Editorial

Some thoughts on tight corners in Medical and Health Care Education

Algumas reflexões sobre cantos apertados na educação médica e em cuidados de saúde

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Philippa Foot, renowned twentieth-century ethicist and one of the pioneers of contemporary virtue ethics, recalled in her preface to the 2002 edition of *Virtues and Vices and Other Essays* how one particular difficult question demanded from her years of thinking, work and research: that of the relation between practical rationality and virtue. It has been claimed that her interest in it sprang from her intellectual friendship with Elizabeth Anscombe, from whom she learned the fresh and revolutionary ideas of Ludwig Wittgenstein and the classical thought of Thomas Aquinas that had been discarded by academics outside the Catholic Church and other Cristian theological spheres. Both seemed to her exciting and compelling but they also appeared to collide with other ideas she held about what it meant to act rationally, namely inspired by Kant's account of practical reasoning. She later described this situation as her "tight corner" problem: she wanted to "be able to say that to act as justice or charity demands is to act rationally in every case, even in the tight corner"[1] where it would lead to self-sacrifice or death, and she recounted her efforts in coming to terms with it. This problem is interesting in itself, as a philosophical issue, but what I would like to focus on is the metaphor of the "tight corner", for I suspect that in medical and healthcare ethics and education there are few worthy of our attention at present.

As was the case with Foot, the most interesting of these tight corners come not from abstract concepts and their applications, but from real-life familiar examples and cases that call our reflection and that need to find their place in the theories we endorse, if we are to endorse them. However, sometimes, that proves to be extremely difficult. Sometimes, a perfect theoretical architecture appears not to capture the unique demands of familiar cases. And that should serve as a warning against conceptual over-simplification. Our urge to explain and to understand has to be carefully balanced with a fine awareness of the complexity and richness of reality, and this becomes evident when what we want to describe is something close to us, something - or someone - that we love. In my recent work in the health humanities, the metaphor of the "tight corner" imposed itself on me, for I have constantly before my eyes real-life close examples that make me very much aware of the perils of over-simplifications of sound philosophical and ethical theories. The broad general (philosophical or ethical) claim I find truthful and important is that narrative is crucial to the ways we, humans, attribute, understand and give meaning to our actions, interactions and lives, even in the tight corner of people who, for several reasons, are unable to construct narratives. But is this possible? And if so - how?

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My starting point is Alasdair MacIntyre's proposal that the kind of unity that human life has is a narrative one. This idea was famously articulated first in his 1918 *After Virtue* and it has been developed, enriched and corrected by himself and others following him since then. The central argument for this claim is that human action is always understood not as an isolated event but from a given description, with reference to a certain context, and considering what was intended with it.[2] Take a simple example: someone is cracking an egg. She could be baking a cake. But she could be a professional baker, whose job is to bake cakes, or she could be Little Red Riding Hood's mother, generously baking muffins for her sick mother, or she could be a cruel murderer, preparing a poisoned cake to kill an innocent victim. So, to simply say "she is cracking an egg" may, of course, be true, but it is insufficient as an account of what is really going on, it does not tell us what exactly is happening, and it is not enough for us to capture the meaning of that gesture. For that, we need to fit it into its story, that is, into a specific narrative. We understand actions (ours and other people's) as moments in stories, stories that are being lived out. When it comes to our own actions, we understand them in terms of the story of which we are the main characters and, simultaneously, co-authors. And so, the intelligibility of human actions and, therefore, of human lives, depends on narrative. Narrative and meaning seem, thus, deeply connected; and that connection extends to narrative and communication. MacIntyre's claim, then, is that narrative is the most basic and essential *genre* with which we describe human actions and lives, because of that connection between intelligibility and narrative, between apprehension, comprehension and expression of something with meaning and the narrative *genre*.[2] And MacIntyre is careful to underline that this connection exists not because narrative is a kind Kantian category of understanding, nor a structure that we somehow impose on reality to domesticate it, but because human action has a historical character in itself. What does he mean by this? He means that to tell and to live out stories is intrinsically human. We can be better or worse narrative artists or literary critics - that is not what matters. What matters is that we become aware of ourselves already in the context of the story that we are living out - a story that we did not start, but that is up for us to continue and develop.

To fully understand the breadth of MacIntyre's claim, it is useful to consider pressing objections that have been put forward against it, and in the context of the Health and Medical Humanities, Galen Strawson's are particularly relevant, since they were the trigger to what became known as Critical Medical Humanities[3] and to the efforts of de-centering health and medical humanities from the notion of narrative and of dealing with the limitations of that concept in health, illness and care contexts. To put it shortly, Strawson argues that MacIntyre and other philosophers who use the concept of narrative to think human identity and ethics typically defend at least one of two distinct but related ideas - what he calls the "psychological narrativity thesis" and the "ethical narrativity thesis".[4] The first is the affirmation that people commonly and naturally "see or live or experience their lives as a narrative or story of some sort, or at least a collection of stories"[4], and the second amounts to defending that "experiencing or conceiving one's life as a narrative is a good thing; a richly Narrative outlook is essential to a well-lived life, to true or full personhood".[4] Strawson claims that they are both false - and not only false but potentially dangerous and harmful since they are misleading, reductive, discriminatory and "potentially destructive in psychotherapeutic contexts".[4]

I do not agree with Strawson's position. Nonetheless, I do think his critique is relevant insofar as it calls attention to hypothetical limitations of the central concept of narrative. It has made me look again to two very close and familiar examples: my own one-year-old youngest daughter, who cannot tell stories, as she is currently only learning to speak, and my father-in-law, a 76-year-old man who suffered a severe stroke in 2012 and has been unable to talk since then. Both lack narrative competencies, but I am very much aware that both can communicate and understand human actions. So, my tight corner is the difficulty in accommodating cases and exemples such as these two, of people who, for several different reasons, cannot or do not know how to tell stories - not even their own story - into the compelling theoretical framework that claims that the way human beings produce, capture and express meaning (of human actions and lives) is a narrative one.

Several recent studies with aphasic patients suggest that these patients find ways to communicate, confirming my informed intuition regarding my father-in-law, and some of them highlight the importance of having someone help make those lost voices heard and understood. I do not claim to have made exhaustive research into this topic but three

very different examples seem illustrative of how this is a relevant topic in clinical practice in general and in narrative medicine in particular.[5,6,7] Some refer to cases in which patients suffer from light to moderate forms of aphasia, but, in any case, what becomes clear is that even when there seems to be a lack of capacity to construe narrative or to tell, on one's own, one's own story, the co-construction of that narrative, as it is called in one of those articles, is a crucial element. This suggests that people without the linguistic ability to construe narratives can communicate at least enough to participate in that co-construction, as I also seem to experience with my baby daughter, and I am sure other parents of babies also have. And so, the relationship between meaning and narrative turns out to be much more complex and far richer than what would seem at first sight.

MacIntyre's reply, in his last book, *Ethics in the Conflicts of Modernity* (2016), to Strawson's criticism, may also help us understand how to accommodate stories and examples as the former within a framework that holds narrative at the center of human experience. His suggestion is to take the concept of narrative in a much more deflated than what Strawson considers. He acknowledges that it simply does not happen that we are constantly thinking about ourselves or other people in terms of narratives - in fact, we are not always thinking about ourselves. It is when we need to explain ourselves to others or come to terms with other people's actions, or when questions such as "how has my life gone so far, and how do I want to proceed from now on?" that the narrative structure emerges.[8] It is because we need to give adequate answers and accounts to questions as such that we find we need to know how to tell our story or the relevant parts of our story.

Two challenges, then, rise from these tight corners for contemporary health humanities and healthcare education: given that a rigid formalistic concept of narrative is not able to comprehend the diversity and richness of human complexity, it becomes evident that a more nuanced understanding of narrative is required - but is it useful to try to make it explicit or is it more promising to leave its limits open? And would changing the focus to the concept of "meaning" or "sense" help see the importance of narrative, in its broadest possible sense, in a less problematic fashion? How do we discover, construct and express the meaning and sense of our actions, experiences and lives, in sickness and in health?

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Indexers

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