We often derive from observation strong intimations of truth, without being able to specify what were the circumstances we had observed which had conveyed those intimations.¹

T he primary focus of literature's first decade as part of the formal curriculum of some American medical schools (1972–81) was on teaching literary workers to help develop students’ capacity for empathy, to enhance their skills in interpretation, and to complement the teaching of knowledge,² to study the narrative nature of the physician-patient encounter.³⃣–⁶ To analyse the conventions of various medical genres,⁷–⁹ and to consider the relationship between a physician's narrative skill and a patient's willingness to accept the diagnosis and comply with recommended treatment.¹⁰,¹¹ During this second decade, scholars also began to explore more intensely the relation between narrative and medical ethics.¹²–¹⁴ T hese two directions of literature-and-medicine scholarship are now coming together: because of the inherently narrative structure of medical knowledge and practice, doctors' intellectual skills and habits better prepare them for a kind of narrative ethics than for the analytic, principle-based ethics that has dominated medical ethics for the past 25 years.

¹ This principle-based ethics is perhaps best represented by Tom L Beauchamp and James F Childress in their textbook Principles of Biomedical Ethics, now in its fourth edition. In this form of analytic ethics, one begins by establishing certain principles—autonomy, beneficence/
non-maleficence, and justice—that are then applied to ethics cases in an effort to resolve a dilemma. The reasoning is deductive, from general principle down to a particular case. By contrast, the kinds of ethical approaches that are referred to under the rubric narrative ethics begin with a particular case, just as physicians begin their diagnostic work with a particular patient in front of them, rather than with an abstract principle or theory. Principlism remains important, especially in quandary ethics and in public policy. But in the USA in recent years, there has been a growing discontent with principle-based ethics and an active exploration of alternative forms of medical ethics.14 In this essay, I examine some of the narrative aspects of medical knowledge and clinical work that help prepare physicians to understand and practise narrative ethics; I then explore several of the alternative approaches to medical ethics that are referred to as narrative ethics.

In Doctors’ Stories: The Narrative Structure of Medical Knowledge,20 Kathryn Montgomery Hunter argues that medicine is “not a science” but “a rational, science-using, interpretive activity undertaken for the care of a sick person” (p 25). The uncertainty inherent in medical practice comes from the unreliability of prediction in the individual case, however reliable prediction may be in the aggregate. As the bridge between these two realms—individual case and general rule—narrative remains, Hunter says, “medicine’s principal way of applying its abstract knowledge to the care of the individual patient” (p 47). This narrative bridge makes possible the interpretive method of “clinical casuistry”, reasoning that always begins with the individual case. Doctors travel back and forth across this bridge, taking the patient’s story of illness to be informed by medicine’s abstract knowledge and then to be interpreted and returned to the patient as a presumptive diagnosis retold in the form of a case history. Hunter compares this method with that of the fictional Sherlock Holmes (panel 1). In this regard, it is of more than passing interest that Sir Arthur Conan Doyle was himself a physician and that he based his famous character on another physician, the expert Edinburgh diagnostician Joseph Bell (figure). In the semiotic terminology of C S Peirce, Holmes’ method is neither induction nor deduction, but abduction—that is, inferential “reasoning from consequent to antecedent”.21

Hunter20 defines clinical casuistry as “the comparative analysis of a particular case with all its special circumstances in an effort to relate that case reliably to a system of received principles” (p 30). The “received principles” are not theoretical, however, but “the tested accumulation of generalizations: practical guidelines, clinical dogma, rules of thumb” (p 30). This method is much the same as that of casuistry in ethics: “practical decisionmaking in particular cases” (ref 33, p 92). In approaching a bioethics case, a casuist “would begin by identifying particular features in the case rather than appealing to universal principles, utilitarian calculations, or rights. The casuist would then attempt to identify the relevant precedents and prior experiences with other cases, attempting to determine how similar and different this case is from experiences with other cases” (ref 33, p 92). This form of analogical reasoning has long been used in theology and law, and Albert R Jonsen and Stephen Toulmin have “rehabilitated”22 casuistry as a method for contemporary bioethics.23 Because doctors use care-based, analogical reasoning in the daily work of medicine, they might naturally be expected to use the same method in resolving ethical problems that arise in the care of individual patients. To work well in ethics, however, analogical reasoning requires both a repertoire of ethics cases and a knowledge of “maxims grounded in experience and tradition” (ref 33, p 93), like the clinical dogmas and rules of thumb that guide clinical casuistry.24 Physicians may not have as many ethics cases in their repertoire as they have medical ones, and they may not, therefore, have established the general maxims that guide the casuistical approach to ethics. Thus, physicians’ skills in clinical casuistry may not, in and of themselves, be sufficient for expert ethical judgment comparable to their expert clinical judgment. But once physicians have acquired an adequate repertoire of ethics cases and a knowledge of generalised maxims, their already well-developed interpretive skills should allow them to become as expert at ethical casuistry as they are at clinical casuistry.

Casuistry is only one of several approaches that can fall under the rubric of narrative ethics, however. Another
well-received approach is that outlined by Rita Charon, who rejects the term narrative ethics, preferring instead to talk about “narrative contributions to the trustworthiness of medical ethics” (p 261). Charon argues that narrative competence and a narrative framework for medical ethics can improve ethics deliberations at four crucial stages: “the recognition of the ethical problem, the written or oral formulation of the problem, the interpretation of the ethical case, and the validation of the chosen interpretation as the most reasonable and helpful among the many alternative interpretations available” (p 261). For Charon, the narrative approach does not constitute an independent method but makes “existing methods work more accurately and effectively” (p 277). Ideally, narrative competence would prevent ethical quandaries by increasing early recognition and resolution of ethical issues. If, however, narrative competence fails to prevent ethical quandaries, Charon endorses the traditional form of principle-based medical ethics. Her hope is that narratively enriched analytic ethics will be more attentive to “the meanings of singular human situations” (p 260).

Charon discusses at some length the choices and potential problems that are inherent in formulating a case—that is, in presenting a case orally or in writing. In his rhetorical analyses of bioethics cases, Tod S Chambers shows how the narrative formulation of a case helps shape the interpretation that ensues. Examining five cases formulated by bioethicist-authors who then analyse and interpret the cases they have written, Chambers shows that the “literary style of these case presentations covertsly supports the philosophical orientation of their tellers” (p 60). His conclusion—that “ethicists persuade through narrative style” (p 61)—may be startling to those who believed that a case could be formulated in an objective, morally neutral style. Presumably, as Charon argues, ethicists and physicians who are narratively competent would be aware of the narrative and ethical choices that inevitably arise in formulating a case. They would also be better able to discern and analyse the unconscious biases that may be reflected in the narrative style of someone else’s case formulation.

Problems with what Charon calls validation point towards a third and more radical approach to narrative ethics. If the retold medical or ethics case that is returned to the patient does not make sense to her, the medical or ethics intervention is likely to fail. The patient who does not recognise her own story of illness and suffering in the medical recasting of it may not accept the physician’s diagnosis or follow the recommended treatment. Howard Brody gives an example of a case in which the crucial step of restoring the patient could easily fail: a patient with persistent cough who fears she has pneumonia, because her aunt has almost died of pneumonia recently, may reject a diagnosis of postnasal drip unless the physician is aware of her fear and can reassure her that she does not have pneumonia. Similarly, if the person who must carry out the action called for by the decision in an ethics case is not persuaded that the decision represents the best interpretation and resolution of the case, he may resist carrying out the act. Charon offers as an example a resident who demonstrates his disagreement with the resolution of a case by choosing to walk instead of run to initiate resuscitation of a patient who has had a cardiac arrest. When diagnoses or ethics decisions are merely delivered to patients or others without their having been involved in validating those diagnoses or decisions, medicine and ethics fall far short of their fullest potential. This third approach to narrative ethics recognises the patient as the author of his or her own life-story, acknowledges the primacy of the patient’s story over abstract theories or principles, and shifts power from professionals—physicians or ethicists—back to patients and their families. In the final chapters of his book Stories of Sickness, Brody discusses what it might mean to reconceptualise medical ethics according to a narrative paradigm. It would require, among other things, a shift from a decisional ethic to a relational ethic. In a later article, as he continues to explore the “ethical implications of a narrative conception of the physician-patient relationship” (panel 2), Brody argues that “when narratives are jointly constructed, power is shared between physician and patient, and the sharing of power constitutes an important ethical safeguard within the relationship” (p 79). In writing about narratives of chronic illness, Arthur Kleinman focuses on the key distinction between “the patient’s experience of illness and the doctor’s attention to disease” (p xii). Kleinman emphasises that...
truly listening to the patient’s experience of illness, which calls empathic witnessing, is a moral and therapeutic clinical act: “That is the existential commitment to be with the sick person and to facilitate his or her building of an illness narrative that will make sense of and give value to the experience” (p 54). As physicians, Brody and Kleinman call for a narrative ethics that is based in the moral relationship of the physician to the patient.

Arthur W Frank, who has written about his own experiences of illness,42 goes further than Brody or Kleinman claiming that narrative ethics belongs to “the realm beyond clinical medical encounters” and that “this sphere is illness outside patienthood” (ref 39, p 156). If physicians wish to take part in this sphere, they must do so not in their professional role but as individuals willing to make a moral commitment to another person. Frank’s concern is “with ill people’s self-stories as moral acts, and with care as the moral action of responding to those self-stories” (ref 39, p 157). In the approach that Frank lays out, narrative ethics has to do with resolving conflicts of medical decision making but with living the examined life and with personal becoming. It is a kind of moral inquiry that requires “thinking with stories” (ref 39, p 159).

Thus we come full circle, back to the kind of medical ethics Robert Coles called for in 1979, as he explained why he taught literature to medical students.43 He wanted to engage his students in moral inquiry of a far-ranging kind that would have them reflect about what it means to be a doctor and live a good life. In the intervening years, as Coles has continued his work, he has found reason to believe that reading and thinking about literature can help prepare medical students to become the kind of physicians who can practise not only clinical and ethical casuistry but also that more demanding kind of narrative ethics for which Kleinman calls:44

“Against the commercialized self-images of our age, which corrode altruism and convert decency into merely a professional gesture, the experience of the healer can be a quest for a kind of human wisdom, a model of forbearance and courage, a form of goodness, a lesson in the essentials of humanity” (p 267).

References

26 Brody H. “My story is broken; can you help me fix it?” Medical ethics and the joint construction of narrative. Lit Med 1994; 13: 79–92.