitations of the evidence.

3. Address counterarguments directly. The commentary would be more persuasive if it presented the strongest objections and responded to them. In particular, it cites "The Limitations of Narrative Medicine" (DOI 10.1007/s11017-025-09713-6) but does not appear to discuss its principal challenge. Relevant concerns include added burdens on overstretched clinicians, unequal access to literacy or protected time, cultural and linguistic differences, confidentiality and consent when patient stories are used, the risk of imposing coherence on patients' narratives, and the limited validity of proxy outcomes such as empathy scores. Please also state clearly that narrative medicine complements, rather than replaces, adequate staffing, clinical training, diagnostic capacity, fair working conditions, and structural reform.

4. Define contextual specificity and transferability. The focus on Bangladesh is a major potential contribution, but the manuscript should separate features specific to Bangladesh from those shared by some South Asian systems, other resource-constrained settings, or clinical communication generally. Please discuss relevant assumptions such as consultation time, workload, teaching structures, linguistic diversity, family involvement, stigma, hierarchy, rural–urban differences, digital access, and faculty capacity. Claims about Bangladesh should use local evidence where available. The conclusion should identify which elements are broadly adaptable, which require cultural or linguistic redesign, and which depend on minimum institutional resources.

5. Make the proposal operational and evaluable. Please describe a feasible minimum model: target participants and setting; responsible department or programme lead; core activities; session frequency and protected time; facilitator preparation; use of Bangla, English, and local narrative traditions; costs and low-cost alternatives; consent, confidentiality, de-identification, and trauma safeguards; and

predefined feasibility and outcome measures. A brief six- or twelve-month pilot framework would make the commentary more actionable. It should identify barriers, unintended burdens, criteria for success or modification, and a pathway from pilot testing to possible expansion.

6. Separate the normative case from the evidence agenda. The claim that narrative medicine should not be treated as a luxury may be defended ethically and educationally even when locally specific effectiveness data remain limited. Consider structuring the discussion around three questions: why narrative competence may matter in the context described; what current evidence establishes and leaves uncertain; and what locally adapted pilot and evaluation strategy should precede broader adoption.

Minor Comments

- Define “narrative medicine” precisely and distinguish it from reflective writing, active listening, communication-skills training, medical humanities, patient-centred care, and empathy education.
- Identify the principal target group: students, residents, physicians, nurses, or interprofessional teams. Explain whether one model is suitable for all groups.
- If digital delivery is proposed, address connectivity, privacy, device access, digital literacy, and possible exclusion.
- Prefer “adherence” to “compliance” where appropriate, and avoid treating resource-constrained health systems as homogeneous.
- Incorporate Bangladeshi languages, storytelling traditions, family roles, and community perspectives as sources of curriculum design, not merely as adaptations of an imported model.
- Split the few sentences exceeding approximately 40 words. Aim for one main idea per sentence and introduce the principal verb early.
- Retain the current funding, competing-interest, and language-editing disclosures.

Recommendation

Major revision. The manuscript should not be rejected on the basis of the concerns above: it has a clear thesis, a timely topic, and a valuable contextual focus. Substantial revision is nevertheless needed to align empirical claims with appropriate evidence, make the literature base transparent, engage fairly with objections, define transferability, and turn the proposal into a feasible and evaluable plan. Addressing these points would considerably improve the commentary’s rigour, balance, and practical relevance.

Declarations

Potential competing interests: No potential competing interests to declare.