

## Teaching Ethics with Narratives

### These guidelines were developed with a few assumptions in mind:

- Participants will be healthcare providers
- Sessions will last about 55 minutes
- Participants will not be sent readings ahead of time
- If participants walk away with at least one new insight about patients' needs and preferences—one thing that might change their practice—then the hour was well spent

### These guidelines refer to narratives published in *Narrative Inquiry in Bioethics (NIB)*

- NIB is available to Washington University through Project MUSE: <https://muse.jhu.edu/journal/521>. We have permission to use the narratives
- Each issue collects stories on a shared experience, representing diverse views of patients, family members, or healthcare professionals
- The narratives are non-fiction—they represent the experiences of real people

### In general, **narratives can be collected in one of two ways:**

- First, narratives may be collected around a **shared experience** such as donating a kidney, experiencing moral distress as a caregiver, or being born with intersex traits. Reading a collection of such stories provides deep understanding of the experience. This approach is best if the experience is often addressed by a particular group (e.g., transplant nephrologists often address living organ donation), or if the purpose is social activism or scholarly investigation of the experience. NIB published stories using this approach.
- Second, narratives may be collected around a **theme** such as informed consent, demonstrating care, prejudice and stigma, effective communication, or peer support. This approach may draw upon stories that address radically different experiences. It has the strengths of being relevant to diverse groups of healthcare providers, and being focused on a particular opportunity for change. In what follows, we adopt this approach. CCRE faculty and staff have identified themes and gathered complementary narratives or excerpts:
  - o Combatting stigma and prejudice in healthcare
  - o Dealing with moral distress—your own and your coworkers'
  - o Communicating what matters most to patients
  - o Caring for vulnerable patients
  - o Caring for caregivers

Each collection is also accompanied by useful background information and specific discussion questions

**Before facilitating a narrative discussion group, distinguish between the goals of typical case discussion and narrative discussion:**

- Typical case discussion is often “adjudicative”—aiming to arrive at an ethically justified solution after considering a variety of facts, stakeholders, ethical principles, and laws
- Narrative ethics discussion is often more focused on listening and understanding. Through listening and understanding, new insights may be gained and new, desirable behaviors learned.
- Narrative ethics is highly contextual; some people refer to it as “microethics” or “a view from somewhere” as opposed to the “view from nowhere” adopted by some philosophers
- Please read the brief essay by Art Frank on “[Reading and Responding to Stories of Illness and Care](#)”, which explores how stories may offer calls for recognition of suffering, guidance, and appeals for change

**General facilitation strategies:**

- **Introduce the session with a 2-minute overview of the topic and the value of narrative ethics.** See specific learning guides for examples
- **Start by reading together an excerpt from a story**
  - o Distribute handouts of the excerpts
  - o If the excerpt is not long enough to provide adequate context, then provide a brief introduction (2-3 sentences) to who is writing and what experience they addressed in their narrative
  - o Read the first excerpt aloud
- **The following are excellent questions to initiate discussion:**
  - o What ran through your mind as you heard this passage from the story?
  - o Why do you think the author told their story? (Think of [Art Frank’s 3-fold taxonomy of what narratives of illness and caring commonly seek.](#))
  - o How would you describe the story teller’s emotional state? How might this emotional state affect the patient-provider relationship?
- **Additional questions may help sustain and deepen discussion:**
  - o Is there anything in this story that we don’t want to hear? Did anything cause you to feel resistance?
  - o Are you surprised by anything that was NOT said by the storyteller?
  - o General follow up questions: Could you say more about that? Does anyone else feel the same way?
- **The following questions might help draw out or consolidate key lessons:**
  - o What assumptions do you think the care provider(s) made in this story?
  - o How did the intentions, beliefs, and emotions of the various people in the story conflict?
  - o When you hear this story, do you want to see the care system or provider behavior change in any way? Is there anything you plan to change in your own work?

- **You do not need to cover all stories or excerpts, but do try to cover at least 3.** Each story conveys some unique points and was selected for a reason.
- **If the group is so large that not everyone can actively discuss the stories (e.g., >10), then ask participants to discuss some questions in pairs, then return to the group to discuss the questions**
- **End the session with a 2-minute summary of key lessons:** This is not the time to introduce new material, but to consolidate learning from the discussion.
- **Do not allow any one person to dominate discussion.** When an individual is dominating discussion, ask other participants to share their views. It is ok to say, “A few people have been relatively quiet during this discussion—I’d love to hear what they think. [Name,] what do you think when you hear this passage/question?”