



REVIEW ARTICLE

Narrative Medicine: Clinical Relevance in Contemporary Practice and Conceptual Alignment with *Āyurvedic* Principles

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Abstract

The rapid technologization of healthcare has improved diagnostic and therapeutic precision but has also distanced clinicians from patient's lived experiences. Narrative medicine emerged in the early 21st century as a response to this depersonalization, defined as medicine practiced with "narrative competence"-the ability to recognize, absorb, interpret and act on patients' stories of illness. It seeks to re-centre the patient's voice, strengthen empathy, and integrate subjective experience with biomedical evidence. *Āyurveda*, is intrinsically narrative in its orientation: *rōga-rōgi parīkṣā*, *daśavidha parīkṣā*, *aṣṭavidha parīkṣā*, *satvāvajaya chikitsa*, and numerous clinical similes show a sophisticated engagement with patients' stories, metaphors and psycho-social context. This article reviews key concepts and evidence in narrative medicine, examines its relevance in an era of artificial intelligence and social media-driven isolation, and critically maps these constructs onto *Āyurvedic* theories and practices. It argues that many of the aims of narrative medicine are already embedded within classical *Āyurvedic* paradigms of individualized (*puruṣam puruṣam vīkṣya*), participatory (*chatuspāda*) and mind-centred (*satvāvajaya*) care. The paper also discusses the constraints of very short consultation times, and the need to integrate narrative-based training into *Āyurveda* education and clinical practice. In an age where loneliness and digital mediation threaten authentic human connection, consciously reclaiming the narrative dimensions of *Āyurvedic* practice is not a luxury but an ethical and clinical necessity.

Introduction

Advances in imaging, laboratory diagnostics, electronic health records and artificial intelligence have transformed biomedical care, but they have also contributed to a reduced interactions between physicians and patients. The clinical encounter increasingly risks becoming a transactional exchange of data points rather than a shared exploration of suffering and meaning. Narrative Medicine works to close this gap by emphasizing the importance of listening to patient stories and applying storytelling in medical practice.

Narrative medicine, an emerging branch of medicine in the last two decades, introduced and elaborated by Rita Charon and colleagues, conceptualizes clinical practice as story-based work⁽¹⁾ and proposes that effective medicine requires narrative competence: "the capacity to recognize, absorb, metabolize, interpret, and be moved by stories of illness."

Over the last two decades, narrative medicine has evolved into a distinct pedagogical and clinical movement within medical humanities, incorporating close reading of texts, reflective writing, attentive listening, and structured engagement with “narrative situations” between physician, patient, colleagues, self and society. A recent scoping review of 274 papers documented applications of narrative medicine across theory, clinical practice and education, demonstrating its integration into multiple specialties and training programmes worldwide.(2) Concurrently, there is growing concern that digital health technologies, while improving efficiency can depersonalize encounters if not counterbalanced by intentional, humanistic practices.

The contemporary epidemiology of loneliness sharpens the urgency of such an approach. The WHO Commission on Social Connection estimates that roughly one in six people worldwide are affected by loneliness, with social disconnection linked to more than 870,000 deaths annually and significantly elevated risks of cardiovascular disease, stroke, depression, anxiety and premature mortality.(3) The US Surgeon General’s advisory similarly concludes that the mortality risk associated with social disconnection may be comparable to smoking up to 15 cigarettes a day, exceeding that of obesity and physical inactivity.(4)

From an *Āyurvedic* perspective, the narrative medicine approaches are explained in the *Samhitās*. *Āyurveda* has long recognized the centrality of narrative, meaning and relationship in healing. This article explores how the contemporary discipline of narrative medicine converges with and can reinvigorate these classical *Āyurvedic* insights.

Methodology

The methodology for this conceptual study is designed to systematically explore the convergence between contemporary Narrative Medicine (NM) and classical *Āyurvedic* diagnostic and therapeutic frameworks.

Study Design

The article employs a systematic conceptual review and cross-disciplinary mapping design. It utilizes a comparative framework to analyze the alignment between the principles of narrative medicine and the classical patient-physician approach explained in the *Āyurveda Samhitās*.

Search Strategy and Data Sources

A dual-track literature search was executed-

- **Narrative Medicine & Medical Humanities:** Electronic databases, including PubMed and Google Scholar were searched using keywords such as "narrative competence," "narrative medicine," and "medical humanities".

- **Classical *Āyurvedic* Literature:** A systematic search of *Bṛhatrayī* (*Caraka Saṃhitā*, *Suśruta Saṃhitā*, *Aṣṭāṅga Hṛdaya*) was conducted to extract thematic correlates pertaining to *rōga-rōgī parīkṣā* (integrated disease and patient examination), *praśṇa parīkṣā* (the methodology of clinical interrogation), and *satvāvajaya* (the principles of cognitive-behavioral and psychological intervention).

Narrative medicine: concept, history and practice

Narrative medicine is subset of medical humanities. The interdisciplinary discipline of medical humanities encompasses the arts, social sciences, and humanities. The social sciences include psychology, medical sociology, medical anthropology, cultural studies, and health geography; the arts include literature, theatre, film, and visual arts; and the humanities include fields such as philosophy of medicine, medical ethics and bioethics, history of medicine, literary studies, and religion.(5) There has been discussion recently about renaming the field “medical humanities” to “health humanities” because the word “medical” tends to exclude both the recipients of healthcare, such as patients and their caregivers, and other healthcare providers, such as nurses, pharmacists, and technicians.(6)

Rita Charon, a physician and a literary scholar from Columbia University, New York, USA first formalized the term around 2000 and defined narrative medicine as clinical practice fortified by narrative competence- “the ability to recognize, absorb, metabolize, interpret and be moved by stories of illness”. (7) She argued that without narrative competence, the patient may withhold the most frightening questions, feel unheard, undergo an unfocused diagnostic work-up, receive fragmented care and ultimately seek other opinions; the resulting therapeutic relationship remains shallow and ineffective.

Charon later described narrative medicine as “medicine practiced by someone who knows what to do with stories,” emphasizing that clinicians routinely confront plots (illness trajectories), characters (patients, families, clinicians), metaphors and moral dilemmas similar to those in literature. Narrative medicine adapts tools from literary theory, such as attention to temporality, voice, point of view, metaphor, and subtext to clinical encounters, enabling clinicians to discern not only “what is the matter” but also “what matters” to patients.

Key narrative situations include: (1) physician–patient, (2) physician–self, (3) physician–colleagues, and (4) physician–society, along with narratives among patients and between patients and families. In each situation, narrative medicine encourages the clinician to: receive the story fully, recognize its structure, interpret its meanings, be emotionally moved, and then act in ways that are clinically appropriate and ethically responsive.

At the level of practice, narrative medicine is often operationalized through four interlinked domains: empathy, reflection and professionalism, and trustworthiness. Practical strategies include sustained, uninterrupted listening at the start of consultations; inviting open-ended narratives (“Tell me what I should know about your health and your life”); attending to non-verbal cues and metaphors; writing about challenging cases; and using reflective groups or Balint-style meetings to process stories with colleagues. These practices have been associated with improvements in communication skills, empathy scores and professional identity formation among health-profession students and practitioners in multiple studies.(8)

Need and scope of narrative medicine in contemporary healthcare

Several converging trends have driven the global interest in narrative medicine: provider-patient miscommunication, declining empathy, increasing medico-legal conflict, and violence against health professionals; all of these have been noted in Indian settings as well. Medical humanities initiatives aim “to educate for sensitivity,” addressing deficiencies in communication, professionalism and ethical reasoning within competency-based curricula.(9)

Time pressure is a critical structural barrier. A large systematic review of consultation times across 67 countries found that in 18 countries primary care consultations averaged five minutes or less; India ranked among the nations with the shortest recorded average, approximately two minutes per consultation.(10) Another study in an outpatient clinic demonstrated that if patients are allowed to speak without interruption at the start of visits, around 80% complete their initial narrative within about two minutes.(11) It suggests that even very brief but uninterrupted listening can yield rich narrative data without unduly extending visits. These findings strongly support the need of structured narrative listening into routine consultations despite time constraints.

At the same time, the digitalization of healthcare through electronic records, telemedicine, algorithmic decision-support and AI-assisted triage has generated concern about depersonalization. Reviews of digital and narrative medicine integration indicate that while digital tools can increase efficiency and data richness, they risk further distancing clinicians from patients if they are not balanced by intentional narrative practices. When used thoughtfully, however, digital platforms can support narrative work by capturing patient stories, enabling reflective writing, and disseminating multimedia illness narratives that foster empathy.(2,12)

Loneliness and social isolation amplify the stakes of this discussion. Global data show that social disconnection is now recognized as a major public health problem, particularly among youth and older adults, with strong links to cardiovascular disease, metabolic disorders, depression, suicidality and all-cause mortality.(3,4,13) In such a context, a clinical space where a patient is genuinely listened to and where their suffering is narratively acknowledged, can function as a rare locus of meaningful human connection. Narrative medicine thus becomes both a clinical and socio-ethical response to the epidemiology of loneliness in an AI-driven, hyper-mediated world.

Narrative medicine in medical education

Internationally, Columbia University (USA) introduced NM as training workshops then introduced courses-Master of science in narrative medicine and Certification of Professional Achievement in Narrative Medicine (Online). The other institutions which introduced NM in medical curriculum are University of Southern California (USA), Ohio state University (USA), University of Edinburgh (UK), Oxford University (UK), Western university (Canada)

Pedagogical methods include close reading of literary texts, reflective and creative writing, small-group sharing of clinical stories, film and visual arts analysis, and narrative interviews with patients or community members. Systematic reviews suggest that such interventions enhance empathy, reflective capacity and tolerance of uncertainty among trainees.

In India, medical humanities entered the MBBS curriculum through pioneering initiatives at institutions such as University College of Medical Sciences, Delhi, and later at other colleges in Mumbai, Assam and Bengaluru. The National Medical Commission’s AETCOM (Attitude, Ethics and Communication) module, introduced as a longitudinal thread from first to final year, reflects an institutional recognition that technical competence must be complemented by humanistic and communicative skills.(14) However, narrative medicine as a distinct, structured component remains underdeveloped in both MBBS and BAMS curricula.

A recent feasibility study surveying 120 community medicine faculty across India reported that respondents strongly endorsed the inclusion of storytelling-based narrative medicine elements in undergraduate and postgraduate community medicine training, noting that cognitive competencies tend to overshadow affective and communication domains if not explicitly nurtured.(15). This suggests a clear opportunity for *Āyurveda* institutions to design narrative-based pedagogical modules aligned with both AETCOM and classical *Āyurvedic* ideals.

Results

Comparative Analysis of Narrative Medicine and Ayurveda.

Definition of health

The classical definition of *swastha* in *Suśruta Samhita* - “*samadōṣa samāgni ca samadhātu malakriya, prasannātma indriya manāh*” includes the clarity of *ātma*, *indriya* and *manas* as essential to health. (16) This is conceptually analogous to narrative medicine’s insistence that the subjective, experiential dimension of illness must be addressed alongside objective pathology. A patient’s story reflects the state of *manas* and its relationship with body and environment; listening to that story is therefore integral, not ancillary, to *roga* assessment and *chikitsa*.

Rōga-rōgī parīkṣā

Āyurvedic diagnostics are fundamentally dyadic: examination of *rōga* (disease) and *rōgī* (patient) are treated as interdependent pillars of clinical success. Classical descriptions of *rōga parīkṣā* through *nidāna pañchaka* (*hetu, pūrvarūpa, rūpa, upaśaya, samprāpti*) and *rōgī parīkṣā* through *daśavidha* (17) and *aṣṭavidha parīkṣā* (18) demand detailed temporal, situational and experiential histories that are essentially narrative in structure.

In *Suśruta Samhitā*, *Viśikhānupraveśanīya adhyāya* while explaining *ṣaṭparīkṣā*, *praśna parīkṣā* is also given importance which emphasises the importance given to listening to the patients.(19)

Daśavidha ātura parīkṣā - prakṛiti, vikṛiti, sāra, samhanan, pramāṇa, sātmya, satva, ahāra śakti, vyayāma śakti, vaya,(17) cannot be adequately assessed without eliciting stories about the patient’s early life, diet, work patterns, coping styles, exertional tolerance and psychological resilience. Similarly, *Aṣṭavidha parīkṣā (nādi, mūtra, mala, jihva, śabda, sparsa, dr̥ik, ākṛiti)* (18) routinely incorporates *praśna* (questioning) regarding habits, routines and perceived changes, again privileging the patient’s narrative voice. Modern expositions of these concepts emphasize that such comprehensive assessment supports genuinely individualized, person-centred treatment plans.

Physician and patient qualities

Charaka identifies *śruta*, *dr̥iṣṭa* and *dakṣya* among essential qualities of the physician,(20) and explicitly highlights *maitri* (friendliness) and *karuṇya* (compassion) towards patients as core professional virtues. *Maitri sarva bhuteṣu* and *karuṇya para-duḥkha praśamana ichchā* demand that the physician be affectively attuned to others’ suffering, paralleling narrative medicine’s focus on empathic engagement.(21)

Qualities of an ideal patient- *smṛiti* (good memory), *nirdeśākāritva*, (obeying the instructions) *abhīrutva*

(lack of fearfulness, *jñāpakatva* (ability to describe disease), also needs effective communication.(22) Together, these traits construct the physician- patient relationships as a partnership where narratives can be told and understood. This relational ideal is poetically captured in *Suśruta Samhita*, where the patient is enjoined to see the physician as a trustworthy figure, and the physician is advised to care for the patient “like a son,” reflecting deep mutual trust.(23) These classical injunctions mirror narrative medicine’s emphasis on trustworthiness and relational ethics.

Narrative situations in Āyurveda

Many of the “narrative situations” enumerated in modern narrative medicine find explicit analogues in *Āyurvedic* texts.

- Physician-patient: Charaka instructs the ideal physician to be a lamp, illuminating the inner state of the patient, recognizing both the visible disease process and the hidden interior.(24)
- Physician-self: The phrase *jitātmāna* refers to the physician's control over their own mind and self. This self-reflection is central to both *Āyurveda* and Narrative Medicine.(25)
- Physician-colleague: *Āśraya* quality of the physician refers to the relationship and approach with the colleagues when needed.(26)
- Physician-society: The description of the ideal physician includes *brahmacharya, jñāna, dana, maitri, karuṇya* and *upakāra* towards all beings, situating medical practice within broader social and ethical obligations, just as narrative medicine emphasizes physicians’ narrative engagement with public health and social justice.(27)
- Physician-family: Texts recommend that the physician maintain harmonious relations with family and community, acknowledging the interpenetration of personal and professional narratives.(28)

Close reading, reflection and clinical reasoning

Narrative medicine emphasizes “close reading” of texts and patient accounts, slow, attentive interpretation of language, structure and silence. *Āyurveda* similarly instructs the physician to examine “in every possible way” (*sarvatha sarvam ālōchya*) before deciding on appropriate interventions.(29) Clinical reasoning is framed as an integration of *pratyakṣa* (direct perception), *anumāna* (inference) and *yukti* (reasoned synthesis), guided by *tarka* (critical reflection) and *smṛiti* (memory of textual and experiential knowledge). (30) These operations closely resemble narrative medicine’s style of attentive listening, interpretive reflection and ethically grounded decision-making.

Metaphor and phenomenology of illness

Āyurvedic clinical descriptions are rich in similes and metaphors that vividly capture patients' experiences of pain and dysfunction- "as if pierced by needles," "as if bitten by ants," "as if struck by a club," "as if burnt by alkali," and so on.(31) Such metaphors are not ornamental; they encode phenomenological detail that guides differential diagnosis and prognosis. Contemporary narrative medicine pays similar attention to patients' metaphorical language, recognizing that metaphors express both bodily sensation and emotional meaning. The longstanding use of such imagery in *Samhitās* indicates an early narrative sensitivity to subjective experience.

Satvāvajaya chikitsa as Āyurvedic psychotherapy and narrative intervention

Charaka classifies treatments into *yuktivyapaśraya*, *daivavyapaśraya* and *satvāvajaya chikitsa*, with *satvāvajaya* defined as the control or withdrawal of the mind from unwholesome objects. Classical and modern expositions describe *satvāvajaya* as a psychotherapeutic approach aimed at restoring balance among *dhī* (intellect), *dhṛiti* (fortitude) and *smṛiti* (memory), using methods such as regulating thought content (*cintya*), re evaluating ideas (*vicārya*), re channeling assumptions (*ūhya*), clarifying goals (*dhyēya*) and providing corrective guidance (*saṅkalpa*). (32)

The practical implementations of *satvāvajaya* are ongoing dialogue, exploration of meaning, guidance towards healthier cognitions and behaviours, requires precisely the kind of disciplined, empathic listening and narrative engagement that narrative medicine advocates.

Thus, when an Āyurvedic physician listens deeply to a patient describing *mānasika* distress, explores the symbolic meanings of that distress, and collaboratively co-constructs a more adaptive narrative, the physician is effectively practicing a form of narrative medicine rooted in *satvāvajaya chikitsa*.

Personalised and participatory medicine

The verse "*puruṣam puruṣam vikṣya*" explains the physician to examine each person individually before deciding therapy. This principle anticipates both precision medicine and narrative medicine: biological individuality (*prakṛiti*, comorbidities) and narrative uniqueness (life context, values, coping) must both inform treatment. Narrative medicine's insistence on seeing the patient as a singular story rather than an instance of a diagnostic category resonates closely. (33)

Similarly, Āyurveda's model of *chatuspāda*- physician, patient, attendant and medicine as four essential of therapeutic success, frames treatment as a participatory process. (34) The patient is not a passive recipient but an active agent

whose mind, adherence and understanding crucially affect outcomes. Narrative medicine's emphasis on shared decision-making and participatory care can thus be viewed as a contemporary restatement of the *chatuspāda* doctrine in modern idiom.

Discussion

Narrative medicine as a bridge between evidence-based and Āyurvedic practice

Modern biomedicine has justifiably prioritized evidence-based medicine (EBM), integrating best available research with clinical expertise and patient values. Yet over-emphasis on guidelines and algorithms can marginalize individual narratives, particularly in complex chronic and psychosomatic conditions. Narrative medicine has been proposed as a complement to EBM, not its alternative: integrating rigorous evidence (*logos*) with lived experience (*mythos*) to enable "evidence-plus-narrative" care. (35)

Āyurveda offers a historically grounded example of such integration. Classical texts place great weight on experiential evidence (*anubhava*), collective clinical wisdom (*siddhānta*), and systematic reasoning (*yukti*), yet they never detach these from patient-specific assessment and *mānasika* context. The contemporary Āyurvedic clinician can therefore adopt an explicitly narrative stance, eliciting detailed illness stories, exploring metaphors and psycho-social determinants, while simultaneously applying both modern evidence and classical *yukti* to individualize treatment.

In musculoskeletal pain, for instance, a purely evidence-based biomedical approach might focus on imaging, pain scores and pharmacologic/physiotherapy protocols. A narrative-informed Āyurvedic approach would also inquire how pain affects work identity, roles in the family, self-esteem and spiritual life, and would integrate *snehana-swedana*, *basti* or other procedures with *satvāvajaya* -type counselling, ergonomic modifications, and lifestyle re-framing. Such a model aligns well with current discussions of "P4 medicine" (predictive, preventive, personalized, participatory) and "compassionate precision medicine" that combine big-data personalization with narrative empathy.

Implications for Āyurveda practice and education

The convergence of Narrative Medicine and classical Āyurvedic principles suggests that narrative competence is a fundamental, rather than elective, component of traditional practice. The following implications detail how this integration can be operationalized in contemporary clinical and educational settings:

- Re-centring listening in busy OPDs, even in high-volume outpatient settings.
- Integrating narrative methods into *satvāvajaya* practice
Clinicians already practicing *satvāvajaya* chikitsa can explicitly incorporate narrative tools: illness narrative elicitation, guided autobiography, pain diaries, metaphor exploration, and letter-writing to one's disease or body. These methods align with *cintya-vicārya-ūhya-dhyēya-saṅkalpa* operations described in classical texts and can be documented as part of the clinical record.
- Developing narrative competence in *Āyurveda* training
BAMS and MD programmes can formally adopt narrative medicine pedagogy in three domains:
 - ♦ **Close reading:** using selected passages from *Samhitās*, patient narratives and short stories to practice attentive, interpretive reading.
 - ♦ **Reflective writing:** To develop narrative competence, BAMS and MD curricula should move beyond factual recall to affective engagement. A specific pedagogical exercise involves "Metaphor Mapping." For instance, when a patient describes pain "as if bitten by ants" or "as if pierced by needles", students should be tasked with a reflective log entry: "*Analyze the patient's use of 'ant-bite' metaphor use. How does this phenomenological detail refine the understanding of dōṣa involvement compared to a numeric pain scale?*" Such exercises align with the AETCOM module's goal of nurturing communicative and humanistic skills.
 - ♦ **Narrative interviewing:** structured exercises in eliciting patient's stories beyond standard *nidāna pañcaka* questions.
- These activities can be aligned with existing AETCOM outcomes and assessed through qualitatively rather than solely factual recall.
- Leveraging digital tools without losing the human core
As teleconsultations, electronic records and AI-driven triage expand, *Āyurveda* practitioners can use digital platforms to document narratives (e.g., patient-written histories, voice notes) rather than only biomedical parameters. However, technology should be consciously framed as a support for, not a replacement of, human presence and listening.
- Protecting clinicians from narrative burnout
Continuous exposure to distressing stories can lead to compassion fatigue. Both narrative medicine and *Āyurveda* emphasize self-care: reflective practice, peer support circles, spiritual disciplines, balanced routines and mental health. Institutions should therefore pair narrative training with explicit supports to maintain clinician's mental health and to prevent burnout.

Challenges and future directions

- **Selective applicability:** Not all clinical presentations necessitate narrative exploration; acute biomedical emergencies prioritize rapid technical intervention over extended storytelling.(36)
- **Resistance:** Both patients and clinicians may resist narrative approaches. Patients often prioritize technical competence over relational skills, while some clinicians adhere strictly to biomedical or evidence-based paradigms.(37)
- **Emotional burden on clinicians:** Intensive narrative engagement can evoke overwhelming emotional responses, potentially leading to compassion fatigue or burnout. Habitual consultation patterns among practitioners may also disrupt narrative flow.(38)
- **Perceived time inefficiency:** Critics highlight narrative medicine's time demands as incompatible with high-volume practice. The perceived contradiction between India's average two-minute consultation time and the two-minute requirement for a complete patient narrative is resolved through the principle of Narrative Efficiency. Rather than viewing storytelling as a time-intensive luxury, it should be recognized as a high-yield diagnostic tool. When an *Āyurvedic* physician allows a patient to speak without interruption, they are not losing time; they are gathering the essential data required to focus the subsequent physical examination, thereby transforming a brief, comprehensive, person-centered consultation. (37)
- **Overemphasis on psychosocial domains:** Some argue narrative medicine neglects biomedical rigor, focusing disproportionately on psychosocial aspects. This critique overlooks narrative medicine's integrative framework, where biological data constitute essential narrative elements alongside experiential factors.(39)
- **Risk of narrative overreach:** Uncritical immersion in patient stories risks exceeding clinical boundaries, treating narratives as ends rather than diagnostic/therapeutic means.
- **Skill acquisition challenges:** Narrative competence demands deliberate training. Nevertheless, communication-proficient clinicians naturally develop these skills longitudinally, with accumulated patient histories facilitating more efficient, relationship-based management.(38)

Nonetheless, the convergence between narrative medicine and *Āyurveda* offers a compelling framework for research and practice innovation. Future work could include: qualitative studies of patient's experiences of narrative-informed *Āyurvedic* consultations; controlled trials comparing standard OPD care with narrative-enhanced care on

satisfaction, adherence and symptom outcomes; curricular evaluations of narrative medicine modules in BAMS/MD programmes; and exploration of AI tools that supports and promotes narrative approaches rather than to suppress empathic human dialogue.

Conclusion

Narrative medicine has emerged as a branch of medical humanities to bridge the gap between a physician's objective clinical knowledge of a disease and the subjective, lived experience of the patient's illness. By employing specific communication skills centred on storytelling, this approach enables healthcare professionals to acquire, interpret, and integrate the diverse perspectives of everyone involved in the care process. Rather than acting as an alternative to evidence-based medicine, narrative practices complement quantitative clinical methods and can be broadly applied across disease prevention, diagnosis, treatment, and rehabilitation. Consequently, the scope of narrative medicine is continuously expanding across three primary domains: theoretical research, direct clinical practice to improve therapeutic effectiveness, and the formal education and training of medical professionals

Narrative medicine arose as a corrective to the depersonalizing tendencies of high-technology, evidence-driven healthcare, insisting that clinicians must cultivate narrative competence to practice truly humane and effective medicine. Classical *Āyurveda*, with its rich frameworks of *rōga-rōgī parīkṣā*, *daśavidha* and *ashtavidha parīkṣā*, *satvāvajaya chikitsa*, individualized and participatory care, and evocative illness metaphors, embodies many of the same insights in its own conceptual language. In an era marked by loneliness, social isolation and AI-mediated interactions, systematizing the narrative dimensions of *Āyurvedic* practice can restore depth to the physician–patient relationship and enhance therapeutic outcomes. Developing narrative competence in *Āyurveda* is therefore not an imported fashion but a return to the core of its own *saṃhitā*-based wisdom, where listening to the patient's story is both diagnostic tool and medicine in itself.

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