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THE ROLE OF NARRATIVE
IN MEDICAL ETHICS

EDITED BY
RITA CHARON & MARTHA MONTELLO

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EDITED BY

RITA CHARON & MARTHA MONTELLO

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This book project was initiated when Professor Stuart Spicker approached us to edit a special issue of *Healthcare Ethics Committee Forum* on narrative ethics, and we want to thank him for the idea. A parent of this book, the *HEC Forum* special issue helped to mobilize interest and commitment from many of our authors.

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INTRODUCTION

MEMORY AND ANTICIPATION: THE PRACTICE OF NARRATIVE ETHICS

RITA CHARON AND MARTHA MONTELLO

The practice of narrative ethics has developed organically, over the past two decades or so, germinating throughout North America, the United Kingdom, Europe, and parts of Asia, suggesting that this approach to ethics has answered a widespread need within the field. Not a top-down activity, narrative ethics emerged from individuals' ethics practices as they, often on their own, found themselves listening in new ways to their patients and thinking in new ways about cases. The public life of narrative ethics—this book, for example—is but a distal part of this process: nurses, doctors, ethicists, and patients have already made local discoveries that health care's primary duties are to bear witness to patients' suffering and to honor their experiences of illness. From those activities—if pursued with rigor, honesty, humility, and accuracy—flow choices, decisions, and actions. From them also flow healing dividends for patients and for caregivers.

Narrative ethics arose as doctors, nurses, ethicists, and patients found themselves taking seriously their acts of reading, writing, and telling. From patients' pathographies and caregivers' stories from practice to ethicists' written cases, what unified these early efforts was the recognition of the centrality of narrative in the work of health care. Although illness is, indeed, a biological and material phenomenon, the human response to it is neither biologically determined nor arithmetical. In extending help to a sick person, one not only determines what the matter might be; one also by the necessity of illness determines what its meanings might be. Such a search requires the narrative competence to follow the patient's narrative thread, to make sense of his or her figural language, to grasp the significance of stories told, and to imagine the illness from its conflicting perspectives. Narrative approaches to ethics recognize that the singular case emerges only in the act of narrating it and that duties are incurred in the act of hearing it. How the patient tells of illness, how the doctor or ethicist represents it in words, who listens as the intern presents at rounds, what the audience is being moved to feel or think—all these narrative dimensions of health care are of profound and defining importance in ethics and patient care.

Responding to a widespread narrativist turn of the time, bioethics is one of

many fields of knowledge and practice to have been profoundly influenced by narrative theory. Various intellectual disciplines in the past two decades have taken the so-called *narrativist turn*: recognizing the extent to which perceptions are embedded in their telling, realizing human beings' reliance on storytelling to get their bearings in life, and acknowledging the innately narrative structure of human knowledge and provisional truth.¹ Historians, cognitive psychologists, social scientists, theologians, psychiatrists, and literary critics have come to recognize the central role that narrative plays in the way we construct knowledge, interpret experience, and define the right and the good.

The goal of this book is to guide readers toward a cognitive, practical, emotional, and aesthetic familiarity with the conceptual frameworks, methods, and powers of narrative ethics. The book's message—like narrative, its topic—unfolds in time. Readers will not find a statement of the propositions of narrative ethics. Nor will they find sets of rules or “steps” for its practice. Instead, like all narratives, this book conveys what truth it knows through a constant interplay among form, content, and the experiences incurred in reading it. We bring you thoughts and experiences of individuals in singular conversations and situations, not as precepts to be obeyed but as layers of exemplars to be absorbed. The experiences of individual authors—especially in the cases in [part 3](#)—will illuminate, we hope, the ways in which narrative practices, informed by the conceptual frameworks in [parts 1](#) and [2](#), contribute to comprehending the ethical plights of patients, students, and professionals, guiding us all to recognize and perform fitting actions in the face of life.

All the authors of the essays ascribe to beliefs about human singularity, about the relational source of identity, and about language's unique power to define, describe, and expose what human beings see and can know. The writers gathered here from a range of intellectual disciplines, health fields, and stages in their own professional development suggest the wide range of the community we hope to engage in this textual conversation. A psychiatrist, a general internist, a pediatrician, an eminent literary critic, and a cognitive psychologist of international renown in the field of narrative knowledge are among the writers here who variously enter into dialogue about narrative approaches to ethics, observing and revealing the conceptual grounds upon which they do their work. The cases the clinicians bring under an ethical gaze consider the meanings of patients' lives over time, reflect on how those meanings change during the course of illness, and explore the way these changes in meaning give rise to the ethical questions at the heart of each narrative.

At the center of each case described in these chapters lies the recognition that serious illness raises the veil in the lives of those involved. Old family secrets, long-time troubling issues, deeply felt but unexpressed emotions—all muted or somehow removed from the surface of daily lives over the years—often become visible and expressed in ways that they are at no other time during our lives. Serious illness can be, and often is, a time of profound change in the lives of patients and those closest to them. What our authors understand and reveal is that narra-

tive methods are uniquely capable of capturing, rendering, and conveying what these times are like for people for whom the veil has been lifted and how that reality affects the ways they perceive the moral choices open to them. And with the honed skill of good narrativists, all our writers show that arriving at a fitting resolution in the ethical realm requires that one develop a sense of the ending. To envision possible endings is the obligatory prelude to choosing one.

A narrative approach to bioethics focuses on the patients themselves: these are the moral agents who enact choices. Theirs are the lives ruptured by the *peripeteia*, or the transformative event, that the cases highlight. The descriptions, analyses, and interpretations of their journeys through the moral realms of illness become our tradition, our storied past, the collectively held touchstones that enable us to know what to do next. Known to us in rich, earthy, singular complexity, these stories of individual patients form our professional canon, both in ethics and in clinical medicine.

We begin this collection of essays with the transforming realization that the patients are the true ethicists. We professionals accompany them, for sure, with diagnostic help, therapeutic moves, and ethical recommendations. Yet, those who shoulder the duties to act ethically and live with the consequences of their actions are the patients and not their ethicists. Perhaps another result of narrative ethics' emergence will be the realization that, for patients and their families, the ethics under question are not located primarily in the technical questions of providing or withholding health care, allocating scarce resources, or preserving autonomy in the face of death. Those are ethicists' ethical considerations. In large part, the ethics in question are the ethics of ordinary life: how to fulfill life goals, to honor obligations, and to make sense of events in ways that make it possible to go on. These ethical issues have not only to do with *bioethics*; they are also the *ethics of life*.

We open the book with a section that locates the work of bioethicists within a universal search for authentic human communion through language and an effort to create meaning in our lives. [Part 2](#) focuses on the conceptual frameworks from literary studies that ethicists and caregivers use in their work with patients. Each of the authors in this section has both formal training in literary studies and considerable and varied experience in the work of medical ethics. Their essays reveal the fruitful connections between the basic elements of literary analysis and the work they do with ethics cases. [Part 3](#) presents the practice of narrative ethics in its clinical particularities. Five practitioners write about real patients, having gained permission where necessary to publish these essays. In each, the conceptual frameworks of the preceding sections are put to work with an honesty and rigor that have inspired the editors' grateful awe during the writing of this book. Each author reveals the sometimes unexpected utility and transformative power he or she found in bringing narrative methods to bear in clinical work with patients. [Part 4](#) examines explicitly some of the consequences of the practice of narrative ethics for our institutions, our training programs, and our notion of what, indeed, qualifies as ethics. The writers in [Part 5](#) then step forward to *do* the

work of bioethics now informed by narrative considerations, letting us see what kinds of questions can be asked and what kind of work can be done with these new methods.

Hourglass in shape, the book starts with generalizations, then narrows—with the help of specific conceptual frameworks from literary studies—to examine very closely one particular story at a time, and then broadens, benefitting from what has been learned from each story to reach a newly achievable plane of realizations about the implications of narrative methods for the work of ethics in medicine. Common themes emerge from the collection of essays that reflect wider and wider circles of signification: the relationship between emotion and reason in moral deliberation, the ethical importance of witnessing the suffering of others, the fundamentally relational nature of understanding between human beings, the possibility of reconciling the inevitable gaps between subjectivity and objectivity, the liminal aspects of illness, and the possibilities for personal transformation open to patients, ethicists, and caregivers. Indeed, the boundaries that generally separate our clinical domains from ethical domains are revealed to be permeable: the same sets of concerns and sources of illumination come to hand whether a doctor treats a patient or an ethicist deliberates about a consultation. The practice of narrative ethics may provide an unforeseen dividend in the new clarity it may give regarding the relations between clinical practice and bioethical practice. We recognize that we are all trying, clinically or ethically, to heal.

Finally, we recognize that individual sick persons and their families are the occasions for vision and insight for us all. As we guide our patients through the ethical rapids and as we come to understand what the moral life requires, we can grow in our own wisdom and usefulness by undergoing formative, authentic encounters with those we hope we serve. Each of us develops his or her own casuistic canon of exemplars of the moral life, regarding that which we witness not necessarily as puzzles to solve but mysteries to behold. Reciprocal and reflective, the practice of narrative ethics demands vision and courage, all the while replenishing one's store of vision and courage. We hope that the communal efforts of this book will embolden us all toward as yet unimaginable bravery, as yet unseen beneficence in the service of patients and their families.

NOTE

1. See Murray Kreiswirth, "Trusting the Tale: The Narrativist Turn in the Human Sciences," *New Literary History* 23 (1992): 629–57; Murray Kreiswirth, "Merely Telling Stories? Narrative and Knowledge in the Human Sciences," *Poetics Today* 21, no. 2 (2000): 293–318; and Donald E. Polkinghorne, *Narrative Knowing and the Human Sciences* (Albany: State University of New York Press, 1988) for discussions of the narrativist turn in several humanities and social science disciplines. See Wallace Martin, *Recent The-*

ories of Narrative (Ithaca: Cornell University Press, 1986) for a précis of contemporary literary narratology.

PART I

NARRATIVE KNOWLEDGE

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CHAPTER 1

NARRATIVES OF HUMAN PLIGHT: A CONVERSATION

WITH JEROME BRUNER

JEROME BRUNER

Professor Jerome Bruner met with *Stories Matter* editor (RC) in March 2001 for a conversation about the role of narrative knowledge and practice in medicine and ethics. Professor Bruner introduced the concepts of narrative knowledge to us all in his seminal studies *Actual Minds*, *Possible Worlds* and *Acts of Meaning*.¹ His formulations of the structure and function of narratives have revolutionized cognitive psychology and the teaching of law, among many other fields. His new book *Making Stories: Law, Literature, Life* discovers how our deepest notions of the self are organized and enacted narratively.² Here he speaks about the unity and the meaning of ordinary living achievable through narrative acts, and he suggests narrative means by which bioethicists can improve their practice.

RC: Medicine and bioethics have followed psychology and law and so many other fields in coming around to respecting the power of narrative and trying to understand how it works in our lives. We have begun to examine how narrative competence might help to make our work with sick and dying people more humanistic and more ethically discerning. Help us understand what narrative knowledge is and why we need to know about it.

JB: However specialized the culture, the fact remains that, whatever the specialized job you do, whether it's riveting bolts or taking care of people on death row, there's some kind of underlying thing that gives a kind of unity and sympathy and possibility for the human condition continuing. You're constantly in the process of making narratives. You meet some guy, he said this and did that, and so on. We're always trying to control them by making them sound as if they're something other than narratives. I laugh when people say, "Those are just stories, just narrative, let's get the facts!" We live by stories, and they're what give sense to our lives. We're such biosocial creatures anyway that they may be part of what gives us our biology. They give us a lot of the biology having to do with health. Of course, you have to figure out something about the dosage—you can't give too much! The dehumanizing process first gets expressed as people being rational—I'm not rational about the people I love or hate! I don't have to justify my loyalty to narrative, I just want to let

it come into work, not because of the fact that it's self-indulgent on my part, but because human society cannot run without it. And I feel very strongly that rather than talking about stories as old wives' tales, we had better look technically at what on earth they do.

RC: How do we live by stories, and how do stories confer unity?

JB: Telling stories is an astonishing thing. We are a species whose main purpose is to tell each other about the expected and the surprises that upset the expected, and we do that through the stories we tell. In my early studies, to go way back, I was interested in perception and selectivity. We're constantly scanning the world selectively in order to minimize surprise but also to find the kind of thing we're looking for. Now, it was physiologist and Nobelist Lord Adrian who first got me off on this kind of thing. He said, you know, the thing that's so interesting about the reticular system is that it goes "Boom!" when something violates expectancy, and what it does is to clear all the residual and vagrant impulses in the cortex so that by the time the surprising message gets there, it can be heard.

I suppose stories are analogous to the reticular system. We start out with some sort of canonical expectancies of what the world is like, how things are going to be, and then all of a sudden things happen differently; you have what Aristotle referred to as the *peripeteia*. Something knocks expectancy galley west, off course; all of a sudden, you get cancer, your wife leaves you, or your accountant calls to say that the market dropped like mad during the night and you have no money left. There's the *peripeteia*, and then you try to cope with the *peripeteia* and to restore a new legitimacy and expectancy in life. Now what's striking about the new kind of legitimacy on the medical side is that usually, as narrowly defined, the upset of expectancy is, "I've got news for you, you're on the brink of death." The ordinary canonicity is that you'll go on living forever, and now somebody tells you it's finite and you're going to be dead.

RC: And what helps people restore legitimacy after these upsets?

JB: We deal with these upsets—we begin to form a style. We talk about someone—say, Bill; he never panics, he always thinks about how this might have been, what he would do—and we say that's how he is himself. So the great thing is that when people come to this stage of being patients, when they come to the likes of you at the hospital and you have to tell them some hard news that you don't know if they'll make it or not, the person wants to deal with it in some way that has some stylistic integrity about it. That is to say, that's true to them, that's true to the people they love, what the people expect of them. I was thinking of something from Rainer Maria Rilke, "A Death of Your Own." Do you know that piece? It's fantastic, it's about this old man who's having a death of his own. It's real Rilke: it destroys your sleep for three nights afterward. It has to do with death, but it has to do with other things, such as the important turning points in your life. You want somehow to relate your death to what you think of as your itinerary, that your death is

going to be like your life in some way. Your death is going to be like your life, the two are going to be of a piece.

RC: Some of us in bioethics have begun to conceptualize our narrative work as trying to do exactly that—helping people to answer the question “In the face of this life, what constitutes a good death?” Can relative strangers help a person to do that?

JB: Well, it’s a funny thing. I’ll tell you one experience that didn’t have to do with death but with blindness for me. I was born blind because of cataracts. Fortunately, they were not opaque, so the light got to my retina. My cataracts were removed by a brilliant surgeon. So I got that done, and well. I’ve even won a few minor squash championships in my time. I went to the Eye Institute at the Columbia-Presbyterian Medical Center in 1950, because I noticed that a secondary membrane was growing into the place where the lens had been taken out. And I went to a renowned doctor named Doctor Drake, who had a big reputation. I went to him. He said, “It’s going to be a bit tricky because we have to go far back on your eyeball.” My postoperative eyes were covered up for two days. I couldn’t tell whether I could see or not. But at the Eye Institute I had a nurse who sensed my anxiety about “Am I blind or am I not blind?” She came in and said to me, “Hi there, blindfold! How are you doing?” I loved that; it was a recognition that I feared I might be blind and not just blindfolded. Her sharing mattered. This was just an ordinary thirty-five-year-old Irish-American nurse. I recall saying to myself, “If she can do it this way on the fly, what’s the matter with the rest of us? Can’t the rest of us do it too?”

RC: What is the “it” that she did for you?

JB: She *recognized* my human plight and shared it with me. There are plights having to do with death, having to do with love, having to do with power, with wanting to help someone you can’t help. Until you get into one of those plights you don’t know what torture is. My nurse recognized the fact that I was not just a “patient,” I was somebody with plights, a human being. Plights are everywhere, but the important thing is to pick your plight, be true to coping with it. And not just this particular plight, but you go back again over the class of plights that you have lived with and how you make what you’re doing now somehow consistent with a style. There’s that wonderful Henry James story about that narrator with his plight of the beast in the jungle, his impenetrable blindness, and then the woman who is in a sense complicit in looking at the thing like that.

RC: May Bartram recognizes Marcher’s plight, all right, but it isn’t a plight you’d want to be left in, and she isn’t able to penetrate his blockhead to let *him* recognize it. Aren’t there plights, like Marcher’s, that you don’t want to be true to but rather free from?

JB: Yes, and the freedom usually *comes from* someone else’s recognition. I’ve had some personal experience with kids, for example, who’ve been in one of those car crashes that shouldn’t happen to anybody, and who have survived

only because they've got soft bones and youth. Let me tell you that story—right from the start. It starts a few years before I began working with these kids. I was out skiing in Aspen over a Christmas holiday, going easily down the hill. The top crust broke, and I went through, and my knee broke. They finally operated, and I had to do a lot of exercises to recover. Rita, you won't believe this. When you went to do your exercises, they put you into a curtained cell, a nice little cell with linen curtains. You did your exercises alone. It was pretty grim and hard to do. And it was like that for long months of treatment.

Now, let me go back to the kids. Soon after this accident, about two or three months after the operation and the exercises, I sailed my sailboat across the Atlantic. One's pretty immobilized on a sailboat. When I got to the other side (I was on my way to Oxford), I discovered I couldn't move my leg—it was all bound up at the knee. I went to the orthopedics department at the university and they said, "Come up and take a remedial class with us." Classes? Hmm. What did I discover? They had a whole little gang together, some of these injured kids included. So I would get through my exercises right out there in the open, on the floor of the gym, and then I'd watch the kids. And the nurses would come up to a kid and say, "You couldn't have done that a week ago. That's fantastic!" And soon I got to talking with and working with the kids, mostly by telling stories about their progress and how they'd be next week.

So I got to thinking. You set up a local culture, and people cheerfully do hand-springs to fit into it. Local cultures are compelling! To me, a culture trades in canonical narrative. Which is, in that case among those kids, we all had a lousy piece of luck. You banged your head, I knocked off my arm. We can manage. Cheryl Mattingly at occupational medicine or occupational science at the University of Southern California recognizes that physical Injury is a thing that's best described by narrative because it comes down to a *peripeteia* and how one copes with it narratively and really. They have some kids, for example, who do bear-chasing exercises, some working against the clock, and some imaginatively rowing across an imaginary channel.

RC: And so your plight was joined to the plights of these kids?

JB: I got through my exercises so fast it would take your breath away. I started dreaming up things I could do to help them with their stuff. Especially games we could play, games *they* liked and could identify with. They loved it; so did I.

RC: Well, isn't that an enactment of the kind of interpersonal commitment you write about in *Making Stories*?

JB: There is a puzzle in all of this. The main thing that made, and makes, *human* culture possible is that you feel a commitment to it and, at the same time, maintain a certain autonomy from it. Commitment works because we're able to sense each other's feelings and beliefs—we are intersubjective to a degree: not only that you do certain things but I know your intentions, and

you know mine. It is in this deep sense that no man is an island. And your very self depends on this intersubjectivity.

In *Making Stories*, I reviewed the literature on how people characterize the self. What I found is that selfhood rests upon a good story, a plot with Self as the agent that heads somewhere and gives continuity. These self-creating narratives are often modeled on classics or prototypical cultural forms. So we manage to maintain a certain autonomy while at the same time adhering to cultural forms. It is a little miracle.

The *real* thing is that in a culture, life is made possible by friends and close others, and not just by abstract forces. It's the small communities we join or form and the commitments we make to them that shape us. At the start of adolescence, for example, just breaking into adulthood, my pals and I formed the Demon Crew. We souped up outboard engines, stuck them on the back of cockle-shell hulls, and raced them. We even entered the Around Manhattan Race, and, incredibly, our boat won it in Class C. And there was even a picture of Lenny, one of our gang, who had actually driven the boat, in a Mobil Oil ad in a yachting magazine the next winter! Funny how that sort of thing provides a template for subsequent stories. They have enormous metaphoric reach in life.

RC: It's the plots about ourselves and the metaphors we use in telling them that let us see where we are going, or even choose where we are going.

JB: That's what I mean about finding a way.

RC: If the self is a series of stories...

JB: certainly a library of stories...

RC: ...can we learn to recognize the stories of others?

JB: If we hadn't been able to, we never would have made it as a species.

RC: And how do we learn to tell and listen to stories?

JB: In some way, we all get to it naturally. I'm still leaving open the question of *where* we get this kind of sophistication by the time we're three or four or even much younger. Even before children are able to understand or tell stories in language, they enact them and they love enactments staged by others. Maybe this narrativity comes from language itself, I don't know, it doesn't matter.

More interesting is where do people get knowledge of *plights*? I wish I knew the answer to that. I struggle with making my law students recognize that this isn't just a *case*, this is a client in *trouble*. And trouble is a narrative idea. You have to have a story for there to be trouble, Aristotle's *peripetia*, and that requires a notion of normality or canonicity, and so on.

The fact of the matter is that if you look at how people actually live their lives, they do a lot of things that prevent their seeing the narrative structures that characterize their lives. Mostly, they don't look, don't pause to look. Not even when they are doctors and are supposed to be concerned with the life-and-death stories of their patients.

RC: As plights go, that's the rather most extreme one.

JB: To put it mildly, yes.

RC: Even if the problem is not serious, it stands for what ultimately will be. That's why my medical colleagues are so determined to get it right. Some of them would be very nervous to hear you talk about stories of plight, because they, like your law students, believe that there's only one way to get it right. How can we help them understand that my singular recognition of your plight counts?

JB: Even if it's wrong. If I said something crazy and wrong to you, like, "The reason you're involved in this work is your old man is a doctor and you're caught up in a generational guilt trip," you would say, "No, no, no." But at least I'm on the wavelength of getting it. That's important.

RC: So, do we make a series of efforts and get it righter?

JB: It's a funny way you doctors think that you have to get it righter. Some of you get your satisfaction out of being right about how you thought the lab tests would come out. But that's not good enough. After all, you play the very, very important role of being a kind of cherished outsider. Not that you're going to detechnicalize sickness or health care, but you've got to rehumanize it as well—relate it to life. Who on earth wants to practice like a robot? Or turn their patients into robots?

RC: No, it's horribly wearing and demeaning and it doesn't work.

JB: Yet, sometimes it works in odd forms. Byron Goode, the anthropologist, talks about something that works, though in an odd way. It is the subjunctivization of illness, something that physicians do for their patients that can give them considerable comfort by putting them in a twilight zone. For example, when you're not quite sure that someone has an illness, you talk about it using language in the subjunctive—might be, could be, et cetera.

I came on this same idea in an old study of mine in which I did an analysis of James Joyce's stories in *Dubliners*, showing his use of subjunctivization in comparison with a brilliantly written thing by an anthropologist describing the ritual activity of *penitentes* in New Mexico. Beautiful pieces of writing, both of them. Joyce is full of subjunctivization. His is a world of possibilities. That's what doctors sometimes do for their patients too. Byron, in his studies in Turkey, found out the extent to which, when it is not quite clear whether the person is an epileptic, for example, folk doctors deal with it by telling about it subjunctively, that they might have this or might have that, which has fantastic comforting effects. Nobody's cured, but life is made somewhat more possible.

RC: By sidestepping the need for finality. Sort of letting everyone slowly absorb it, if it were to come to pass. Elliot Mishler taught us in his examination of conversations between doctors and patients that what we have a chance to do—and we ordinarily fail at it as doctors—is to absorb the meaning of what patients try to tell us. Doctors can do this if they choose to, and nurses, like your nurse at the Eye Institute, and ethicists as they do clinical consultations.

JB: So you absorb what patients say and then you try to develop it. There's the

big overall picture, but the fact of the matter is, there are pictures along the way over and over again. You want to be good at it, for patients or students or friends. It's not only our human responsibility as teachers and doctors and lawyers, it's somehow advantageous. Everywhere you look, you run into the recognition of the fact that a human plight is never an island unto itself. So, what should you do? You connect.

NOTES

1. Jerome Bruner, *Actual Minds, Possible Worlds* (Cambridge, MA: Harvard University Press, 1986); Jerome Bruner, *Acts of Meaning* (Cambridge, MA: Harvard University Press, 1990).
2. Jerome Bruner, *Making Stories: Law, Literature, Life* (New York: Farrar, Straus, and Giroux, 2002).

CHAPTER 2

THE ETHICS OF MEDICINE, AS REVEALED IN LITERATURE WAYNE BOOTH

The drama *Wit*, by Margaret Edson, mostly located in a hospital ward, has become one of the most celebrated plays of this decade. The heroine, a middle-aged woman dying of ovarian cancer, reports to the audience both how she is feeling, as she endures each miserable step of her decline and treatment, and how her miseries relate to her professional life as a teacher of literature. She discovers only slowly that the treatment she has been receiving from top doctors is part of the drug research experiment they are aggressively pursuing. The play provides mounting evidence that the doctors care far more about their research results than about her pain and death; it is possible that they have even violated the standard rules about patient consent. As the heroine, Vivian, dies, she leaves her bed, takes off her garments, and appears before us beautifully nude. She has escaped, by dying, from the inhumane treatment of those doctors and various assistants. Only one nurse has exercised genuine “kindness,” teaching the teacher that she should have shown more kindness to her own literature students.

We are thus left with a powerful but complex response: grief at Vivian’s suffering, relief over her escape, and fury at the cruel behavior of the doctors, who have in scores of ways revealed that they are more interested in pursuing research results than in what she feels or whether she survives.

The play is not just about the ethical issues of medical treatment. It is aggressively “literary”; Vivian constantly celebrates the beauty of John Donne’s *Holy Sonnets*,¹ remembering her skillful—and excessively bossy—teaching of students to understand how Donne probes the meaning of death. But though the play never abandons her interest in literature, and in how Donne’s work faces the problems of death, its plot depends on our taking an aggressive ethical stance that relates only obliquely to the study of literature. The power of the ending requires us to share, without question, the author’s implied judgment that humane, honest, compassionate treatment of patients is ethically far more important than the pursuit of research results. Thus it can be said to impose on us—some serious researchers might say “dogmatically” or “unfairly”—a decisive ethical conclusion about issues that have plagued philosophers forever: When “truth” and “goodness” clash, which should win? Is it immoral to use a patient’s life in the pursuit

of truth? Though almost everyone would agree that her doctors have behaved immorally if they did not obtain her consent to be an experiment subject, are they genuinely to blame for “using” her to get results that may be a blessing to many future patients?²

Once we begin to think seriously about such questions, implicitly raised in many modern literary works, the issues raised can feel overwhelming. In this essay I can touch only briefly on three of them.

Most obvious is a question that has been faced by philosophers and literary critics for millennia: Is any moral judgment defensible as something more than personal preference? Are there moral or ethical judgments that can be considered rational or demonstrable? Though the moral stance of *Wit* is controversial, can the controversy be thought of as serious pursuit of genuine ethical knowledge? Is there any such thing as genuine ethical knowledge? Second, is it legitimate for any critical reader or spectator to intrude his or her moral views upon the judgment of the work’s “literary” or “aesthetic” quality? If I decide (as I personally do not) that *Wit*’s ethical stance is wrong, should that decision reduce my judgment that the play is really wonderful, as a work of “art”? On the other hand, if I share the attack on the doctors, is it right to allow that sharing to increase my admiration for the play, as a work of *art*? No spectator who embraces the play escapes that sharing. But is that increased admiration ethically defensible? Third, is it reasonable to claim that “literature,” with all its ambiguities, can teach us—whether patients or medical practitioners—essential ethical truths about the world of health, disease, medicine, and right and wrong ways of facing pain and death? (By “literature” I don’t mean merely fictional works. I include autobiographies, memoirs, even journalistic accounts, if they have “literary” elements: anecdote, metaphor, stylistic heightening of emotion.)

Underlying my probing of these three points will be the claim that the pursuers of medical ethics have paid far too little attention to the “fact” that some novelists, poets, and dramatists have probed the issues more deeply than most overt “thinkers” have managed to do.³

One: How do we face the claim, still offered by many, that *all* ethical and moral judgments are at best subjective, mere statements of preference? For the utter relativists, the moral skeptics, Margaret Edson’s “argument,” in *Wit*, that it is immoral to deceive and wound a patient in the service of research results—genuine truth—is simply her personal bias. They might even go so far as to suggest that she takes the stance because, since a majority of playgoers will not be doctors, she can count on their sharing her undemonstrable bias, thus increasing the play’s success.

The extreme form of this position says that it is never right for you and me to impose our moral judgments on others, since such judgments have no cognitive basis. Judgments about right and wrong are never “factual,” in the scientific sense of empirically demonstrable. So what right have I to impose on others my deep conviction that to do or say this or that is just plain wrong, or vicious, or sinful, or unforgivable?

We defenders of moral judgment point out in reply that such skepticism always sneaks in a moral judgment of its own: it is morally *wrong* to impose any moral judgment—except this one. “You are absolutely morally unjustified in your claim that some moral judgments are absolutely justified.”

The hard fact is that all of us, even the most extreme overt relativists, practice that kind of imposition. Ever since “Adam and Eve” partook of the fruit, in Africa, millions of years ago, rising above their animal kin and discovering the difference between good and evil, every one of us has known—at least when not exhibiting sheer madness—that *some* actions committed by *some* of our brothers and sisters *ought* to be forbidden, prevented, or punished, or at least proved to be wrong. Ask any skeptic you know whether it would be right to pass a law forbidding the expression, in print or conversation, of his or her skeptical views. The answer might cautiously avoid terms like “moral” or “ethical,” but it would reveal that the skeptic is committed to at least one unqualified—and scientifically unprovable—“ought.”

This paradox in the extreme skeptical position does not, however, make the problem go away. Ask your skeptical friends whether Timothy McVeigh was morally justified in bombing the federal building in Oklahoma City, and you’ll receive a unanimous “no,” even if they go on to say that their judgment is merely culturally determined (I’m assuming that readers of this book do not include many of those who, out of deep “moral” opposition to the U.S. government, think McVeigh behaved morally). But if we ask readers of this book whether we as a nation were right in killing McVeigh, we will land in deep controversy—the kind of irresolvable debate that seems to provide evidence supporting the moral skeptics. Neither side can *prove*, factually or scientifically, that the other side is wrong. The best they can do is show statistics about what the death penalty does or does not do in changing behavior.

The skeptics who claim that, because of these ambiguities, ethical judgments can never be called knowledge will always win if we grant that the test of knowledge is demonstrability in the “scientific” sense: no conviction is demonstrable unless it can pass the test of “falsifiability.” Many have joined Karl Popper in arguing that we do not really *know* any proposition, unless we know the logical steps that might disprove it if it were untrue. If we do not know that those steps do not in fact falsify it, our proposition is simply personal opinion, in fact guesswork.⁴ Only if you know what steps would be required to disprove an assertion, and if your commitment to doubting leaves the assertion standing, can you claim to have knowledge.

The test is a powerful one in dealing with certain problems. I often use it myself in trying to test my own guesses about how literary works are put together: devise more than one hypothesis, and then decide which one is falsifiable.⁵ But stated as a universal dogma, it is highly questionable, as Popper himself sometimes seemed to acknowledge. How, we may ask, does one *know* that the method of testing is *in itself* universally valid? Can the criterion itself be put in falsifiable terms according to its own dictum? Obviously not. It is a value judg-