Slow motion ethics: Narrative responsibility in clinical care

Daryl Pullman

Abstract
Narrative theory is a dynamic and evolving field of inquiry that has made tremendous inroads in the medical humanities over the past 40 years. Numerous authors have popularized the idea that “thinking narratively” can produce important insights about the illness experience for physician and patient alike. This paper draws on aspects of narrative theory to emphasize the moral responsibilities that arise when we step into another person’s life narrative, becoming a character in her or his story. This has especially significant ethical implications for the physician–patient encounter in that each character in this shared story experiences time somewhat differently. This gives rise to the notion of “slow motion ethics” and a somewhat unique perspective on the moral responsibilities clinicians bear toward their patients.

Keywords
Narrative ethics, clinical ethics, physician-patient relationship, professional responsibility

When the telephone rings at 3am it is seldom good news, especially when your children aren’t under your roof. Hence it was with some trepidation that I answered. The person at the other end informed me she was calling from our local hospital. Our son had been involved in a climbing accident, and was currently undergoing emergency surgery to repair a badly fractured ankle. I was assured he was in fine shape otherwise, and there was no need to panic. After surgery he would be transferred to a ward and it would probably be several hours before he would be ready for visitors. I was encouraged to wait until the morning to see him.

The morning visit was convenient as my office is in the medical school attached to the teaching hospital. I went directly to the ward when I arrived and found our son awake and raring to go. As an avid rock climber he was anxious to know how long he’d have to stay in the hospital, whether there would be any long-term affects from the injury, how long it would be before he’d be able to climb again, and so forth. I was in no position to answer his questions, and the busy nurse who popped in and out from time to time deflected his many inquiries: “The doctor will be around soon,” she said. “You can get your questions answered then.”

As promised, a short while later the senior orthopedic resident arrived leading an entourage of junior residents, clinical clerks, and other trainees. We watched as she led her group through the four bed ward, holding court from the foot of each successive patient’s bed. In a matter of minutes she had dispensed with the other patients and was now at my son’s bedside, clipboard in hand. “I’m Dr. So and So,” she mumbled as she scanned the chart and proceeded to do a quick assessment of color, temperature, and feeling of the toes peeking out from the end of the cast. “Can you feel this?” she asked as she hurried through her examination, to which my son gave an equally hurried and uninspired “Yeah.” “Good” she said as she wheeled to go, “you should be out of here by this afternoon.” “What about this?” my son called out, pointing at the IV bag of antibiotics next to his bed, “They said I’d have to stay until this was finished.” “Oh, right…” replied the doctor as she continued her retreat, “you should be out of here by tomorrow morning.” And then she was gone.

“What the ’explicative’ was that?” asked my son, looking to me for an answer. “That,” I said, “was really poor bedside manner.” Fortunately, about that time the nurse who had witnessed the brief exchange popped her
head back in the door. “Sorry about that,” she said, “the doctor is really busy. I’ll be back later and I’ll try to answer your questions ...”

Anyone who has spent time either as care provider or patient can relate to the general scenario just described. Hospitals are crowded, hectic, and often impersonal environments, and the physicians, nurses, and other health professionals who work there are generally run off their feet. But while this is an explanation for the perfunctory manner in which this physician dealt with our son that morning, it is certainly not a justification for such a seemingly care-less exchange. This physician was operating at warp speed to get through a multiplicity of somewhat routine encounters that defined her morning rounds, presumably so she could get on to other more important tasks. But this moment in my son’s life was unfolding at a comparative snail’s pace as he struggled to make sense of an experience with which he was wholly unfamiliar and that was anything but routine for him. Put otherwise, the interaction between this physician and this patient marked a point at which the separate narratives of their individual lives intersected, and for a brief moment each became a character in the other’s life story. It is this contrasting perception of a singular interaction between physician and patient that is the focus of this reflection. For it is encounters such as this that give rise to the notion of narrative responsibility and which call for a reflective process I refer to as “slow motion ethics.”

Narratively informed and narrative ethics: A brief review

Narrative theory is a dynamic and evolving field of inquiry that has made tremendous inroads in various aspects of the social sciences and humanities over the past 40 years. Its influence in the medical humanities can be traced to the 1980s with works such as those by Brody and Kleinman. Others have helped popularize the idea that “thinking narratively” could produce important insights about the illness experience for physician and patient alike. We are now a generation removed from these early contributions that helped shape our understanding of the role of narrative in the medical humanities and in health care ethics in particular, so perhaps a brief refresher is in order.

Baldwin draws a useful distinction between “narratively informed” and “narrative” ethics. The former refers to the process of drawing upon narrative to enrich our ethical insight and understanding. Here the narrative content might be drawn from literary fiction such as Tolstoy’s The Death of Ivan Ilyich to inform discussion about death and dying, Solzhenitsyn’s Cancer Ward to illuminate aspects of the physician–patient relationship, or Davies’ The Cunning Man to gain insight about the complex process of becoming a skilled clinician. Another approach to narratively informed ethics draws directly on the personal narratives of patients and those intimately involved with them as sources of rich data that can inform our moral reasoning. On this view such personal narratives provide insights that enable a fuller moral response to the situation at hand. Irrespective of whether the source of the narrative content is literary or personal, however, in a narratively informed ethic the role of narrative is subordinate or an adjunct to some other ethical framework. John Arras advocated for this kind of complementary role for narrative in the process of moral justification. As such, in a narratively informed ethic, narrative provides some portion of the content for ethical reflection, but other theoretical perspectives such as principlism or care ethics provide the method or form of moral reasoning.

Narrative ethics, by way of contrast, accords narrative a more central role in the process of ethical reasoning. Rather than merely enriching the content of moral reflection, in narrative ethics it is narrative that provides the form for structuring ethical reflection. Again Baldwin identifies two broad approaches within narrative ethics. Narratology focuses on the elements or components of any narrative experience such as context, character, plot, and perspective. A key element of this approach for bioethics lies in the element of “resolution.” All stories require some sort of movement toward closure or resolution,” states Baldwin “and it is this movement that is important in narrative ethics” (Baldwin 2015, p. 4/10).

While the foregoing attends to the eventual outcome, resolution, or “closure,” at the end of the narrative process, the alternate position on narrative ethics focuses on the process itself. On this view, the narrative process is foundational to the ethical enterprise. Put otherwise, the journey is as important as the eventual destination. Polkinghorne observed that narrative is the primary means by which human existence is rendered meaningful. We human beings are hard wired to make sense of the world as we experience it; the stories we tell ourselves and others are our means of doing so. “It is through narrative,” writes Baldwin, “that we understand experience, construct our sense of self, generate meaning and purpose, experience time, communicate with others, and act in the world. Human beings are homo narrans” (Baldwin 2015, p.5/10).

Thinking narratively, then, is somewhat akin to breathing. It is just something we do routinely without reflecting much on the process or its implications. Becoming consciously aware of such “routine” processes, however, can be an occasion for attending to their normative implications. In contrast to a narratively informed ethic in which narrative plays a somewhat ancillary role to other ethical approaches, on this account of narrative ethics understanding narrative structure is primary in ethical reflection; other ethical frameworks thus play a secondary and supportive role in illuminating aspects of the narrative process.
Narrative structuring and narrative responsibility

Part of the task of a narrative ethic is to alert participants to the role of narrative in structuring their experiences. Each of us is telling a story in which we are the main character. Other persons become characters in our story playing either minor or major roles depending on circumstances. But each of these others is also telling their own story in which they are the central character, and in which those who interact with them take on various parts.

Narrative structuring refers to the manner in which stories shape our understanding and give meaning to our experience, both individually and corporately. For even as each of us is experiencing our individual life story at the micro level, we are participating in a variety of other corporate or community narratives that structure various levels of our experience, shaping and informing our identities in the process. Our individual stories are, for example, woven into our family’s narrative, as well as that of our community, our faith (or lack thereof), and even our nation. Depending on circumstances we may identify closely with such larger narratives, willingly weaving our own story into that larger fabric. Conversely, we might seek to distance ourselves from a larger narrative if it is associated with something we find unpalatable or ethically problematic. I may, for example, identify as a proud Canadian when an athlete or team representing my country performs well on the international stage, but be less inclined to tout my Canadian identity when the focus of the story is my country’s history of colonialism and the continuing maltreatment of our indigenous peoples.

Recognizing the manner in which narrative structures our experience points to the descriptive aspect of narrative ethics; attending to the responsibilities each of us incurs by virtue of our participation in the various narratives in which we play a part, speaks to the normative task. This points to the notion of narrative responsibility.

Although not described explicitly as such, the notion of narrative responsibility figures prominently in physician Harold Brody’s work. "My story’s broken: Can you help me fix it?" Medical Ethics and the Joint Construction of Narrative is the title of one of Brody’s contributions. Brody’s focus throughout this piece is on the patient’s narrative that has been “broken” by illness. Narrative responsibility for the physician entails attentive listening to the patient’s illness story in order to provide an appropriate clinical response. While physicians need to know details of the patient’s story in order to provide medically indicated interventions, patients need to know their stories are being heard, and that their perspective is understood by their physicians. Empathic listening can contribute to the healing process both literally and symbolically. Brody explains: “It’s as if the patient senses that by allowing the physician to understand his disease, he will in turn be healed, by the symbolic route, as well as by whatever specific remedies the physician might apply” (Brody 1994, p. 81).

The insights provided in Brody’s account are important and worth revisiting. However, by limiting his discussion to the patient’s illness narrative while ignoring the physician’s own narrative as it intersects with the patient’s story in the clinical encounter, Brody misses an opportunity to expand on other aspects of this notion of narrative responsibility. For the manner in which a given physician might respond to any given patient’s illness story, will be affected by events unfolding in that physician’s own personal and professional life. Framing the clinical encounter as the intersection of two unfolding narratives thus serves to highlight the mutual responsibilities we share for one another through the various stories in which we participate on a continuing basis. In particular, as far as the clinical encounter is concerned, it gives rise to the notion of slow motion ethics.

Slow motion ethics

All of us participate in numerous narratives throughout the course of any given day. The nature and degree of our ethical responsibilities to the others in whose narratives we are privileged to play a part, depends on the nature of the relationships we share with them. Many such narrative encounters are incidental and seemingly trivial, like an interaction with the grocery store clerk, for example. The few minutes in which we interact with the clerk entails playing a small part in the narrative of his or her life which, when read through the lens of narrative ethics, entails moral responsibilities. That being said, our ethical responsibilities in such incidental narrative encounters generally extend no further than treating these others with dignity and respect. This is not to suggest that demonstrating as much is itself a trivial matter. An act as simple and profound as giving or receiving a cheerful smile, or a courteous response, can do much to affect emotional states long after narrative paths have once again diverged. Framing such interactions as entailing a degree of ethical responsibility for someone else’s life story is one way of foregrounding the significance of even such routine encounters. But our most profound and meaningful narrative encounters and concomitant ethical responsibilities, generally involve characters whose stories are closely intertwined with our own such that our narrative arc is affected both negatively and positively by the trials, tribulations and triumphs of those with whom we identify most closely.

Among the myriad of narrative interactions we experience on a continuing basis, the physician–patient encounter is somewhat unique, at least for the patient. Physicians are relative strangers to most patients and encounters with them are generally brief. In this regard, the roles physicians and patients play in each other’s respective narratives are more akin to grocery store clerks than to that of close intimates. The physician’s own narrative is generally not
closely aligned with that of the patient nor is the patient’s narrative intimately related to the physician’s story as a whole. Indeed, professional ethical standards generally aim to ensure that such narrative intimacy is minimized. Thus when Brody speaks of “fixing” the patient’s narrative, he is not implying that the physician can or should attempt to repair all that might have gone awry in any given patient’s life story. Rather the physician is attending to a particular illness event in the patient’s life story, albeit an event that could well have significant short and long-term implications for how the rest of the patient’s narrative will unfold. It is the significance of such illness events that serves to elevate the physician’s role in the patient’s life narrative beyond that of the grocery store clerk. Brief and infrequent though they may be, physician–patient encounters are imbued with tremendous meaning and significance for the patient.

One of the paradoxes of the physician-patient relationship is that although they are relative strangers to one another, patients entrust physicians with some of the most personal and private details of their lives. Physicians examine patient’s physical bodies, touch and probe them intimately, and inquire into aspects of their day to day experiences that patients might be wont to share with even their closest acquaintances. Depending on circumstances patients will entrust their very lives into the hands of these veritable strangers, permitting physicians to cut them open, repair broken body parts, remove damaged tissue or diseased organs, and so forth. It is difficult to overstate the profound level of faith and trust patients must place in their physicians during these clinical encounters. It is because the stakes are so high and opportunities to interact with their physicians so rare, that time tends to slow for the patient at that point when his or her own life narrative intersects with that of their physician. Each word spoken or action taken by the physician unfolds in relative slow motion for the patient, carrying significance and meaning out of any proportion to the actual length of the narrative encounter.

Of course, while most patients deal with only a single physician at any given time, physicians generally have numerous patients whom they see throughout the course of a regular day. Thus, from the physician’s perspective, the physician–patient encounter is a rather routine affair. It is understandable then that one patient’s problem can become somewhat indistinguishable from that of another. The physician’s daily narrative consists of a series of such clinical encounters and there are often more patients than time available. Time pressures physician experience are often exacerbated by administrative processes and directives that aim for greater “efficiencies” in how they manage their professional roles. Time for busy physicians thus tends to speed up as they rush from one patient encounter to the next. Routine problems are in turn handled routinely.

It is at this point that the notions of narrative structuring, narrative responsibility and slow motion ethics converge to illuminate the moral significance of each physician–patient encounter. No matter what the reason that occasioned an encounter with a physician at this point in the patient’s life narrative, for the patient this event is anything but routine. Slow motion ethics reminds the busy clinician of the significance of each separate narrative encounter in which she is involved throughout her day, and the concomitant moral responsibility that comes with being entrusted with another person’s story. As such it is morally incumbent upon the physician to adjust the time frame of her own story so as to match that of the patient into whose life narrative she is now stepping.

Recall now the busy surgical resident introduced at the beginning of this essay, who assessed my son’s fractured ankle. We can imagine that this surgeon’s own personal narrative included years of hard work and dedication as she made her way through university and medical school and now into a much coveted surgical residency program. As a busy senior resident she would have myriad responsibilities, the most significant of which would no doubt entail performing actual surgeries in the operating theatre. We can only speculate as to how her own life narrative was unfolding on that particular morning when, for a brief moment, her story intersected with that of my son. Judging by the alacrity with which she navigated from one bed to another, spending no more than a minute or two with each successive patient, it was clear that other priorities were dictating the pace of her day.

Indeed, it so happened that as I left my son’s room a few minutes after his shared moment with the young surgeon, that I passed her at the nursing station. She was in the process of debriefing with the group of trainees accompanying her that morning, and the meeting was just breaking up upon my arrival. I acknowledged that she was clearly very busy, but wanted to let her know I was the father of the last patient she had just seen. I then handed her my card and asked that she give me a call if and when she had a moment. Glancing at my card she said she had a minute right then if I wanted to talk, so we stepped into a private meeting room. I explained I had been observing her bedside manner with various patients, including my son, and she appeared to be somewhat abrupt, impersonal, and even distracted in her approach. Her response was to produce a lengthy computer print-out with what appeared to be a list of names. “These are the patients I need to see this morning, before getting back to the OR at 10 am” she explained. “I don’t have time for hand holding.”

I acknowledged once again that it was clear she was very busy, however, I assured her that hand holding was neither expected nor required. “But looking your patients in the eye,” I said, “and smiling as you introduce yourself while calling them by name, will go a long way to reassuring them that you recognize them as individuals, and that you’re there to care for them.” While I didn’t launch into a discussion of narrative ethics and all that it entails, the simple acts described would indicate to each patient that
at that moment in time this physician had stepped into his or her life story, that she understood the privilege and responsibility of being there, and that the pace of the physician’s day was slowing to match that of her patient, rather than the reverse. This is the essence of slow motion ethics.

**Conclusion**

Narrative theory is a powerful tool, alerting each of us to the privilege and responsibility of participating in one another’s story. It is an especially effective heuristic in the medical context when physicians not only step in and out of the life narratives of their various patients on a continuing basis, but when those patients effectively entrust their stories into the hands of their physicians for the few moments they share together. Slow motion ethics aims to remind the busy clinician of this reality, and of the ethical responsibilities that come with each individual patient encounter.

**Declaration of conflicting interests**

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The authors received no financial support for the research, authorship, and/or publication of this article.

**ORCID iD**

Daryl Pullman https://orcid.org/0000-0001-9478-9644

**References**

1. Brody H. *Stories of Sickness*. New Haven and London: Yale University Press, 1987.
2. Kleinman A. *The Illness Narratives*. New York: Basic Books, 1988.
3. Hunter KM. *Doctor’s Stories: The Narrative Structure of Medical Knowledge*. Princeton, NJ: Princeton University Press, 1991.
4. Frank A. *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press, 1995.
5. Baldwin C. Narrative ethics. *Encyclopedia of Global Bioethics* 2015: 1–10. DOI: 10.1007/978-3-319-05544-2_302-1
6. Frank A. The standpoint of storyteller. *Qual Health Res* 2000; 10: 354–365.
7. Arras JD. Nice story, but so what? In: J Lindemann Nelson (ed) *Stories and Their Limits*. New York: Routledge, 1997, pp.65–88.
8. McCarthy J. Principlism or narrative ethics: must we choose between them? *Med Humanit* 2003; 29: 65–71.
9. Charon R. Narrative contributions to medical ethics; recognition, formulation, interpretation, and validation in the practice of the ethicist In: ER DuBose, RP Hamel and LJ O’Connell (eds) *A Matter of Principles?* Valley Forge, PA: Trinity Press International, 1994, pp.260–283.
10. Chambers T. *The Fiction of Bioethics: Cases as Literary Texts*. New York: Routledge, 1999.
11. Polkinghorne D. *Narrative Knowing and the Human Sciences*. New York: State University of New York Press, 1988.
12. 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.