Chapter

7 Towards a Narrative Model of Knowledge Translation

Narrative medicine has traditionally focused on the 'bedside' – the clinician's attentive listening to patient stories, which is assumed to foster empathy, reflexivity, and improved individual care. Throughout this book, we have argued that while this focus is valuable, it is not sufficient. Narrative is not confined to the clinical encounter; it permeates all aspects of the creation and communication of medical knowledge itself, from the formulation of research questions and study designs to the production of reviews, guidelines, and policy recommendations in order to enhance public uptake. Scientists and clinicians always operate and interact in a story-laden environment; they construct, negotiate, and interpret narratives at every stage of research and practice. Moving beyond the bedside does not mean abandoning narrative medicine's ethical commitments; it means extending them into the systemic processes through which medical knowledge is produced, translated, and put to work.

Our expanded view of narrative and medical knowledge aligns with the emerging field of **translational medical humanities (TMH)**. Recently described as a 'third wave' in the medical humanities (Bleakley 2023), TMH builds on the critical medical humanities associated with the second wave in the development of this subdiscipline (Whitehead et al. 2016). While the second wave focused predominantly on critique, exposing the epistemological, ethical, and political assumptions of biomedicine, TMH retains this critical stance but couples it with a constructive ambition by drawing attention to the conditions under which biomedical and cultural forms of knowledge are translated across various domains. In other words, it seeks to lay bare the translational practices that underpin the complex entanglements of scientific, cultural, institutional, and experiential knowledge.

Central to TMH is the concept and rhetorical repertoire of *translation* as a bridge between medicine and the humanities. Traditionally, fields such as translational medicine and translation studies operated with distinct and seemingly incompatible notions of what translation entails (Arnaldi et al. 2022). TMH brings these paradigms into dialogue, using translation as an analytical and methodological lens to understand how knowledge moves, changes, and acquires meaning across contexts. From a TMH perspective, medical knowledge is not a stable 'source' that can be transferred intact from the domain of research to that of practice, but the outcome of ongoing collective meaning-making among heterogeneous actors, including researchers, clinicians, policymakers, patients, institutions, and publics (Engebretsen, Fraas Henrichsen, and Ødemark 2020). Accordingly, knowledge translation (KT) is never a petrified or linear process; it necessarily involves interpretation,

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recontextualisation, and narrative reframing as evidence is redeployed in new social, clinical, and political settings.

By foregrounding translation as an interpretive and semiotic process, TMH challenges dominant models of KT that rely on linear, decontextualised metaphors of transfer. The persistent gap between research and practice cannot be closed simply by improving dissemination or implementation strategies, because that gap is not merely technical – it is epistemic and cultural. In TMH, a simplistic 'follow the science' mentality gives way to approaches that interrogate how scientific authority is constructed, how evidence is framed and made relevant, and how sociocultural forces shape what counts as legitimate knowledge and action (Arnaldi et al. 2022; Błumczynski and Wilson 2023). Translation is not viewed as a channel for communicating facts but as a site where 'facts' are **re-narrated**, contested, and ethically evaluated.

Alongside translation, our model of TMH acknowledges **narrativity** as a central mechanism of KT that must be explicitly addressed through a *narrative approach to translational medicine*. To date, narrative medicine has largely celebrated individual patient stories and clinicians' reflections, but it has been critiqued for failing to engage with broader structures of power, policy, and evidence. Earlier in the book, we noted that narratives are not necessarily benign or empowering, as the literature on narrative medicine seems to assume; they can obscure and exclude just as easily as they can enlighten and empower. Thus a reimagined narrative medicine must critically examine which stories are told (or silenced) and how personal, institutional, and cultural narratives intersect.

In this final chapter, we synthesise these insights into a framework for narrative-informed KT that operates across scales, from the micro-narratives of individual experiences through the meso-level of clinical guidelines to the metanarratives of evidence-based medicine and scientific progress. By integrating narrative theory into models of KT, we aim to foster a more reflexive, inclusive, and human-centred approach to translating medical knowledge.

7.1 Limitations of Traditional Knowledge Translation Models

As discussed in detail in Chapter 3, mainstream models of KT – from the simplistic 'bench-to-bedside' linear pipeline to more recursive approaches like the knowledge-to-action (KTA) cycle – provide useful roadmaps, but they capture only part of the story. Such models depict how evidence should move from producers (researchers) to users (clinicians, patients, and policymakers) through the stages of synthesis, dissemination, and application. They tend to treat knowledge as a stable commodity that merely needs repackaging and transfer, rather than as the product of a dynamic process that evolves and mutates through interpretation. The linear pipeline model, for example, envisions a unidirectional flow (discovery → evidence summary → clinical application), glossing over the social and textual mediations involved at each step. While more iterative and context-sensitive, the KTA framework still implicitly assumes that 'knowledge' enters the process as a finished product, for example as a systematic review or guideline, and that the main challenge is overcoming external

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'barriers' to its uptake. What these perspectives downplay is the hermeneutic dimension of translation: the fact that knowledge must be continually translated, rewritten, re-narrated, reframed, and even reconceived as it travels across contexts.

A critical blind spot in traditional KT approaches is their failure to interrogate the nature of evidence itself as it is being 'moved' across different sites. The World Health Organization's (WHO's) 2004 definition of KT speaks of 'reliable and relevant research results' to be communicated and tailored to new settings, implying that results are self-contained truths that simply need better distribution. This overlooks the reality that what counts as reliable or relevant evidence is itself narratively constructed. For example, the forms of evidence privileged in many KT systems – clinical trials and meta-analyses – are produced in specific, privileged sites of narration with highly predetermined formats (e.g., the systematic review) and exclusion criteria. By elevating these forms above all others, standard models of KT inadvertently marginalise other kinds of knowledge such as qualitative studies, patient testimonies, and local knowledges that do not fit the high-evidence template. This creates a pipeline bottleneck in which only knowledge that is narratively formatted in certain ways (quantified, aggregated, decontextualised) is allowed to flow forward. In other words, selective appropriation is built into the very practices of evidence synthesis. And yet conventional KT frameworks treat the outputs of such practices as neutral inputs to be disseminated.

Another limitation of conventional models of KT is how they handle context and what they view as barriers. The KTA cycle wisely emphasises the need to adapt knowledge to local contexts and iterate the process based on feedback, acknowledging that implementation is not a one-size-fits-all affair. But even here, the language used often casts local culture, patient values, and practitioner experience as obstacles to be overcome or as mere implementation facilitators, rather than as equally legitimate forms of knowledge that should feed into and interact with what is being translated in the first place. A narrative perspective flips this view: what KT literature labels as barriers might be seen more productively as alternative narratives or knowledge systems that resist assimilation. For example, in the abortion guideline case discussed in Chapter 6, opposition to the WHO 2022 guideline from religious groups was not just a barrier to evidence use; it was grounded in a fundamentally different narrative about morality and authority. A purely technical KT approach might attempt to 'educate away' such resistance, whereas a narrative-informed approach would engage it as a counter-story to be understood, negotiated with, and even integrated into a more pluralistic understanding of the issue.

Traditional KT models have tended to be technocratic, framing translation as a series of rational tasks (synthesise evidence, identify barriers, tailor messages) that presume a largely uniform reality. What they miss is the textual, interpretive, and political labour involved at every step of the way – the very labour that our narrative approach seeks to illuminate and elevate.

7.2 Towards Deep Knowledge Translation

Throughout this book, we have shown that KT in the domain of reproductive health is fundamentally shaped by various narrative processes. Whether examining the

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WHO *Abortion Care Guideline*, the Cass Review on puberty blockers, or professional guidance on preimplantation genetic testing for aneuploidy (PGT-A) in in vitro fertilisation (IVF), we see that evidence does not simply 'move' from research to practice. Instead, evidence is (re-)narrated through particular formats and genres – such as guidelines, reviews, position statements, consensus documents – and into particular epistemic configurations. As a facet of the narrative feature of *genericness*, discussed in Chapter 2, these narrative formats determine what counts as relevant evidence, who is authorised to speak, what kinds of uncertainty are highlighted or downplayed, and what practical and moral conclusions become thinkable. In other words, narrative-laden translations do not merely accompany evidence; they structure the very conditions under which evidence is understood, trusted, contested, and acted upon.

Taken together, these cases point to the need to rethink KT in a way that takes narrative seriously, not as an 'add-on' for better communication, but as a constitutive dimension of how knowledge is made portable, persuasive, and governable across different sites. We have built in this book on recent developments in the TMH in order to offer empirically grounded conceptual analysis that zooms in on one specific repertoire from the humanities – namely narrative theory – and demonstrate its relevance for the translational pipeline. We propose our narrative model of KT as an approach that treats narrative as a core dimension of translation, demonstrates how narrative genres shape the meaning and uptake of evidence, and provides a vocabulary for tracing the epistemic and ethical consequences of how evidence is storied as it moves between research, policy, clinical practice, and public debate.

Our narrative model of KT does *not* imply treating knowledge derived from the humanities as just another evidence base or expecting narrative theory to generate its own guidelines or recommendations; such attempts would fundamentally misrepresent the role and strengths of insights drawn from the humanities in translational contexts. Instead, the contribution of the humanities lies in enabling what we might call **deep knowledge translation**: a form of translation that does not merely adapt knowledge to context, but reflexively interrogates the very formats, assumptions, rationalities, and epistemic hierarchies within which translation takes place. Where conventional KT models tend to ask how knowledge can be moved more efficiently from evidence to implementation, a humanities-informed approach asks more foundational questions: what counts as knowledge here? Through which narrative formats is it made intelligible? What values and assumptions are embedded in these formats? And what alternative translations are being foreclosed when one narrative configuration is privileged over others?

In this sense, translational narrative medicine does not add new content to the evidence pipeline; it transforms how KT is conceptualised and practised.

7.3 The Paradox at the Heart of Knowledge Translation

Dominant models of KT are structured around a central paradox (Engebretsen, Sandset, and Ødemark 2017). On the one hand, these models explicitly acknowledge that knowledge must be contextualised in order to be usable. Implementation science, guideline adaptation frameworks, and KT theories all emphasise the need

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to tailor evidence to local settings, populations, and practices. In this view, knowledge cannot be transferred wholesale; it must be interpreted, adapted, and negotiated in context.

On the other hand, standard KT models are built on a hierarchical, abstract conception of knowledge. Evidence is assumed to move 'upwards' through increasing levels of abstraction: individual studies are stripped of contextual particulars and aggregated into systematic reviews, reviews are synthesised into generalised knowledge claims, and these claims are distilled into guidelines intended to have universal validity. In this process, context, uncertainty, and narrative specificity are progressively filtered out in the name of rigour, objectivity, and generalisability. This tension between the demand for contextual sensitivity and the drive towards abstraction is not just a technical inconvenience; it reflects a deeper epistemic assumption that knowledge becomes more reliable to the extent that it is detached from the circumstances of its production and narration. From the perspective elaborated in this book, this assumption is deeply problematic.

If, as narrative theory holds, all knowledge is fundamentally narrative-based, then no act of abstraction can ever fully escape context. Abstraction itself is a narrative operation, a specific way of emplotting evidence, assigning relevance, foregrounding certain actors and outcomes while backgrounding others. Thus what presents itself as purified, context-free knowledge is in fact knowledge that has been recontextualised into a different narrative frame – one that often remains implicit and therefore unexamined.

7.4 Knowledge as Narrative and Inter-narrative Web

Understanding knowledge as narratively constructed also means recognising that every knowledge claim is embedded in an *inter-narrative web*. New evidence never enters an epistemic vacuum; it only becomes meaningful by relating to existing stories, values, metaphors, and explanatory frameworks that are already familiar to its audience. In this sense, knowledge persuades not by logical force alone, but through what Walter Fisher calls *narrative rationality* (Fisher 1987; Engebretsen and Baker 2022): it must resonate with what people already believe, fear, hope, or morally value. This does not mean that it has to confirm what the audience already believes; it simply means that it has to take the audience's values and beliefs into consideration and engage with them productively. As Fisher (1987:24) argues, human beings 'experience and comprehend life as a series of ongoing narratives, as conflicts, characters, beginnings, middles, and ends'. Evidence that cannot be narratively integrated and negotiated – because it contradicts and fails to engage with deeply held values, disrupts established plots, or challenges core identities – will therefore often be resisted or reinterpreted, no matter how strong its scientific credentials. Narrative rationality thus helps us explain why the same evidence can be compelling in one context yet rejected in another, and why translational efforts that ignore the inter-narrative web risk misreading both resistance and uptake.

Narrative *emplotment* is therefore not an optional embellishment of communicating knowledge but its primary mode of intelligibility. New findings do not speak for themselves through empirical content alone; they become meaningful only to the

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extent that they can be situated within an already existing narrative landscape. To make sense of a new finding – whether it concerns mosaic embryos, the safety of abortion, or the use of puberty blockers – people inevitably relate it to stories they already know: stories about technological progress or prudent restraint; about risk and responsibility; about normality and deviation; about childhood vulnerability, autonomy, and care. These narratives might be scientific, clinical, political, moral, or cultural, and they rarely operate in isolation. Instead, they overlap, reinforce, and sometimes contradict one another, creating a dense interpretive environment within which evidence acquires significance.

The case of mosaic embryos provides a clear illustration. The empirical finding that an embryo may contain both euploid and aneuploid cell lines does not, by itself, dictate how such embryos should be classified, how the finding should be communicated to patients, or whether these embryos should be used in IVF. For this finding to become actionable knowledge, it has to be emplotted within a broader story about what IVF is for and how uncertainty should be handled. In the Preimplantation Genetic Diagnosis International Society (PGDIS) guidelines, mosaicism is narrated within a story of technological refinement and progress: improved testing yields ever more granular knowledge, enabling more precise decision-making. Within this narrative, mosaic embryos are treated as manageable technical objects, and uncertainty is framed as a temporary challenge to be overcome through refined classification, strong laboratory competence, and expert judgement. By contrast, the American Society for Reproductive Medicine (ASRM) guidelines embed the same phenomenon in a narrative of clinical caution, emphasising patient counselling and the ethical risks of overinterpretation. Here mosaicism is a sign of the limits of current knowledge rather than its expansion. The ASRM narrative emphasises the danger of overinterpreting uncertain findings and situates decision-making within a broader story of relational care rather than one of technical optimisation. Accordingly, an overlapping body of evidence yields different conclusions not because the data differ, but because it is woven into different narrative plots: one favouring innovation and control, the other favouring restraint and protection from harm.

A similar dynamic can be observed in debates about puberty blockers. Limited evidence of long-term outcomes can support either a narrative of precaution, which frames childhood as requiring maximum protection from harm, or a narrative of care and autonomy, which treats withholding treatment on the basis of limited evidence of potential adverse effects as a source of risk and suffering. In both cases the uncertainty is the same, but its meaning shifts depending on whether the story is about safeguarding vulnerable children or about alleviating present distress and respecting a young person's developing agency.

These examples demonstrate that evidence does not travel as a self-interpreting entity. It travels as part of a story, and that story draws on broader narrative repertoires that extend far beyond the immediate scientific domain. Narrative emplotment thus functions as the connective tissue between empirical findings and social action. It is through emplotment that evidence becomes legible as a problem in need of intervention, a risk to be managed, a justification for caution, or a mandate for change. Recognising this dynamic is crucial for understanding why KT cannot be

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reduced to the simple transmission of facts, and why narrative analysis is indispensable for tracing how evidence acquires force and authority, and leads to specific consequences as it moves through the translational pipeline.

From this perspective, effective KT does not depend on stripping away narratives to make knowledge more abstract or portable. On the contrary, it depends on tracing, engaging with, and explicitly acknowledging the narrative and inter-narrative networks through which knowledge circulates. By attending to the narrative imprints and trajectories embedded in these networks, knowledge can be adapted to new uses and repurposed in new contexts. Translation fails when such networks are ignored, denied, or overwritten by claims of neutrality. The humanities, narrative theory in particular, can contribute to the success of KT by providing conceptual tools for identifying the genres, rationalities, metaphors, silences, and value commitments that shape how knowledge is produced, mobilised, and received. This narrative focus lies at the core of what we describe as *deep knowledge translation*.

7.5 Translational Leaps and Political Co-option

Our case studies demonstrate that interpretive shifts are not a flaw in the translational process; they are both unavoidable and, in many respects, necessary. Without reinterpretation, evidence could never travel from the laboratory context into clinical or policy domains. Evidence does not simply dictate its own translation, and translation necessarily entails reframing. Our cases also show that *how* evidence is framed during these shifts has consequential effects on its subsequent uptake and mobilisation. Distinct epistemic values such as commitments to innovation, precaution, standardisation, or professional autonomy shape the narratives through which evidence is rendered actionable, and these narratives in turn open up opportunities for some political responses while foreclosing others. When such epistemic commitments remain implicit or unacknowledged, they become especially susceptible to political co-option.

The case of the PGDIS guidelines (Chapter 5) illustrates this dynamic clearly. Although the document was produced as a set of conditional, profession-specific recommendations, premised on the fact that PGT-A is already being used and aimed at promoting responsible laboratory practice, it has been mobilised in policy debates as evidence that PGT-A is inherently safe, clinically effective, and ready for widespread public adoption. In national healthcare systems where the technology remains restricted or prohibited, the guidelines are thus reinterpreted not as conditional advice addressed to settings in which PGT-A is already practised, but as an affirmative endorsement of the technology itself. This repurposing depends on a series of translational leaps. Guidance addressed to laboratory professionals is re-narrated as proof of clinical efficacy, conditional recommendations are transformed into general approvals, and demonstrations of technical feasibility are conflated with ethical acceptability and social legitimacy. Crucially, these leaps are not merely the result of error, misunderstanding, or bad faith. They are enabled by the narrative structure of the original translation, which foregrounds competence, standardisation, and control, while backgrounding uncertainty, disagreement, and unresolved normative questions. In doing so, the translation creates a discursive space in which evidence

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can travel further than originally intended, and can be made to do political work that exceeds its stated scope.

A similar dynamic can be observed in the case of the Cass Review (Chapter 4). Although the Review explicitly states that it is not a clinical guideline and does not seek to ban gender-affirming care as such, its sustained narrative emphasis on evidentiary weakness, uncertainty, and potential harm produces a powerful protective storyline. Within this storyline, transgender children and adolescents are consistently framed as a highly vulnerable population, clinicians as operating in a landscape of unacceptable uncertainty, and existing services as insufficiently evidence-based. This narrative configuration has significant translational consequences. By foregrounding uncertainty and risk while backgrounding evidence of benefit, lived experience, and existing international consensus, the Review lends itself to a precautionary interpretation in which restriction appears to be the ethically responsible course of action. This framing has been used by certain policymakers, media figures, and advocacy groups to justify measures such as limiting access to puberty blockers to research settings, closing existing services, and imposing age-based bans – steps that go further than what the Review itself explicitly recommends. The Review's narrative does not merely inform policy; it provides a moral and epistemic grammar through which restrictive policies come to seem reasonable, necessary, and even compassionate. This translational trajectory illustrates how narrative emphasis, rather than formal recommendations alone, can shape downstream use of knowledge.

Importantly, this dynamic cannot be explained by the evidence alone. The same empirical uncertainties could, in principle, have been emplotted within a narrative of provisional care, shared decision-making, or iterative learning under conditions of uncertainty. The fact that they were instead mobilised within a narrative of protection and restraint reflects a particular set of epistemic and ethical priorities – priorities that remain largely implicit within the Review itself. The problem, then, is not that the Review *uses* narrative (all translation does), but that its narrative commitments are not made explicit or open to critical examination. This lack of transparency allows these commitments to be taken up as self-evident grounds for far-reaching policy change.

A comparable pattern can be observed in the reception of the WHO *Abortion Care Guideline* (Chapter 6). The guideline frames abortion as essential healthcare and embeds its recommendations within a combined narrative of public health evidence and human rights obligations. Within this narrative, barriers such as criminalisation, conscientious objection, and restricted access are presented as systemic harms that undermine safety, dignity, and equity. For audiences aligned with this framing – such as global health advocates, reproductive rights organisations, and certain policymakers – the guideline comes across as a pragmatic, evidence-based intervention to prevent avoidable morbidity and mortality.

However, the same narrative framing is read very differently in other environments. Critics rooted in moral, religious, or sovereignty-based narratives see the guideline's human-rights framing of abortion as an ideological overreach. The WHO's authority as a neutral health care institution is contested, and the guideline is portrayed as a political intervention beyond the organisation's mandate. Again, the divergence in

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uptake cannot be explained by disagreements over scientific facts alone. It is the narrative emplotment – abortion as care versus abortion as moral transgression or political imposition – that determines whether the guideline is embraced as legitimate guidance or dismissed as an illegitimate exercise of power.

The question is not whether narrative plays a role in KT – it unquestionably does – but whether that role is acknowledged and subjected to critical scrutiny. The problem is not that evidence gets narrated, but that its narration is often treated as neutral, inevitable, or merely technical. When narrative framings remain implicit, they acquire a taken-for-granted authority that enables translational leaps, selective uptake, and political instrumentalisation to occur without accountability. By contrast, recognising narrative as a constitutive element of translation would allow these framings to be openly debated, contested, and possibly reconfigured, thus opening up space for more reflexive and ethically attuned forms of KT.

7.6 A Narrative Model of Knowledge Translation: From Reorientation to Principles

A narrative approach to translational medicine responds to these challenges by reorienting the very aims of KT. Rather than treating it primarily as a problem of efficiency (how quickly and widely knowledge can be disseminated) or fidelity (how faithfully evidence is preserved as it moves across contexts), our approach foregrounds reflexivity and responsibility as central translational virtues. The guiding question shifts from *whether* evidence has been correctly transmitted from one epistemic site to another, to *how* the narrative framing of that evidence shapes the horizons of possible interpretation, use, and misuse as it travels.

This reorientation is motivated by a central insight borne out across our case studies: translation is never a neutral process. Evidence does not circulate as a stable object whose meaning remains intact across different contexts. Rather, it is continually reworked through narrative operations that assign salience, define relevance, configure uncertainty, and orient action. Translation is constitutive of meaning, rather than a secondary process in its elaboration. Meaning does not precede translation; it emerges through translation. Thus a narrative approach to translational medicine begins not with the assumption that evidence must be shielded from narrative distortion, but with the recognition that narrative reconfiguration is intrinsic to the KT process itself.

As evidence moves from the laboratory setting to research articles, to systematic reviews, to guidelines, and finally to policy and practice, it is continually re-narrated. A finding may be cast within a precautionary expert review, a rights-based guideline, or a technologically optimistic consensus statement. Each format selectively foregrounds some issues and backgrounds others, imposing particular senses of urgency, caution, or progress. None of these narrative choices is value-neutral: decisions about what counts as uncertainty, whose voices are considered authoritative, or whether innovation is celebrated or restrained all encode epistemic and moral commitments, often implicitly.

Because narrative reconfiguration embeds particular values, it also has political and ethical consequences. Once evidence is translated into a narrative that

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privileges certain values, that narrative enters wider institutional, legal, and cultural arenas where it may be taken up in ways that exceed the original scope or intent of the translators. Our cases illustrate that a precautionary narrative can legitimise restrictive regulations, a technocratic narrative can justify market expansion, and a rights-based narrative can be interpreted as either a pragmatic public health measure or an ideological overreach, depending on the context. In this sense, translation is not merely an epistemic process but also a governmental one: it shapes which actions come to be seen as legitimate, responsible, or inevitable.

Deep KT, as we envision it, therefore requires making these narrative, epistemic, and ethical layers visible and subject to scrutiny. It involves asking not only *what* is being translated, but *how*, *by whom*, *for whom*, and within *which* narrative traditions. It also means resisting the temptation to resolve narrative plurality into a single authoritative story. Although closure can be pragmatically useful, the empirical cases discussed in this book show that premature narrative closure risks erasing legitimate contestation and disguising value conflicts as mere technical issues to be resolved by consensus.

7.7 Seven Principles of Deep Knowledge Translation

To operationalise our proposed reorientation of narrative medicine and KT, we outline seven principles of deep knowledge translation.

1. *The Principle of Narrative Constitutivity – Narrativity is constitutive of KT, not incidental to it.*

Deep knowledge translation begins with recognising that narrative is not a secondary layer added onto a stable, faithful articulation of knowledge. Every act of translation – from a primary study into a review, from a review into a guideline, and from a guideline into policy – constitutes knowledge anew through narrative emplotment. Translation inevitably involves selecting certain plots, temporalities, protagonists, and explanatory frames that shape what the evidence becomes capable of doing in practice.

This principle rejects the implicit assumption in many models of KT that meaning exists fully before translation. Instead, we maintain that meaning emerges through translation. As our case studies demonstrate, evidence about puberty blockers, mosaic embryos, or abortion safety does not acquire practical significance until it is emplotted within narratives of progress, protection, care, or risk. Deep knowledge translation treats these narrative operations as central objects of analysis rather than as invisible background work.

2. *The Principle of Epistemic Reflexivity – Every translation embeds epistemic and moral values that must be made explicit.*

Deep knowledge translation demands systematic reflexivity about the values encoded in narrative choices. Decisions about how to handle uncertainty, which types of evidence to prioritise, and the scope of recommendations are never purely technical or methodological. They reflect normative commitments about what counts as

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responsible knowledge, what level of risk is acceptable, and what actions are deemed legitimate.

The contrast between the PGDIS and ASRM guidelines on PGT-A illustrates this principle clearly. Their divergence is not just a matter of interpreting data differently; it stems from different value judgements about technological promise, professional responsibility, and patient vulnerability. Deep translation insists that such epistemic values be acknowledged rather than naturalised. Making these values explicit enables those downstream – clinicians, policymakers, patients – to understand why knowledge has been framed in a particular way, and to consider alternative framings that might have been possible but were left out.

3. *The Principle of Narrative Plurality – Legitimate translation does not require narrative closure.*

Standard KT efforts often aim to resolve plural perspectives into a single authoritative narrative, treating consensus as the endpoint of translation. Deep knowledge translation resists this impulse. It recognises that certain forms of disagreement, especially those rooted in divergent moral, social, or experiential standpoints, cannot and should not be erased through further abstraction or synthesis.

The Cass Review illustrates the risks of premature narrative closure. By privileging a single protective narrative centred on evidentiary weakness, the Review marginalises alternative narratives grounded in lived experience, affirmative care, and relational autonomy. Deep translation, by contrast, advocates creating translational spaces in which multiple narratives can coexist, be acknowledged, and remain in productive tension – without collapsing into relativism or paralysis.

4. *The Principle of Contextual Accountability – Translation must remain accountable to its contexts of reception.*

Because narratives travel, a translation's impact cannot be judged solely at the point of its production. Deep knowledge translation asks how a given narrative framing is likely to function once it circulates through new political, institutional, and cultural environments. This means anticipating how narratives might be reinterpreted, instrumentalised, or even weaponised beyond their original context or intent.

The WHO *Abortion Care Guideline* demonstrates this principle. Its framing of abortion as healthcare works as pragmatic public health guidance in some settings, yet in other contexts it is read as ideological overreach. Deep translation does not presume to control all these downstream interpretations, but it does require acknowledging their possibility and taking responsibility for how narrative choices can enable particular forms of uptake or resistance.

5. *The Principle of Translational Traceability – Narrative transformations across the translation pipeline should be traceable, not hidden.*

Deep knowledge translation insists on making visible how knowledge changes shape as it moves through different translational stages. Rather than presenting guidelines or policies as if they were direct, unmediated expressions of evidence, this approach calls for documenting and reflecting on the narrative transformations that occur as

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knowledge is translated from empirical findings to evidence synthesis, to recommendations, and finally to implementation.

This principle directly addresses the kind of translational leaps identified in the PGT-A case, where laboratory guidance was repurposed to justify a broad public policy expansion. Ensuring traceability allows us to pinpoint where a conditional, context-specific narrative has been generalised, and where interpretive judgements – rather than evidence alone – have driven the translation forward.

6. *The Principle of Ethical Responsibility – Translation is an ethical act with real-world consequences for those who benefit from it or are harmed by it.*

Because narrative framing influences who is protected, who bears risk, and whose voices are heard, KT must be understood as having ethical ramifications that go beyond issues of factual accuracy. Deep knowledge translation thus treats KT as an ethical practice, not merely a technical procedure.

Throughout our case studies, different narrative framings have been shown to produce different distributions of vulnerability and agency: in one framing, transgender youths are patients in need of protection; in another, they are agents entitled to receiving affirmative care. Embryos can be framed as technical objects or as morally significant entities. Abortion seekers can appear as rights-bearing persons or as moral transgressors. Deep translation requires paying attention to how a given narrative configuration allocates agency and vulnerability, asking who benefits, who is marginalised or silenced, and who is exposed to risk by adhering to a given narrative.

7. *The Principle of Supplementarity – Humanities-derived knowledge does not replace scientific evidence; it exposes and guides how evidence is made meaningful.*

Finally, deep knowledge translation emphasises the supplementary role of the humanities in relation to science. The humanities' job is neither to generate alternative evidence nor to adjudicate empirical disputes. Instead, the humanities operate at a different level, revealing and informing how evidence is narrated, contextualised, and ethically oriented.

In line with the broader notion of TMH, we position the narrative approach to KT as a *meta*-translational practice, one that interrogates the conditions under which translation itself becomes authoritative, persuasive, and legitimate.

By extending narrative medicine beyond the bedside and into the processes of knowledge production and implementation, and by elaborating and demonstrating the strength of a broader definition of narrativity, we hope to have shown that evidence-based practice must remain attuned to the stories, values, and contexts that give evidence meaning. Applying the principles outlined above, our narrative model of KT can address the challenges observed in our reproductive health case studies and offer a template for a more reflexive, inclusive, and ethically responsible approach to translating medical knowledge into practice.

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