Narrative based medicine: Narrative in medical ethics
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suspected melanoma; and knowledge of a long term health risk for a young woman with a predisposition for breast cancer that may lead to better chances of early detection and more successful treatment. In the language of medical ethics, intervention by a doctor could be described as an act of beneficence to all three persons. Intervention in the second and the third scenarios might also be understood as promoting autonomy—that is, increasing the options of the women so that they could make an informed choice.

However, intervention by the doctor is also associated with ethical costs. In the first scenario, the doctor would have to change his plans and break a promise to his daughter. The ethical cost of intervention in the second scenario is invasion of privacy. The woman concerned might also find it embarrassing to discuss her “black spot” on the bus. The woman is certainly aware of the lesion on her face; she has probably seen a doctor already or she may have refused treatment no matter what the nature of the black spot. In the third scenario, the most obvious ethical cost of intervention is a lifelong emotional burden for a young woman told she has a hereditary predisposition to cancer at an age when any medical action would be premature.8–11

In the past, doctors have strived to convince lay people of the importance of public health measures such as proper sanitation, vaccination programmes, or a healthy lifestyle. The doctors of today and tomorrow face a different challenge—the public has high expectations of prevention, early detection, and treatment of diseases; disease or death are not regarded as natural events; and a poor outcome is often attributed to a medical omission or mistake rather than the natural course of a disease. In such an environment, important health policy decisions, such as breast cancer screening programmes in young women, are made for political rather than medical reasons.12 We conclude that doctors nowadays feel a need to resist rather than support a trend towards the increased invasion of medicine into everyday life.

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### Narrative based medicine

#### Narrative in medical ethics

Anne Hudson Jones

The contributions of narrative to medical ethics come primarily in two ways: firstly, from the use of stories (narratives) for their mimetic content—that is, for what they say; and secondly, from the methods of literary criticism and narrative theory for their analysis of diegetic form—that is, for their understanding of how stories are told and why it matters. Although narrative and narrative theory, like the form and content of a literary work, are inextricably bound up with each other, I will discuss them separately to help chart the evolving appreciation for the importance of narrative in the work of medical ethics.

The use of stories

During the past two decades, stories have been important to medical ethics in at least three major ways: firstly, as case examples for the teaching of principle based professional ethics, which has been the dominant form of medical ethics in the Western world; secondly, as moral guides to living a good life, not just in the practice of medicine but in all aspects of one’s life; and thirdly, as narratives of witness that, with their...
experiential truth and passion, compel re-examination of accepted medical practices and ethical precepts.

Stories as cases for teaching principle based medical ethics
When medical humanities programmes were first established in American medical schools in the 1970s and ‘80s, historians, ethicists, and lawyers usually preceded scholars of literature on the faculty. In the early years, the presence of literature in medical humanities programmes was often justified by its service in the teaching of medical ethics. Literary stories were useful in “fleshing out” issues or dilemmas in medical ethics by showing them embedded in a particularised human context complicated by powerful emotions and complex interpersonal dynamics. Works by physician-writers have become staples of such teaching, and the short stories of Williams’ and Selzer’s have become especially well known and frequently taught.

Narrated retrospectively from the doctor’s point of view, stories such as Williams’s “The use of force” and Selzer’s “Brute” offer insight into why a presumably good doctor with beneficent intentions none the less ends up harming his patient in an abuse of power. The first uses of these stories as cases for medical ethics may well have been limited to discussions of standard ethical principles such as autonomy or respect for persons, beneficence and non-maleficence, and social justice. In principle based ethics, or principlism, general ethical principles are applied in a deductive analysis of a case to determine logically the best ethical resolution of its issues or dilemmas. In both “The use of force” and “Brute,” a doctor physically assaults a patient in order to diagnose or treat. The ethical issue is whether such powerful medical paternalism can be justified by appealing to beneficence—that is, by claiming that what the doctor did was for the patient’s own good. But by attending to the richly evocative language used by the doctor-narrators of these stories, readers have the opportunity to learn about more than patients’ autonomy and doctors’ paternalism. They can learn how ethical principles and arguments may sometimes be used to rationalise unethical behaviour that is driven by sexual attraction, anger, or pride.

Although still controversial, the use of such stories as literary cases to complement the teaching of principlism is the most basic way in which narrative has been important to medical ethics.

Narratives as moral guides for living a good life
The second way in which literary narratives have been important to medical ethics is best articulated by Coles, who is concerned with moral inquiry of a far ranging kind that does not limit itself to the practice of medicine. He is concerned with what it means to live a good life and, coincidentally, to practise medicine. Not professional medical ethics but existential ethics or virtue ethics is what he seeks to develop in his medical students. For this purpose Coles believes that reading novels such as Eliot’s Middlemarch, Lewis’s Arrowsmith, Fitzgerald’s Tender Is the Night, and Percy’s Love in the Ruins works better than studying analytic ethics.

Although Coles chooses more complex literary texts than the short stories that are often used as cases for the teaching of medical ethics, he chooses novels whose main characters are doctors. Yet narratives that serve as moral guides for living a good life need not be topically about medicine, as Hawkins has argued in describing her use of Dante’s The Divine Comedy with medical students. From this broader perspective, any narrative that might instigate moral reflection about what it means to be a good person, to live a good life, and to practise a profession in an ethical manner could be considered important for medical ethics.

Narratives of witness
Autobiographical accounts by patients or by their family members or friends can also be important for medical ethics. These works can have considerable value as narratives of witness. Some of these narratives offer commentary from the patient’s point of view on such ethical issues as autonomy and respect for persons, truth telling and informed consent, beneficence and, sometimes, maleficence—doctors’ negligence, incompetence, and errors. As these narratives have begun to appear on the internet, they have reached larger audiences and have had the potential for more influence on the practices of doctors and institutions.

Patients and their family members and friends are not the only ones who write important narratives of witness. By writing narratives from their personal experiences, doctors and other healthcare professionals also can have a powerful effect on the public discussion of an ethical issue. In the United States, for example, it was doctors’ narratives of assisting patients’ suicides that broke through decades of professional silence and opened debate about this issue in American medical journals. In 1982, after Selzer published his fictional story “Mercy,” about a doctor’s unsuccessful attempt to help a terminally ill patient die by giving him an overdose of morphine, he received hate mail. A few years later, when the journal of the American Medical Association (JAMA) published “It’s over, Debbie,” an anonymous, presumably factual account by a doctor who had deliberately given a patient who was terminally ill with cancer an overdose
of analgesics to speed her death, a Cook County state's attorney took the journal's editor to court to try to force him to reveal the author's identity. The effort was unsuccessful. And a few years later, after Quill published an eloquently written account of prescribing drugs for a patient who, he knew, intended to use them to commit suicide,\(^7\) he was brought before a grand jury but was not indicted. Despite the general legal prohibition against physician assisted suicide in the United States, exemplified by the legal action taken against JAMA and Quill, doctors' narratives have helped compel re-examination of this controversial ethical issue.

**Methods of literary criticism and narrative theory**

In the past decade, scholars have begun to use the methods of literary criticism and narrative theory to examine the texts and practices of traditional medical ethics. What are now referred to as narrative approaches to medical ethics, or narrative contributions to medical ethics, use techniques of literary analysis to enhance the principle of principle based medical ethics. In contrast, what has become known as narrative ethics has reconceptualised the practice of medical ethics, seeking to replace pricinplism with a paradigmatically different practice.

**Narrative approaches to medical ethics**

In those early years of medical humanities programmes in the United States, the presence of literature was justified either on the basis of its service to medical ethics or on the basis of claims that reading literature helps teach students "to read in the fullest sense,"\(^6\) a skill that helps prepare them for the clinical work of listening to and interpreting patients' stories\(^9\) as well as reconfiguring and retelling those stories as medical cases with plots and causality.\(^7\) To read in the fullest sense students must have mastered certain basic skills of literary analysis. The same questions that they learn to ask about a literary text—who is the narrator?; is the narrator reliable?; from which angle of vision does the narrator tell the story?; what has been left out of the narrative?; whose voice is not being heard and why?; what kind of language and images does the narrator use?; and what effect does that kind of language have in creating patterns of meaning that emerge from the text?—can also be used in the examination of ethical texts and practices.

One of the best examples of applying these methods to ethical texts is Chambers's work examining the inherent value biases in the ways that ethicists construct their cases.\(^22\) Chambers shows that from their very first choices—of point of view, diction, images, and other features of style—ethicists construct cases that lead readers to the conclusions that emanate from the author's ethical theories and preferences. Chambers is the best known advocate of using the methods of literary criticism and narrative theory to help doctors and ethicists examine their ethical practices. The title of her article, "Narrative contributions to medical ethics: recognition, formulation, interpretation, and validation in the practice of the ethicist,"\(^22\) is in itself almost an abstract of the article and a summary of her position. Making doctors and ethicists more aware of the narrative aspects of their medical and ethical practice will make them better doctors and ethicists, she argues.\(^22\) She hopes that narratively competent practitioners will be able to prevent ethical dilemmas from arising by having conversations about ethics and values with their patients before a medical crisis throws them into an unanticipated ethical dilemma.

**Narrative ethics**

Hunter's work on the narrative structure of medical knowledge has helped clarify some of the mental processes involved in medical education and practice.\(^33\) Unlike analytic philosophers who are trained to work deductively from general principles to the particular case, doctors are trained to work in the opposite direction, beginning with the particular case and then seeking general medical principles that might apply. Hunter argues that this practice is not inductive but absorptive, as doctors tack back and forth between a particular case and the generalised realm of scientific knowledge.\(^30\)\(^33\)\(^34\)\(^35\) This process is similar to the ethical practice of casuistry, which was revived and rehabilitated in an influential book by Jonsen and Toulmin.\(^23\) In casuistry, ethical examination begins with the features of a particular case, then seeks to recall similar paradigm cases that may shed enlightenment about the best resolution for the case at hand. Casuistry is, arguably, one form of narrative ethics.

But narrative ethics has underlying assumptions that casuistry does not share. Foremost among them is a focus on the patient as narrator of his or her own story, including the ethical choices that belong to that story. Brody has described a narrative ethics in which the doctor must work as coauthor with the patient to construct a joint narrative of illness and medical care.\(^26\) This coauthoring involves more than simply recognising the patient's autonomy as author. Brody calls it a relational ethic.\(^26\) Kleinman\(^27\) and Frank\(^28\) have written about it from differing perspectives, the doctor's and the patient's respectively, but both agree that such a narrative practice is relational and requires the doctor to be an empathic witness of the patient's suffering.

In an ideal form, narrative ethics recognises the primacy of the patient's story\(^26\) but encourages multiple voices to be heard and multiple stories to be brought forth by those whose lives will be involved in the resolution of a case.\(^22\) Patient, doctor, family, nurse, friend, and social worker, for example, may all share their stories in a dialogical chorus\(^29\) that can offer the best chance of respecting all the persons involved in a case.\(^31\)

To move narrative ethics into a next phase of development, proponents must determine how training for competence in narrative ethics might best be achieved. Reading and interpreting complex written narratives certainly helps, and that is part of what literature and medicine has been doing for 25 years.\(^34\) But for those whose professional training has not included such experiences, continuing education that focuses on specific narrative skills may be helpful.\(^15\) Whether or not attaining greater narrative competence would make analytically trained ethicists more open to
the possibilities of narrative ethics remains to be seen, but such training will do them no harm and it may lead to richer ethical discourse for us all.


A memorable incident

When is a spade not a spade

I was visiting professor of anaesthetics in a hospital outside Britain when I was asked to see an emergency admission with a severe haematemesis. The patient was elderly, wasted, disoriented, somewhat dehydrated, hypotensive, and tachycardic. He had a chronic gastric ulcer. He had been an inmate of the local mental hospital for the previous 20 years. He was a Jehovah’s Witness. His medical superintendent left the decision about blood transfusion to his wife who was on her way in. The surgeon would accept my decision about whether to operate or not. I telephoned the chief administrator. He would not give permission but would consult the minister of health (it was that sort of country) as the state was legally responsible for the patient’s welfare. Within 10 minutes (it really was that sort of country), the reply came. The doctors should sort it out with the patient’s wife.

We met the wife in the board room. An elderly, shy woman, she was accompanied by a younger Pickwickian man, her pastor. Harshly I explained that without the operation the husband would die; with the operation but without blood there was just an outside chance of survival. If blood was available there was a very good chance that he would survive. The reply stunned me.

“If he should go to sleep,” said the pastor. I interrupted, “Of course he will go to sleep. That is why I am here.” Again the statement, “If he should go to sleep, if God wills that he goes to sleep.” I interrupted, rather angrily, “Yes, he will go to sleep. I will make sure of that, that is up to me, not God.” Another interruption, “Doctor, you do not understand. We mean, if he should go to sleep, that is cross over, pass away.” I was incensed. Such hypocrisy, such cant, a spade was a spade and not an agricultural implement. “You mean if he dies,” I snapped.

I saw the wife wince, and her hand stretch out towards the pastor, who held it gently. Then she said slowly, “He was a good man doctor, before he became ill. You will do your best, please, won’t you. But no blood. To him, it would not be right.” After that I had no choice.

The surgeon agreed to do the minimum, just undersew the bleeding ulcer and stop the bleeding. I would keep the patient alive. The surgeon kept to his word. The ulcer was easily located and swiftly undersewn. I juggled with plasma expanders and salt solutions to correct his blood volume and dehydration, keeping him pain free and relaxed. But the blood pressure stayed ominously low.

The peritoneum was closed and I breathed a sigh of relief mixed with pride at my achievement. Then came a soft cry from the surgeon, a subcutaneous stitch had hit a vein somewhere. By the time it was located 30ml of blood were lost, just one swab full. The blood pressure fell irrecoverably and the patient died.

What did I learn? Humility was one lesson. I might know it all, but I was not God. Bullying folk to accept my beliefs was wrong, especially when they obviously knew they were further endangering the life of someone they loved dearly. Their own moral dilemma was a hard enough burden. The remaining lesson? Euphemisms do have a place in providing comfort to the distressed. But 25 years later I still wonder if I was right clinically.

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