The Principles and Practice of Narrative Medicine

Rita Charon, Sayantani DasGupta, Nellie Hermann, Craig Irvine, Eric R. Marcus, Edgar Rivera Colón, Danielle Spencer, Maura Spiegel
CHAPTER 5

Deliver Us from Certainty: Training for Narrative Ethics

Craig Irvine and Rita Charon

Neither our understanding of who we are nor our very existence in a cultural world can be separated from the stories that we and others tell about ourselves.
—Jens Brockmeier, Beyond the Archive

Stories are the primordial means through which we make sense of and convey the meaning of our lives. It is to this that the philosopher Paul Ricoeur points when he speaks of “life as an activity and a passion in search of a narrative.” Indeed, for Ricoeur, a life is “the field of a constructive activity, by which we attempt to discover . . . the narrative identity which constitutes us.” Medical sociologist Arthur Frank continues Ricoeur’s thought by proposing that “[o]ur very selves are perpetually recreated in stories. Stories do not simply describe the self; they are the self’s medium of being.” Narrative accounts of oneself—autobiography, memoir, psychoanalytic transactions, clinical accounts, dreams, that which one tells oneself in secret, or casual tales one tells to friends—not only report one’s narrative identity but, more radically, create that which is experienced as the “self.”

Narrative medicine arises from the awareness of this relation between narrativity and identity. Our principles and practices of intersubjectivity and rela- tionality, our election of close reading as a signature method, our elevation of creativity in the work of healthcare, our collaborative teaching methods, and our narrative clinical practices all bear the mark of this centering commitment to comprehend and live in the light of this narrativity/identity reciprocity. Since illness and injury are among the most exposing experiences of the mortal life, the experiences that lift the veil on the large objects in the room of one’s life, narrative medicine is present when a person urgently comes to face
or question or embrace his or her identity. Who am I now suffering, now recovering, now dying? What matters to me now? In the face of this illness or injury, what is the best way forward in my life?

In this chapter we try to articulate the practical consequences of narrative medicine’s growing understandings of the possibilities for a narrative identity. Within healthcare, questions of narrative and identity frequently arise in the setting of bioethics, and so we probe here the role of narrative medicine in the practice of bioethics. This probe brings us to concentrate on narrative ethics, that subdiscipline of clinical bioethics that starts with the narrative accounts patients give of their lives and helps patients to envision and then choose among the alternative futures ahead. Sometimes practiced in the face of thorny ethical dilemmas at the end of life and sometimes practiced in the relative calm of everyday healthcare, narrative ethics extends skilled close listening to patients, families, and clinicians so as to midwife a narrative view of a person’s situation. Unlike other bioethical approaches that attempt to apply universal laws and principles to solve individual ethical problems, narrative ethics arises from the patient’s singular situation to bring unique algebras to the tangle of values, meanings, choices, desires, and loves in this particular life or this particular death. We also acknowledge the contributions of the literary field called narrative ethics. Parallel but distinct from bioethics’ narrative ethics, it illuminates the fundamental duties of the listener or reader of another’s narrative. These duties are incurred both in listening to oral narratives and reading literary written texts. Finally, we propose that narrative ethics is narrative medicine as it unfolds in the setting of bioethics, bringing methods of teaching and practice to those who try to help others in their living and their dying.

What Stories Do for Us: Narrative Understanding as Ethics

The primacy of narrative acts in perceiving, experiencing, representing, and interpreting the world is acknowledged across diverse disciplines. Historians, psychologists, social scientists, educators, theologians, philosophers, psychiatrists, and literary critics, as detailed in this chapter, have all come to recognize the central role that narrative plays in our lives. While the interest in narrative theory and practice may be a relatively recent phenomenon in many disciplines, the salience of narratives—and of the narrative capacities that are developed in and called forth by engaging with them, at least for literary texts—have enduringly been recognized as foundational in human learning and thought. Ricoeur argues that ethics first turned to narrative more than
24 centuries ago, when Aristotle wrote his *Poetics*: “Aristotle did not hesitate to say that every well-told story teaches something . . . [I]t is certain that tragedy, epic and comedy, to cite only those genres known to Aristotle, develop a sort of understanding that can be termed narrative understanding and which is much closer to the practical wisdom of moral judgment than to science, or, more generally, to the theoretical use of reason.” While theoretical understanding can only speak abstractly of the relation between ethical principles and human action, narrative understanding as a form of practical or phronetic understanding offers imaginative thought experiments through which we learn, in Ricoeur’s words, “to link together the ethical aspects of human conduct and happiness and misfortune” (p. 23). From this Aristotelian opening, Ricoeur develops his thesis that emplotment, or “the process of composition, of configuration” central to narrative, “is not completed in the text but in the reader and, under this condition, makes possible the reconfiguration of life by narrative. I should say, more precisely: the sense or the significance of a narrative stems from the intersection of the world of the text and the world of the reader” (p. 26). The literary text opens before it a world of possible experience, in which it is possible to live. Not something closed in on itself, the text is a projection of a new universe distinct from that in which we live. When we read, therefore, we belong, at the same time, to the world-horizon of the work in imagination and the world-horizon in which the action of our “real life” unfolds, multiplying exponentially that which can properly be called one’s lived experience. We will see that listening to the oral narratives heard in clinical bioethics has similar consequences for the listener of widening horizons and enlarging one’s actual experience.

The philosopher Hans Gadamer speaks of the “fusion of horizons” essential to the art of understanding a text. Through the actions of this fusion we expand our own vision of reality, our own state of being, indelibly changing us toward the next encounter with a text. Each new narrative work opens new horizons in which we might experience, explore, and try on alternative realities, new ways of being-in-the-world. Visual art, music, drama, and dance each expand horizons in their particular sensory and imaginative ways.

We always already live in imaginative worlds. The very worlds of sense and experience are configured uniquely by each perceiver, for consciousness itself is shaped by narratives we have heard. Thought, fantasy, belief, emotion, attachment, and ultimately action are in their making shaped by the stories that have framed each person’s individual consciousness. Hence, what we call experience is not a pure blank reality. It rests in some way on prior perceptions, on antecedents and imagined subsequents. This is not to suggest that there is no innovation, for the imagination creates the new and the never-seen, yet always from a perceptual foundation inflected by one’s individual private experience.
If each person perceives and experiences reality, at least in part, through individual narrative means, reality cannot be treated as replicable or universal fact. Serious engagement with narrative texts—reading them closely, writing them, grappling with what they mean—challenges the belief that we can define and dominate reality through technical mastery. The indeterminacy of stories baffles the mind that seeks concrete, unambiguous conclusions. As one enters the narrative world of a text, one lets go of the conviction that a key to its meaning is to be found anywhere but in the experience itself of encountering it.  

Cleanth Brooks, one of the American leaders of the New Critical literary movement of the 1940s and 1950s, asserted that the poem is something that cannot be paraphrased:

Is it not possible to frame a proposition, a statement, which will adequately represent the total meaning of the poem; that is, is it not possible to elaborate a summarizing proposition which will “say” briefly and in the form of a proposition, what the poem “says” as a poem. . . . Could not the poet, if he had chosen, have framed such a proposition? Cannot we as readers and critics frame such a proposition? The answer must be that the poet himself obviously did not—else he would not have had to write his poem.

In like manner, a story is something whose content cannot be reduced to analyzable data. Meanings, ethical and otherwise, are not extractable from a story as if they exist separate from its form. Instead, a story relinquishes its meaning only to the reader or listener who undergoes all the story’s elements—its plot, its genre, its diction, its metaphors, its allusions, its temporal and spatial natures. The reader or listener who enters that story experiences the integrated flow of all these features, none of which is elective to the full measure of the story. The full story is required for the reader to understand its ethical or personal or affective meaning. The reverse is true as well, suggests literary scholar Marshall Gregory in Shaped by Stories: “Not to understand the ethical vision of a story is also not to understand its aesthetic shape.” (italics in original).

The reader who enters the world of a text recognizes its rules of conduct and is influenced by its moral compass and its shaping power. Narrative ethics as we understand it in narrative medicine reminds writers and readers that narratives of any kind by necessity privilege certain perspectives and positions, that marginalized voices are often silenced, and that commitments to equality require “equal access” to the author/teller position. We can learn to respond to stories that exclude the marginalized with a demand for additional stories—not just any additional stories, but ones in which the point of view shifts to favor how the world looks to the characters previously silenced.
Narrative and Bioethics

How have these concepts about narrativity and identity come to influence the work of bioethics? Novelist Richard Powers, who has placed several of his novels in medical settings, proposes a profound use for serious reading:

Story is the mind’s way of molding a seeming whole from out of the messiness of the distributed, modular brain. At the same time, shared stories are the only way anyone has for escaping the straightjacket of self. Good medicine has always depended on listening to histories. So any attempt to comprehend the injured mind naturally inclines toward all the devices of classic storytelling. . . . Only inhabiting another’s story can deliver us from certainty.21

Escaping the straightjacket of self: this could be the clarion call of ethical practice. As Powers makes clear, this straightjacket that imprisons us in our selves is fashioned by our own certainty. By allowing oneself to enter into an alien narrative world—as glimpsed through a conversation with a friend, an interview with a patient, or a novel by Richard Powers—one can shift the strictures of assumption, prejudice, genealogy, and habit to expand the mind by contact with the world of another. Many of the consequential acts of ordinary life require the capacity to perform acts of envisioning otherness—a capacity, we assert, that is developed in becoming a close reader. Whether the other is an intimate or a stranger, the inhabiting of the other’s narrative world requires feats of imagination, self-stilling, empathy, and challenging of assumptions.

Philosopher and novelist Iris Murdoch is among those who have helped us understand the importance to moral life of imagining the other’s story. In her novel The Black Prince, Murdoch’s protagonist Bradley Pearson says, “When we do ill we anaesthetize our imagination. Doubtless this is, for most people, a prerequisite of doing ill, and indeed a part of it.”22 As Martha Nussbaum has written, “Murdoch felt that we would only get to the right choices if we understood better the inner forces militating against goodness. And in her view, the main such force was our inability to see other people correctly.”23

Consider Powers’ escape from certainty in the context of healthcare. Typically, the professional is assumed to know more—and to know with certainty—about the illness situation of the patient than does the patient. The patient’s lived experience of having the disease does not automatically count for much in healthcare’s proceedings. The power is all on one side. When disagreements between them arise, the power asymmetry privileges the stance of the professional. If a patient consents to medical treatment, the treatment...
proceeds. If a patient refuses medical treatment, the patient is charged with incompetence.

Such asymmetries of power in healthcare and beyond were challenged in the 1960s by the emerging Civil Rights movement, the women’s movement, and the populism that included a commitment to patients’ rights. Beginning around the same time, medicine itself was rocked by a series of events that either created new ethical quandaries or amplified existing ones, each of them demonstrating a power asymmetry between patients and clinicians and requiring a response from bioethics. Chief among these events included the redefinition of death as the cessation of brain rather than of cardiac activity (1968), publication of information about the Tuskegee syphilis experiment (1972), the nationwide legalization of abortion (1973), the suit brought by Karen Ann Quinlan’s parents requesting that she be removed from a ventilator (1975), and the death of “Baby Doe,” a child born with Down syndrome whose parents withheld lifesaving treatment (1982). Biomedical ethics arose as an institutionalized, interdisciplinary academic discipline in response to these and other events, as the nation faced an urgent need for ethics experts to help resolve the escalating number of increasingly complex biomedical ethics cases. When ethical or legal dilemmas in the care of a particular patient arose, clinicians turned to the bioethics consultant for help in deciding what to do.

While there were several competing ethical frameworks governing the development of medical ethics practice, principlism soon emerged as the dominant approach. In 1979, Tom Beauchamp and James Childress published their Principles of Biomedical Ethics.24 Elaborating and expanding on the principles promulgated in the Belmont Report,25 published the year before, Beauchamp and Childress invoked four principles—(1) respect for autonomy, (2) nonmaleficence, (3) beneficence, (4) justice—“to provide frameworks of general guidelines that condensed morality to its central elements and gave people from diverse fields an easily grasped set of moral standards.”26 The ethics expert applies these universal principles to a particular case, determining which among the principles should govern action. Beauchamp and Childress insist that the method principlism employs in resolving ethical dilemmas is not one of simple deduction: “[N]either rules nor judgments can be deduced directly from principles, because additional interpretation, specification, and balancing of the principles is needed in order to formulate policies and decide about cases.”27 Principles are understood as prima facie duties. When a conflict arises among these principles, Beauchamp writes, “some balance, harmony, or form of equilibrium between two or more norms must be found; or, alternatively, one norm overrides the other.”28 Beauchamp and Childress insist that their principles should be understood only as guidelines. Applying these guidelines in clinical decision making requires, Beauchamp writes, that they be “interpreted
and made specific . . . [I]nterpretiveness and imaginativeness in their use is essential and to be encouraged.”

We applaud Beauchamp for noting the essential role inventiveness and imaginativeness play in clinical decision making; we believe their use should be more than simply “encouraged.” Indeed, to note that inventiveness and imaginativeness are essential without providing the tools for developing and applying them is problematic. The application of universal principals, even only as guidelines, without sufficient attention to the complexity and uniqueness of each particular situation—an attention that requires creativity and imagination—fosters a sense that clinicians and ethicists, or clinician ethicists, are “above” the stories of the patients and families facing ethical quandaries. Such detachment reflects an all-too-pervasive attitude in healthcare—the adoption of an ideal of objectivity that rests on the assumption that one must remain outside the story of the other.

During his research on physicians who are genetic counselors, medical sociologist Charles Bosk asked “Bill Smith,” a physician caring for patients with severe congenital illnesses, how he “came to grips with all the ‘accidents’ or ‘mistakes’” in human biology that manifest in the genetic illnesses he saw. Following is Smith’s response:

What you have to do is this, Bosk. When you get up in the morning, pretend your car is a spaceship. Tell yourself you are going to visit another planet. You say, “On that planet terrible things happen, but they don’t happen on my planet. They only happen on that planet I take my spaceship to each morning.”

Arthur Frank recommends that Smith’s response “should be read aloud to every medical school class as an example of how professional practice can warp an otherwise decent mind.” Assuming this disembodied perspective, Frank continues, physicians, nurses, social workers, chaplains convince themselves that they are shielded from the “terrible things” happening on hospital planet. They practice a “spaceship ethics,” taking refuge in principles that place them outside, or above, the complicated, ambiguous, contradictory lives of those others who sicken and die (p. 147). To board the spaceship they must deny their own embodiment, a denial for which they pay dearly.

Since the mid-1980s, several alternative ethical frameworks have challenged principlism’s dominance in biomedical ethics. Among the most prominent of these challenges is the common morality framework proposed by K. Danner Clouser and Bernard Gert. Common morality’s primary objection to principlism is that there is no comprehensive theory undergirding its principles. Clouser and Gert contrast the principles of Beauchamp and Childress with traditional ethical principles, like those of utilitarianism, that
are “shorthand” for comprehensive ethical theories and systems. They suggest that principlism is not supported by such comprehensive theories or systems; on the contrary, it acts only as a reminder to “think about justice” or “think about helping people.” By suggesting that a comprehensive theory undergirds their principles, Clouser and Gert argue, principlists mislead us into believing they have provided a firm foundation for our moral decision making when they have not. Instead, they have provided a way to justify our personal, biased, often arbitrary moral reasoning: “Since the principle was not nearly sufficient for determining judgment,” Clouser asks, “what idiosyncrasies, what biases, what subjective elements entered into the moral decision or judgment?” In contrast to the superficiality of principlism’s principles, Clouser asserts that common morality’s approach combines cognitive, aspirational, procedural, and juridical elements in a complex system that has four main components: moral rules, moral ideals, the morally relevant features of situations, and a detailed procedure for dealing with conflicts.

Casuistry is an alternative—or possibly a complement—to principlism that bases its reasoning in cases rather than abstract principles. A centuries-old form of moral reasoning, casuistry reentered the ethical arena in 1988 with the publication of *The Abuse of Casuistry: A History of Moral Reasoning*, by Albert Jonsen and Stephen Toulmin. It was then applied to bioethics in 1992, when Jonsen, Mark Siegler, and William Winslade published the first edition of their *Clinical Ethics*. Cases are concrete because they represent a “congealing” of circumstances. While each case is a unique combination of actors, actions, places, and times, it is also generalizable to other, similar types of cases. Jonsen describes how the ethicist schooled in casuistry sets about describing and evaluating the “circumstances, that is, the particulars” of a case—the “who, what, why, when, and where”—including the “manifold institutions and practices that constitute a social order,” which moral philosophers, in their fascination with a universalist rationality that “transcends particular practices of life,” have too long ignored. Ethicists who focus on universal forms of reasoning may be very skilled at theorizing, but they have proven themselves inept, casuists contend, in considering the particular circumstances of ethical cases. Yet casuistry is not simply a method for calling attention to the particular circumstances of a case; it is also a way of assessing these circumstances in seeking a resolution for ethical dilemmas. The arguments casuistry makes...
in seeking resolution are not long chains of reasoning; instead, they are enthymemes (“No one is obliged to do what is futile”) or maxims (“Do no harm”) that, Jonsen writes, “are open to challenges of various sorts. . . . In some cases, these challenges can be met within the casuistry itself, as with the question, ‘Is resuscitation in this case truly futile’, but in others, they require an ascent to a more speculative philosophy, for example, the careful examination of the concepts of efficacy, authority, and probability that underlie the term ‘futility’” (pp. 244–45). In the latter cases, casuistry must call on moral philosophy, although the need for this arises infrequently. In every instance, however, the final step is to compare cases, “seeking to identify cases similar to the one under scrutiny and to discern whether the changed circumstances justify a different judgment in the new case than they did in the former” (p. 245).

Virtue-based ethics, also an ancient form of moral reasoning, offers another alternative to principlism. The primary focus of virtue ethics is not on principles, a comprehensive ethical system, or cases, but, as Edmund Pellegrino asserts, on “the agent; on his or her intentions, dispositions, and motives; and on the kind of person the moral agent becomes, wishes to become, or ought to become as a result of his or her habitual disposition to act in certain ways.” Of course, this standard—the model of the virtuous person—varies from culture to culture and era to era. As Alisdair MacIntyre argued in his seminal work, *After Virtue*, the dominance of virtue ethics declined, post-Enlightenment, with the gradual decrease of consensus on philosophical and theological norms of moral judgment. Pellegrino emphasizes that the revival of virtue ethics, which he bases on the Classical-Medieval conception of virtue, focuses on “professional ethics,” or the “realm of the ethics of physician- or nurse-patient relationship,” not on “the growing body of other ethical issues commonly subsumed under the rubric of ‘bioethics’—i.e., the issues of withholding or withdrawing life-support, euthanasia and assisted suicide, embryo research, organ and tissue transplantation, managed care and the like; the whole panorama of new issues growing out of medical technological advances.” There is little hope for recovering a normative role for virtue in resolving these dilemmas, Pellegrino insists, because there is no agreement about the foundations for the virtues that apply to them, whereas in professional ethics, agreement on the nature of the end, or telos, of the healing relationship is possible (p. 267). For Pellegrino, the virtues that most facilitate healing in the clinical relationship are (1) fidelity to trust and promise, (2) benevolence, (3) effacement of self-interest, (4) compassion and caring, (5) intellectual honesty, (6) justice, and (7) prudence (*phronesis*, or practical wisdom) (pp. 269–70).

In the dynamism of contemporary bioethics, principlism and the challenges to principlism continue to help practitioners and patients choose fitting approaches to individual ethical concerns. The alternatives to principlism
considered above have arisen in efforts to rectify the impersonality, detachment, or superficiality of principlism. Other ethical frameworks—feminist bioethics, collective ethics, and perspectives from social justice—raise overarching concerns about autonomy, structural justice, and institutional morality that challenge all mainstream bioethical approaches’ concentration on personal as compared to public morality. \(^44\) We turn now to discuss narrative ethics, an ethical practice that centers on the contributions of narrative knowledge to moral lives. We will propose that a narrative approach answers the shortcomings of principlism while recognizing feminist and structural justice frameworks as means to move forward in facing both the personal and global ethical concerns within healthcare.

## Narrative Ethics

Narrative ethics emerged from within mainstream clinical bioethics in the 1980s as a means to perform a “ground-up” ethics that would start with the situation of the singular patient and move toward fitting ways of thinking about a particular patient’s situation instead of trying to fit sanctioned theories or rules to the individual case. As we will see below, its emergence coincided with the development of a conceptual narrative ethics from within literary studies, separate from but supportive of the narrative ethics of healthcare. A community of clinicians and scholars dedicated to the practice of bioethics who were trained in literary theory, narratology, philosophy, and religious studies came to realize the importance of narrative approaches to the concerns of patients and their families. Unlike principlism and its accompanying alternative modes of bioethical practice summarized above, which arose to adjudicate medical wrongdoings or to resolve technology-driven biomedical problems, narrative ethics emerged from broad intellectual movements within literary and interpretive thought. Influenced by and convened in such movements as the medical humanities, human values in medicine, and patient-centered healthcare, narrative ethics merged the perspectives of humanities scholars with the viewpoints of clinicians facing ethical situations in patient care. Together, they sought ways to bring ethical decision making closer to the patients’ lived experience, with the realization that patients themselves are the ones who perform the ethical work of illness. \(^45\)

Rather than starting from the objective features of a clinical situation and asking what a person should do next, narrative ethics focuses on how that person came to be here and where the path forward might lead. What has happened to lead to this situation? What alternative endings to this story can be imagined? The patient’s lived experience—including his or her experience of
illness—in all its particularity and meaning guides the thinking and judging regarding medical action that ensues. The narrative ethicist is trained to pay close attention to what patients, families, and clinicians say and write about the situation. From literary, linguistic, or social science disciplines, the ethicist learns to recognize the genre, point of view, metaphor, diction, and temporality of a conversation or a written text to understand what the story’s content might in fact tell. They comprehend the power and implications of the rhetorical and performative aspects of these accounts. In these ways, the ethicist gradually develops a nuanced sense of what it might be like to be within this story—imagining the forces acting on the patient and other agents in the narrative, using the evidence of conversations with families to construct a mental image of the patient’s situation. Gradually, as the careful listener is able to sense the climate of this narrative world and what it might be like to live within it, he or she asks questions that show the patient and family that their world is being taken seriously, respected for what it is, not contested. With this recognition as a basis, the work of narrative ethics can proceed.

What does this practice of narrative ethics look like? To exercise compassion in adjusting treatment to the particularities of this patient’s life story, to remove the blindfold of a universalist principle of justice and attend to a patient’s specific needs, indeed to exercise any of the virtues, which are never enacted universally but rather in unique situations with particular persons, requires narrative skill. Stories, Arthur Frank suggests, “give lives legibility; when shaped as narratives, lives come from somewhere and are going somewhere. Narratability provides for legibility and out of both comes a sense of morality—practical if tacit answers to how we should live.”

Part of the charge to the narrative ethicist is to identify who the tellers of this story are. The narrative ethicist elicits accounts from those who need to be heard in order to have a full enough view of the patient’s situation—family, friends, neighbors, professional caregivers. Using approaches from qualitative research in the social sciences and narrative inquiry from the literary/narratological disciplines, narrative ethicists understand what to do with competing or contradicting versions of situations, and how to seek and find some kind of coherence or at least unity, albeit uneasy, over the full account given. They encourage the participants, including professional caregivers, to each hear one another’s accounts and then assess what has been collectively revealed in dialogue with all involved.

Whether the patient is a stranger newly admitted to the hospital or a patient known for decades in a primary care practice, coming to appreciate his or her story from the inside is not an easy or low-stakes act. To enter the unknown world of another insists that one lay down one’s own assumptions about the very source of meaning, thereby escaping Powers’ straitjacket of the self. It takes the courageous willingness to admit that one’s own values and priorities
are not supreme. Opposing values and points of view must be honored to be as capable of illuminating the meanings and necessities of life as coherently as one’s own. Seeing others fully and faithfully means seeing them in all their particularity, ambiguity, and contradiction while being forced to question one’s own convictions. Therefore, to decide to listen, to attend to the other’s story, is already to take an ethical stand. To enter the story, the listener must experience its moral complexity in all its ambiguity and challenge to one’s own moral sense.

What, now, do narrative ethicists do in performing ethics consultations in a hospital or practicing with ethical skill as a clinician? In practice, narrative ethicists have been listening very closely to stories told by patients and their families, searching for the necessary voices that might have been silenced. Some narrative ethicists write these stories down, knowing that the knowledge of complex events is enhanced through acts of representation, like writing, that confer form on what is until then chaotic and formless. Narrative ethicists might suggest that patients and families write or dictate stories so that their stories, too, through representation, can become visible and can aid in envisioning the way forward. By reading these accounts together, patients, ethicists, and clinicians can together discover central but sometimes hidden elements in the situation they face. Narrative ethicists invariably spend time with patients and families to get to know something about the patient’s and family’s climate, their ways of making sense of things, their habitual means of coming to decisions about important matters. The ethicists sometimes become mediators between the clinicians and the patients, helping them translate to one another what they cannot seem to convey on their own, smoothing the way for frank conversation not dominated by blame and mistrust. Religious scholar and ethicist Larry Churchill writes, “Narrative is a profound mode for understanding ethics consultations, not because it resolves problems, but because it forces us to attend to the human voices, including our own, behind what is being said.” Churchill nominates humility as the ethicist’s most important virtue, reminding us all of the paucity of answers and the gravity of the questions.

The Narrative Ethics from Literary Studies

We turn now to the second “narrative ethics” to be considered here. Around the same time that narrative ethics surfaced in bioethics, literary studies of the 1980s created its own field of narrative ethics. Rather than the need to solve biomedical quandaries, this narrative ethics became a fundamental inquiry into questions of narrativity and identity. It is crucial for bioethicists to
understand literary narrative ethics—crucial for the intellectual, relational, and structural aspects of addressing moral problems in healthcare. In effect, literary narrative ethics supplies the intellectual foundations to the practice of narrative ethics in healthcare settings.

Within literary studies and its branch called narratology, a particular focus arose on the relationship between narrative and ethics. This narrative ethics gathered scholars who began to pay fine attention to the ethical relationships between readers and their texts. They came to understand that one cannot read a novel or poem or essay without being ethically engaged in both the plight of the characters and the acts of the author in telling about them. Reading, they came to see, is an active process that calls forth ethical discernment from the reader in judging the actions of characters, in assessing the reliability or unreliability of a narrator, in measuring up the moral climate and claims within the story—a world whose moral climate makes claims or poses challenges in one’s own life. As the character’s consciousness and conscience is exposed in the text, the reader’s consciousness and conscience too may be awakened. Literary critics and philosophers propose that the narrative text affords grounds for the serious reader to examine personal choices and realities afresh, for the relationship between a reader and a text forms a context for ethical acts. Although not addressing itself to problems in healthcare, the literary narrative ethics has been a source of knowledge and perspective to which bioethics’ narrative ethics owes a tremendous debt.

To read, closely and seriously, embarks the reader on a committed search for the sources of meaning within the text and within the experience of reading it. Literary scholar Adam Zachary Newton writes in his Narrative Ethics that narrative ethics “attribut[es] to narrative discourse some kind of ethical status . . . [and] ethical discourse often depends on narrative structures.” The reader answers to a moral imperative to open himself or herself to the author’s and characters’ ways of making moral sense of their worlds. Perilous, such literary work exposes the reader to another’s way of making sense of events of life, challenging the reader to accept the proposed “ground rules” within any narrative text and, by extension, within whatever world that narrative text depicts. In the words of literary scholar J. Hillis Miller, “Ethics and narration cannot be kept separate, though their relation is neither symmetrical nor harmonious.”

Literary scholar Wayne Booth, author of the seminal The Rhetoric of Fiction, stakes out his ethical position in The Company We Keep to suggest that books, seriously engaged with, function as friends in the reader’s life, and that the reader’s gradually developing ethical stance influences what he or she makes of a particular book while each book, in turn, contributes to the further development of that ethical stance. Booth points out that, as is the case with friends,
one can accept or reject the company of a book, sometimes as a matter of taste and sometimes as a matter of moral principle. In view of the persuasiveness of violent or sectarian literatures available widely in the media, Booth’s caution has been taken seriously as a measure of the power of reading in developing a life-long moral compass.

Literary narrative ethicists remind us that the literary text exerts ethical force not only in its plot but also in its form. Narratologist James Phelan insists that the ethical work of the reader is done not only in weighing moral choices made by characters but also in examining the ethics of representation itself: “I . . . [tie] ethical response to the techniques of narrative itself, as I focus on the links among technique (the signals offered by the text) and the reader’s cognitive understanding, emotional response, and ethical positioning.” So the dual processes of form and content work on the reader, letting the reader inspect the proposed reality of the world depicted while simultaneously undergoing the personal process of having come to know that world. Reading, in effect, is a laboratory in which the reader comes to know his or her deep-seated modes of judgment—of the beautiful, of the revolting, of the gripping, and of the moral.

From the worlds of psychology and philosophy come complementing means of making sense of the ethics of reading. Originator of the field of cognitive psychology, and more recently of cultural psychology, Jerome Bruner asserts the primacy of a literary form of narrative for meaning-making: “Narrative seems to depend for its effectiveness . . . upon its ‘literariness’. . . . It relies upon the power of tropes—upon metaphor, metonymy, synecdoche, implication, and the rest, to ‘expand the horizon of possibilities’.” Aristotelian philosopher Martha Nussbaum has been drawn to literary work, especially the late novels of Henry James, as a source of philosophical thought on questions of freedom and responsibility. Her Love’s Knowledge makes the case that philosophical thought cannot be consummated within philosophical language, and rather requires the putting-into-words peculiar to the novelist to express, and only then to understand, the thoughts embroiled in words: “To show the force and truth of the Aristotelian claim that ‘the decision rests with perception’, we need . . . texts which display to us the complexity, the indeterminacy, the sheer difficulty of moral choice, and which show us, as [Henry James’s The Golden Bowl] does, the childishness, the refusal of life involved in fixing everything in advance according to some system of inviolable rules.” Both form and content of literary works are seen, in these two comments, to be salient to the projects of appreciating moral worlds and being prepared to make some distinctions, if not choices, in their midst.

This excursion into literary study’s practice of narrative ethics brings us organically back to the practice of narrative ethics within bioethics.
types of narrative ethics converge on the realization of the saturation of the moral in everyday life. Whether we listen to the story of a patient in the office or we read the words of a well-wrought novel, we are taking seriously human beings’ capacity to formulate, in words, what they are going through. We use the same narrative skills in both the literary and the clinical contexts. Trained to capture the evidence of words, we can try to meet the tellers or writers in their world, at least permitting ourselves to picture what living in that world must be like. Our task as listeners or readers is to experience the full force of the accounts of others, to appreciate the gravity of being exposed to the meaning-making efforts of others, and to become aware of the impact of such accounts on our own moral development.

In teaching narrative ethics within our Master of Science in Narrative Medicine graduate program at Columbia, we teach the literary as well as clinical faces of this practice. In addition to the clinical practice of helping patients, families, and clinicians arrive at fitting decisions about healthcare, teaching narrative ethics entails training in the close reading of literary, legal, and clinical texts. The narrative ethicist has a duty to examine whatever texts or oral communications influence macro-level as well as micro-level discourses about ethical issues, whether in the academic press or in popular and social media. Close reading of clinical ethical cases, of nonfiction accounts of ethical conflicts, and literary representations of the moral issues in healthcare are all important in the development of the narrative ethicist. Understanding the narrative structures of all types of texts and images and following the interplay between the narrative and the ethical enable the learner to identify the intellectual, clinical, and ideological forces at work and to respond thoughtfully to them. Such study exposes learners to the complexities of bioethical discourses in all communicative frames and equips them to help others make sense of the barrage of information on healthcare ethics. Such capacities contribute to both the ethicist’s intellectual growth and potential to be of help to individual patients and families within their illnesses.

Perhaps the most consequential aspect of both forms of narrative ethics is to expose the ethical nature of narrative engagement in the world. As the particular illuminates the universal, so the personal ethical dilemma of one patient points to societal and global inequities and widespread threats to safety and equality. Feminist bioethicist Susan Sherwin proposes a “public ethics” that would address urgent global threats ranging from climate change to the escalating wealth/health disparities. Urging bioethics to recognize its responsibilities in facing collective moral threats as well as individual moral dilemmas, Sherwin details the contributions a feminist relational approach can bring to a bioethics of this scale, a contribution irreversibly narrative in nature:
Feminist relational theory looks not only at the behavior of individual patients, providers, and administrators, but also at society and asks how dominant values and institutional options tend to direct individuals in particular directions despite obvious problems with these options. It encourages us to seek changes at all levels of human organization, both formal and informal, in pursuit of moral values. As such, it provides an important model for ethicists willing to take on the challenge of developing a public ethics aimed at guiding humans away from the potential catastrophes ahead.60

Such an approach demands far-flung horizons with a capacity for vast conceptual range that can take in not only the predicament of one person or one institution but also the interconnected genesis of global threats. Sherwin continues to propose that “[w]hat we need is an approach to ethics that encourages humility regarding our own interpretations without abandoning the value of searching for reliable guidelines and being willing to promote their discussion and adoption” (p. 18).

The qualities required of bioethicists—if we are to consider widening their scope to address the ethics of the collective—resemble the capacities endowed by both forms of narrative ethics. The discernment of the network of responsibilities and the ability to move from the part to the whole and then back to the part are, from their genesis, hermeneutic skills built on elemental narrative powers. To even raise such questions within a society demands the narrative skills to open conversations, to solicit diverse points of view, and to tolerate the disagreements without resorting to silencing dissidents. Forms of narrative competence, these are the interventions that may enable us to raise our ethical sights above the local toward the contemplation of a justice for more than a few.

Philosophers Jens Brockmeier and Hanna Meretoja propose that “[i]f there is one point we consider essential for the hermeneutics of narrative, it is the way in which it brings together engagement with issues of storytelling in linguistic, discursive, and artistic contexts with the wider existential relevance of narrative practices for our (self-) understanding and being in the world.” We take the growth in both forms of narrative ethics as a signal of the serious study of engagement, of human contact, of the growth toward the radical humility to seek the word of one, to see the perspectives of the many, to find means to accept alien ways of making meaning, and so to live more fully—together with those with whom we’ve been thrown—the lives we’ve been given to live.

The Pedagogy and Practice of Narrative Medicine’s Ethics

Narrative medicine is poised to integrate the literary narrative ethics and the clinical narrative ethics, being a citizen of both worlds, so that the clinical
ethics deliberations can proceed in light of the literary and rhetorical insights now available from narrative study.

Narrative ethics is an ethics practiced with narrative competence, which we define as the fundamental human skill of recognizing, absorbing, interpreting, and being moved to action by the stories of others. This ethics can be practiced both by ethicists/consultants who obtain narrative training and by clinicians whose narrative training enables them to attend carefully to the ethical dimensions of their own practice.

Narrative ethics, in a manner of speaking, is narrative medicine practiced in the setting of bioethics. As Frank writes,

[N]arrative ethics is more interested in preventing breakdowns in mutual understanding from happening in the first place than in adjudicating conflicts over preferred courses of action. The primary focus is to prevent situations from turning into cases. Thus narrative ethics necessarily morphs into narrative medicine, including in its purview how everyday clinical practice proceeds and how well such practice honors people’s stories of suffering. . . . Ethics conflict—autonomy being set in opposition to beneficence—can be avoided by a physician who practices narrative medicine . . .”

One way to develop the narrative competence required of narrative ethics is through the study of literature and the development of the skills of close reading. To listen to patients’ stories with a view toward understanding how the storytellers find themselves in their present situation requires the same narrative competence used in reading a literary text. We propose that the close reading of great literature develops the narrative competence necessary to understand, through Aristotle’s phronesis, moral complexity and ambiguity. Although principlists are fully aware of the importance of attending to the complexities of each unique case, they do not provide guidance on how to facilitate this attention. Casuists focus on the particularities of each case yet do not elucidate the way that narratives are shaped, how they function, what they mean, or how one enters the case at all. Gesturing, in a broad way, to the narrative nature of casuistic reasoning does not get us far.

We teach narrative ethics by teaching narrative medicine—close reading, creative writing, responding to the writing of others, co-constructing narratives. Not only the reading of the text but talking about it and writing in its shadow seem to be required for the reader to achieve dividends of the learning. In the formation of the narrative ethicist, these same powers of sight and meaning, achievable by the close reader and writer, are the necessary equipment for coming to envision and comprehend the meaning-making of patients, families, clinicians, and wider communities. Once they have learned to
be close readers, they have the capacity to become close listeners. Once they have strengthened their skills of representation in writing, they can lend this skill to the patients for whom they care and whose accounts they may attempt to configure into a written narrative.

Through these pedagogies, the reader comes to recognize his or her habitual moves in interpretation as well as his or her blind spots, assumptions, and prejudices. The contrasting responses of respected fellow readers need not lead to antagonistic arguments to declare the winner but rather can open mutual examination of the contingent grounds of any one interpretation. Together readers realize the range of possible interpretations, which helps to deliver each one from the peril of certainty. Narrative training is the staple of training in narrative ethics, hand in hand with close and critical attention to the stories that unfold in illness and care, recovery and death.

This pedagogy performs another critical function for those who would practice narrative ethics: it strengthens creativity. We see the importance of the work of imagination in moral life—we cannot choose to live that which we cannot imagine. Clinicians must be skilled at this imagining if they are to provide opportunities for patients to choose among the possible alternatives open to them. To engage in this work is to exercise both ethical discernment and narrative recognition—the phronesis of Aristotle to which Ricoeur refers. Narrative recognition or logic does not insist on narrative consistency: often ethical conflicts arise because the way someone has been telling her story no longer fits the changed circumstances of her life. In such a case, the effort is not to make the next story fit the narrative patterns of the old, but to help the patient to imagine new ways to tell and to interpret her story, ways that open possibilities for moving forward rather than living in the past.

We teach that narrative ethics has a responsibility to move toward social justice. The reason to develop the skills of escaping the straightjacket of self is to actively acknowledge and respect otherness. Proposing that reading novels makes possible “the will to believe in the possibility of alterity,” literary scholar Dorothy Hale concludes that

the novel reader’s experience of free submission, her response to the ‘hailing’ performed by the novel, becomes . . . a necessary condition for the social achievement of diversity, a training in the honoring of Otherness, which is the defining ethical property of the novel—and is also what makes literary study, and novel reading in particular, a crucial pre-condition for positive social change.66

The understanding of narrative ethics that emerges from the practice of narrative medicine now comes into view. Several qualities surface as part of the practice of a narrative ethics that is itself an aspect of narrative medicine.
Narrative ethics is reflexive ethics: An ethics oriented toward narrative focuses on the ubiquity of moral considerations in healthcare and not only on the moral reasoning that is applied from afar in ethical crises. As a reflexive practice, narrative ethics is lived, in real time, whenever patients and those who care for them work together, enabling the participants to recognize as ethical issues that arise and to respond to them throughout their work together. (See Chapter 12 of this volume for a discussion of reflexive clinical practice.) Reflexivity engages a community of witnesses to consider values and to empower moral choices. Here we see narrative ethics’ solidarity with feminist ethics and care ethics. As Hilde Lindemann Nelson writes,

On the theoretical-juridical model, morality is a matter of applying codified rules derived from comprehensive theories as criteria for assessing wrongdoing and making rational choices. The narrative approach . . . sees morality instead as a continuous interpersonal task of becoming and remaining mutually intelligible. It is expressive of who we are and hope to be; it is collaborative in that it posits, not a solitary judge, but a community of inquirers who need to construct ways of living well together. And it is feminist because it offers a means of resisting powerful ideologies, whether these be of gender, medicine, ethnicity, or all three at once.

Although narrative ethicists indeed participate in ethics consultations and contribute to resolving acute quandaries in the lives of patients they have not previously known, those narrative ethicists who are themselves clinicians also practice a tonic form of ethics within the texture of the clinical care itself. Called everyday ethics, slow ethics, or microethics, this form of ethical practice pays attention to the ordinary aspects of patient care instead of the dramatic eruption of quandary situations. In these cases the narrative ethicist is the clinician, not the consultant, and the context of ethical practice is the dutiful professional care of the patient. Mutual, reflexive knowledge between these two develops over episodes of care, be they 30 hours in the Emergency Department, 4 days of an inpatient stay, or decades in the clinic, laying the groundwork for a shared practice of careful listening and recognition.

Emotions and feelings are present and helpful in narrative ethics: Both literary narrative ethics and clinical narrative ethics acknowledge the importance of emotions in an ethical practice. As they examine the processes of reading in neuroscientific and aesthetic terms, narratologists are taking up questions of empathy, affect, agency, and imagination. Questions of the place of emotions and individual patient/clinician relationships in clinical decision making are an important part of narrative ethics as well as of other healthcare practices, including relational ethics and care ethics.
than being seen as interfering with clinical judgment, emotions of empathy or compassion are recognized to be a source of care. Issues of self-care for clinicians, moral distress of clinical practice, and what has been called “ethical mindedness” also require complex and conscious handling of and interpretation of emotion in practice, and have reminded narrative ethicists to care for the carers as well as the patients.  

(See Chapter 2 of this volume for a discussion of the place of emotion in narrative medicine’s teaching and practice.)

**Narrative practices are not only the therapeutic means, but the therapy itself:** The narrative acts of giving accounts of the self, skilled listening to such accounts, and co-creating narratives of illness not only propel toward care but bring about healing. They are not adjunct to the care; they are the care itself. Narrative medicine and narrative ethics are learning from practices arising from gerontology and palliative care that entail storytelling as a ger- minal part of the care itself. Aging and dying persons come to recognize themselves, frame their life histories in ways that make sense to them and to others, and leave behind something of beauty and singularity. Both narrative medicine and narrative ethics recognize the therapeutic power of the practices of unhampered expression and careful listening. Literary scholar Derek Attridge could have been writing about facing a patient instead of reading a literary work when he wrote that “the impulse to do justice to the work, which means to make it happen anew (and always differently) in one’s reading of it, is an ethical impulse: in Levinasian terms, to respond to the other not as a generalizable set of features or a statistic but as a singularity.”  

Achieving the attention and performing the representation constitute the giving of care—care that extends both to the patient and the provider of care.

These reflections on a narrative ethics consonant with the practice of narrative medicine are the beginnings, we hope, of a deepening relationship between the two. In a reciprocity reminiscent of that between narrativity and identity with which we opened this chapter, narrative medicine and narrative ethics can together create concepts and methods to singularize clinical care and ethical care. Both practices have the power to recognize those who participate in care, those who come to be heard, and those who do the work of listening.

**Postscript**

The effort really to see and really to represent is no idle business in face of the constant force that makes for muddlement.

—Henry James, *What Maisie Knew*
We deliver to patients that which they came to the clinic for when we humbly, meticulously, in affiliation listen to what patients say and then do justice to it. Knowing that the presence of this clinician and this patient will result in a singular outcome, the process of care nourishes both, either with hoped-for relief of suffering or with acknowledgment of having been of use. The technical interventions follow upon this singular, selfless listening. The result will be both the product of and the evidence of a healing relationship between teller and listener.

In an interview describing how she understands her own literary efforts, Toni Morrison says that her “books are about very specific circumstances, and in them are people who do very specific things. . . . The plot, characters are part of my effort to create a language in which I can posit philosophical questions. I want the reader to ponder those questions not because I put them in an essay, but because they are part of a narrative.” Reflecting on Morrison’s words, the philosopher George Yancy writes that

Morrison is not depicting abstract and universal truths, but ‘accidents of private [and public] history’ that philosophically shed light on what it means to be a self. . . . Morrison is able to place the reader into an imaginative lived space, a powerful narrative space that is able to articulate modalities of lived existence . . . . Hence, one might say that Morrison posits philosophical questions that are linked inextricably to narrative. After all, our lives are lived narratives, journeys of pain, endurance, contradiction, death, intersubjectivity, suffering, racism, sexism, terror, trauma, joy and transcendence. Avoiding abstract and non-indexical discourse, Morrison reveals the power of literature to embody the flesh and blood reality of what it means to-be-in-the-world.

It is this capacity of literature to embody the reality of being-in-the-world that gives narrative practices in healthcare their powers. A practice of ethics within narrative medicine is creative, shot through with imagination, innovation, and singularity. It is reflexive, where both parties see the self more clearly by virtue of their contact. And it is reciprocal, leaving behind no debt, no lien, no diminishment but instead mutual growth, even at the ends of life. It is a powerful and respectful way for humans to meet—two subjects—to contemplate mystery, to tolerate doubt and fear, to accept help, to recognize love. It is, in the end as in the beginning, the word.

We will give Ricoeur the last word. In his groundbreaking philosophical work Time and Narrative, Ricoeur writes: “We tell stories because in the last analysis human lives need and merit being narrated. This remark takes on its full force when we refer to the necessity to save the history of the defeated and the lost. The whole history of suffering . . . calls for narrative.”
Notes

1. Brockmeier, Beyond the Archive, 181.
6. Robinson, Narrating the Past.
9. Peters and Besley, “Narrative Turn.”
10. Reed et al., “Narrative Theology.”
11. Ricoeur, Time and Narrative.
16. Although this chapter will not treat works other than literary texts, there are parallel critical works in aesthetic and musical theory that contribute to the argument for the ethical dimensions of creative work in other media. See as one example Rabinowitz, “Rhetoric of Reference.”
17. See Ricoeur, Time and Narrative, vol. 1, especially chapters 1 and 2.
22. Murdoch, Black Prince, 162.
24. Beauchamp and Childress, Principles of Biomedical Ethics.
32. Frank, Wounded Storyteller, 147 (cited hereafter in the text by page numbers.)
33. Cole, Goodrich, and Gritz, Faculty Health in Academic Medicine.
38. Jonsen and Toulmin, Abuse.
41. Pellegrino, “Toward a Virtue-Based,” 254.
42. MacIntyre, *After Virtue*.

43. Pellegrino, “Toward a Virtue-Based,” 265 (cited hereafter in the text by page numbers).

44. For discussions of feminist ethics and public ethics, see Sherwin, “Whither Bioethics?” For recent reviews of the development of feminist bioethics, see Scully, Baldwin-Ragavan, and Fitzpatrick, *Feminist Bioethics*. For examinations and critiques of feminist bioethics’ contributions to theoretical philosophy, see Nelson, “Feminist Bioethics,” and Rawlinson, “Concept of a Feminist Bioethics.”

45. Two collections of essays published at the turn of the century helped to state the case for narrative ethics and to state its limits, convening in print authors writing from multiple clinical and theoretical perspectives. See Nelson, *Stories and their Limits*; and Charon and Montello, *Stories Matter*. See also Brody, *Stories of Sickness*; Hunter, *Doctors’ Stories*; and Carson, *Interpretive Bioethics*.

46. Phenomenologists writing about the ethics of illness have helped patients and clinicians to recognize both the complexity of any one patient’s experience of illness and the gulfsthat can separate the worldviews and values of patients and professionals. The seminal work of S. Kay Toombs, Richard Zaner, Drew Leder, and, more recently, Havi Carel contribute both theories and methods for clinicians who want to make contact with patients’ lived realities and to take them into account as choices are made. See Toombs, *Meaning of Illness*; Zaner, *Conversations*; Leder, *Absent Body*; and Carel, *Illness*.

47. See Tod Chambers’s influential study of the literary genre of the ethical case history, *Fiction of Bioethics*. See also literary scholar and patient Kathlyn Conway’s probing study *Beyond Words*, which inspects language’s capacity or inability to express that which the patient experiences in serious illness.

48. Frank, “Why Study People’s Stories?”, 111.

49. For background on qualitative research methods of asking questions and arriving at some conclusions, see Hurwitz, Greenhalgh, and Skultans’ *Narrative Research*. Kathleen Wells’ *Narrative Inquiry* and Elliot Mishler’s *Research Interviewing* give strong accounts of narratively based ways to seek underlying unities contained in accounts.

50. See a 2014 Special Issue of *Hastings Center Reports* on narrative ethics, edited by Martha Montello, that collects perspectives from many of the ethicists and clinicians who pioneered these practices from the emergence of the field (Montello, *Narrative Ethics*). Dawson Schultz and Lydia Flasher suggest that the responsibility of the ethicist to get the story straight is an act of clinical phronesis (Schultz and Flasher, “Charles Taylor”).


52. For introductions to narratology’s narrative ethics, see Newton, *Narrative Ethics*; Booth, *Company*; J. Hillis Miller, *Ethics of Reading and Literature as Conduct*; and Phelan, *Living to Tell* and “Rhetoric, Ethics.”


63. Frank, “Narrative Ethics as Dialogical,” S16–S17 <<subsequent citations not found>>

64. Neuroscientific studies of the consequences of reading literary fiction support hypotheses that reading serious literature enhances the reader’s capacity to recognize or imagine emotional states in others. See Kidd and Castano, “Reading Literary Fiction,” and Djikic, Oatley, and Moldoveanu, “Reading Other Minds.”

65. See Beauchamp, “Principlism and Its Alleged Competitors.”
Initially triggered by the work of Carol Gilligan and Nel Noddings in a feminist theory of moral development, care ethics has developed theoretical and practical guidelines for a radically practice-oriented conception of personal responsibilities of caregivers. See Tronto, *Moral Boundaries*; and van Nistelrooij, Schaafsma, and Tronto, "Ricoeur and the Ethics of Care."


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