Stories and Their Limits

Narrative Approaches to Bioethics

Edited and with an Introduction by
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causes may lie in our heritage of Cartesianism, together with a patient-centered bioethics. Failure to recognize the epistemic difficulties with autobiography seems to me to stem primarily from the ghosts of Cartesianism that continue to haunt us despite all our denials and attempts at exorcism. Blindness to the moral weaknesses of autobiography is, I believe, rooted in the much too simple patient-centered ethics that was traditional in medicine and has been taken over uncritically by contemporary bioethics. In its contemporary guise, a patient-centered ethics takes the form of an ethics centered in patient autonomy. Although Cartesianism and patient autonomy are largely separate traditions, they support each other in creating a focus on autobiography in bioethics.

The Epistemology of Autobiography

We are, often without even noticing it, still under the spell of two related Cartesian legacies: (1) Motives, interests, beliefs, desires, and attitudes are primarily mental states; action or behavior is, at most, an effect of these mental states. (2) Mental states exist in a consciousness, and since each of us is aware of our own consciousness, each of us knows her own beliefs, values, feelings, and so on. For convenience, I will call these twin Cartesian legacies the view that we are transparent to ourselves.

This Cartesian notion of self-transparency may seem doubly irrelevant to bioethics. In the first place, we deny that we accept any such pre-Freudian, pre-Hegelian (pre-Socratic) notions. And, on some level, we do reject them. But they are deeply embedded in our common sense and our culture. Consequently, unless we are constantly vigilant, we find ourselves falling victim to this heritage despite ourselves. Secondly, Cartesian self-transparency may also seem remote from narrative bioethics because we deal in ethics, not epistemology. But ethics is not independent of epistemology. As I shall try to indicate, this tradition is neither remote nor irrelevant.

Within these Cartesian premises, the problem of knowledge is the problem of knowing whether there is a correspondence between our own consciousness and something outside it. Thus each of us knows her own mind, but there is a major problem of knowing other minds. We have direct access to our own consciousness but none to someone else's, and inferences from behavior—including verbal behavior—to mental states are always precarious. Each of us is thus in a position of unique epistemic authority with respect to our own minds—your knowledge of my beliefs, desires, motives, intentions can never be better than mine. Indeed, your knowledge (if any) is derivative from mine, depending as it does on my reports about my mental states.

Within narrative bioethics, this Cartesian legacy yields a nearly exclusive fascination with autobiography. Autobiographies are authoritative. The stories
we are concerned with, the stories that are to figure in narrative ethics are the patient's stories—as told by the patient, of course. If there is no problem with knowing our own minds, but major obstacles to knowing the minds of others, then autobiographies are the stories we need, the stories to rely on in narrative ethics.

Were we not under the Cartesian spell, we would immediately recognize this as palpably naïve. The authoritative account of someone's life is her own—her autobiography? Of course not! In our everyday lives and dealings with each other, nobody would take a first-person account as the definitive or even the most reliable word on the subject. "I am the only one at work who understands the business." Hmm. "I was just trying to help her get control of her life." I wonder. "My ex-wife..."—whatever follows that expression is deeply suspect. Would anyone be fool enough to take a former President's autobiography as the definitive account of what he was doing while he was President?

We may think that President Nixon's account of his White House years is riddled with lies. But lies are only one problem and they arise only at the final stage, the stage at which I tell my story for others. But autobiography plays an earlier and more basic role, too—I tell the story of my life for myself. The narrative we tell about ourselves is part of living a life that is a life, with unity and coherence, rather than just a bunch of experiences that happened to the same person.

The fact that we tell—and perhaps must tell—ourselves stories about our lives introduces an important ambiguity into what we mean by autobiography. The story I tell myself about my life is not an autobiography to which you can ever have access—probably not even if we are intimate, certainly not if we are strangers. We all have secrets. So you must be content with the story I tell for public consumption. That will not normally be exactly the way I see my life. The autobiographies we can consider in bioethics are thus all "secondhand" autobiographies, stories retold for an external audience. They may contain lies and distortions; they will normally be crafted for their intended audience. We shall return to this point.

First, however, if we escape the spell of Cartesianism, we quickly see that even the stories we tell ourselves contain lies and distortions. Self-deception is an important feature of our lives and an important phenomenon for an evaluation of autobiographies. In fact, there are at least four different sets of epistemic problems with autobiographies: (1) ignorance; (2) innocent mistakes; (3) self-deception; and finally (4) lies. Let us briefly consider each of these.

Ignorance and innocent mistakes are the simplest of these problems, so let's start here. There are many things that we do not know about events in our lives. What I do not know cannot figure in my autobiography, however important it
notably Mead's—it is only through the responses of others that I come to have knowledge even of what I am saying (as opposed to merely thinking), and thinking is itself derivative from saying. So much for innocent mistakes. They are innocent and thus not very interesting, though they do raise interesting problems for a narrative ethics based on autobiography. Yet perhaps the most interesting thing to be said about innocent mistakes is that it is hard to find a really convincing example of one. Why did you not notice your rage? Everyone else did! And how could you have overlooked your desire for revenge? It colored virtually everything you did! You, an explorer? You?

The important mistakes in my autobiography may not be innocent. I have an important stake in which story I tell about my life. As a result, autobiographies are often—even standardly—riddled with self-deception. Self-deception is motivated, not innocent. If I am telling the story and the story is about me, I will normally want to leave the audience with a favorable impression about the central character. The first audience of my story is myself, and I desperately want to feel good about myself. The stories I tell myself are imbued with that mission. Most of us do in fact manage to construct ourselves in a favorable light, at least to ourselves. (Even those who are habitually "down on themselves" usually feel that they are more honest with themselves or have higher moral standards than those who feel good about themselves.) Self-assessment and self-judgment are always epistemically suspect; consequently, autobiography is, in important respects, seldom the most trustworthy story of a life. In fact, one of the reasons I often do not even know what I am because I have many wants that I don't want to admit to myself.

Let's move on now to stories told for others. I am also very much interested in what the broader, outside audience thinks of me. I would like to leave a good impression. I want almost everyone to be impressed with me and what I have done, everyone to think well of me, everyone to like me. The first thing this causes me to do is to tell my story in light of the ideas I have about the beliefs and values of the audience. I tell different stories for different audiences, and they may all be inaccurate, if only by reason of one-sidedness.

Joanne Lynn argues that most seriously ill and dying patients are desperately trying to be "a good patient." They very much want to do a good job of dying in the eyes of doctors, family, and friends—the audiences. After all, this is their last chance to do well, their last chance to leave a good impression, their only chance to die well. If Lynn is correct, the autobiographies of terminally ill people—including their statements about what kind of treatment they want—will usually be decisively shaped by this desire to meet the norms and expectations of different audiences. Viewed in this light, it may not be surprising that many patients tell one story to one doctor, another to another, yet a third to a nurse, and still other stories to various members of their families. If I detect different expectations, I will tell different stories.

Of course, a variety of stories may all be true. All stories of a life are incomplete (or they would take about as long to tell as to live). And it may be that different stories—different emphases perhaps—are appropriate for different audiences and different purposes. I know, for example, that you are a clinician and you are interested in a story focused on health and illness. So I may leave things completely out of my story that are much more important to me than my health. But my motivation in shaping my story to its audience is also normally not purely altruistic. I edit, shade, stretch, distort, and often even lie in an attempt to secure a more favorable response from my various audiences.

Now, lies and self-deception are intimately related. There are at least three important feedback loops between the stories I tell for various audiences and my self-knowledge. First, it is much easier for me to tell you a story that you will find convincing if I believe it myself. Consequently, I can easily fall victim to my attempts to impress or deceive you and end up believing the stories I have told for public consumption. Lying often ends in self-deception.

Second, my desire to leave a favorable impression on you is deeply confusing to me—it makes it harder for me to distinguish my own wants from your expectations or hopes of me. When a patient opts for more treatment for her cancer, how, then, can we assume that she knows what she wants, as opposed to wanting what she thinks we expect of her? Lynn thinks she may well not know what she wants. Of course, she may want most whatever will leave a favorable impression on the audience. But presumably our ethics of informed consent is not to reduce to an elaborate game in which patients are forced to try to guess what medical treatment we want them to choose.

Third, partly as a result of these first two feedback loops, there may well be limits to how long and how thoroughly I can tell a story for public consumption without becoming what I pretend to be. A very dramatic example is provided by police who work with undercover agents. The very lives of undercover narcotics agents, for example, depend on their ability to tell their cover stories convincingly. Police officers relate that an agent—any agent, anyone—can go underground for only about six months before she literally loses track of who she is. She will, for example, no longer remember that she is a police officer or who her father is. And if we believe that the story we tell about ourselves is the basis of identity, we will be forced to conclude that an agent can only go underground for about six months before she becomes a different person.

So much for a brief overview of ignorance, mistakes, self-deception, and lies in autobiographies. There is one more reason for concern about the epistemic trustworthiness of autobiographical accounts: I am normally the central character in
my autobiography. But if I see myself as the central character, won't my account tend to overlay the importance of my own role and contribution, and correspondingly to underrate the place and contribution of others? Thus, when I tell the story of the philosophy department at East Tennessee State University during my years as chair, it tends to place too much emphasis on what I did.

**Multiple Autobiographies**

Autobiographies contain many epistemic weaknesses; they are all epistemically suspect. But even if they are often mistaken, isn't there something privileged about autobiographies? Right or wrong, honest or distorted, an autobiography is, after all, the way I see my life; it expresses the meaning my life has for me. And that is what is important for stories of illness and for medical treatment decisions.

But we have already seen that the autobiography I tell myself is not available to you. Should we even say that the story I tell myself is the way I see my life? "How could it fail to be the way I see my life? My conscious experiences are my conscious experiences, after all! The way I see myself and my life may be mistaken, but it is the way I see it!" But that is the voice of the Cartesian legacy again. If we recognize self-deception, doesn't "the story I tell myself" become systematically ambiguous? If my desire for revenge colors virtually everything I do but I deny this to myself, or if I see myself as an explorer but unfailingly choose the familiar and the secure... what are we to say?

I think we must say that I am telling myself at least two stories simultaneously, one in which the desire for revenge does not figure at all, but also another in which it looms large and is justified. But I am unaware of this second story, unaware of it despite the fact that I am telling it! Strange as this may seem, I think we must say that I am telling myself multiple stories, for my action (as opposed to my deceptive conscious awareness) is also story-driven. It, too, has narrative unity.

Now, if you take my conscious story that I do not seek revenge as the whole of my story or even the center of it, you will treat me inappropriately, and I will be disappointed, frustrated, or enraged by what you do. For the stories I consciously tell myself will be only one part of my own sense of my life. I can articulate for myself only some of the meaning my life has for me; some of that meaning I may be quite unaware of. Thus, dealing most sensitively and effectively with a self-deceived, inarticulate, or unreflective person—any of us to some extent—will involve attempting to ferret out all the stories she tells herself, including those she is not aware of.

The meaning my own life has for me is thus never completely captured in the stories I am aware of. Self-knowledge, on the account I am suggesting, would involve coming to acknowledge this multiplicity of autobiographies, learning to ferret out and articulate all of them, dealing with the discrepancies among them, and then ceasing to tell oneself the self-deceptive stories. Only with perfect self-knowledge would my autobiography be single, and only then would it accurately convey the complete sense or meaning my life has for me.

**Autobiography and the Clinical Encounter**

Exclusive reliance upon patient autobiographies would do more than place narrative ethics on a perilous epistemic foundation. It would weaken the practice of medicine, as well. Wherever accuracy is important, there are serious questions about whether we ought to attend exclusively—or even primarily—to autobiography. Consider, first, small things. Medical students are taught to double the amount of alcohol I say I consume and perhaps also the number of cigarettes I say I smoke. The veracity of the sexual history I give is suspect, as is the story I tell about what I eat or why I am seeking pain medication. Users of illegal substances often deny use. Child abuse, spouse abuse, and elder abuse invite cover stories.

Consider next the following examples: "He says that he hates his job and being on disability would be wonderful. But I know how depressed he is whenever he can work and how horrible he feels about himself when he doesn't have a job." "He'll tell you that impotence is no big deal at his age, but it bothers him tremendously." "She says she's doing OK, but she stays drunk or high most of the time since her accident." "He says his memory is pretty good, but I'm afraid to leave him alone for even a few hours." "She says she still gets around pretty well, but there are many days when she can barely make it to the bathroom and back. She wants you to think she can take care of herself because she's terrified of going into a nursing home."

Moreover, because health, sickness, and medicine often touch on very intimate features of our lives, they evoke all kinds of very basic attitudes about what is appropriate to tell whom and how the audience will evaluate me if I reveal this fact about myself. I have seen patients who are unable or unwilling to admit the amount of pain they are suffering for fear of being thought weak or unmanly. Bulimia is something many young women cannot talk about. The spectacle of my death may be too terrifying to mention. Or I may be too ashamed of my terror to mention that.

We have seen that the story a clinician or bioethicist receives is seldom the story the patient tells herself. It may well not be the story the patient would tell another audience. But even if a clinician could elicit the story I consciously tell myself, that would normally not fully capture the meaning my life and action have for me. For all these reasons, sensitive and appropriate treatment of me in the clinic or hospital depends—just as it does in other contexts—on a careful
That's usually an important part of what makes them healthy. Certainly there is no central character in a healthy family.

Another part of what makes families healthy is that there is, in important respects, not one story for each family member, but only one story among them. The claim that there should be (in many significant respects) only one story in a family is not the claim that families should be monolithic entities, committed to one set of beliefs and values, with no tolerance for deviance. There can be difference, conflict, even basically different perspectives within one story. Rather, the point is that families (couples, friendships) in which too many different stories are told are typically characterized by lack of communication and understanding, and also by an absence of intimacy and sharing.

Who tells the story when lives are intertwined? It is a privilege and a power to have the right to tell the story. In other contexts, it is normally the privilege of the powerful—the dominant man—to tell the official story of "his" family and "his" family life. But in bioethics, we listen to the patient's story.

Reliance upon patients' autobiographies both reflects and reinforces a patient-centered bioethics. The patient-centered feature of bioethics seems entirely justified and even noble—it's just advocacy for the vulnerable. But in bioethics, as elsewhere, when we attend exclusively to one family member's story, we tend to ignore or discount the ramifications on the lives of the rest of the family. They are only bit players of marginal importance in the story we are concerned with. Exclusive reliance upon autobiography thus systematically undervalues others and overlooks or discounts the importance of their interests.

There are at least two forms of oppression involved in reliance upon any one family member's story.

First, it silences the others. A focus on the patient's autobiography silences all other members of her family. Their interests and their autobiographies do not count. And the family is in fact all too effectively silenced by our bioethics and in our health care system. Decisions are made every day that promote the patient's interests at truly staggering costs to the lives of other members of the patient's family. These decisions are routinely made as if families were no more than patient support systems or as if the interests of other members of the family were somehow morally irrelevant. We do not even ask whether it is morally legitimate to impose these burdens on the patient's family—in fact, a patient-centered ethics implicitly requires that we not consider the interests of the family. Because our ethics has so thoroughly silenced families, we can congratulate ourselves on an ethic that places the patient's interests over all others and on having faithfully served the patient's interests.

But it is wrong to consider only the well-being of one member of a family when the lives of the others will also be dramatically affected. To do so is tacitly to reduce all other family members to means to the well-being of the one family.
member who is ill. Because this is wrong, it is also wrong to listen exclusively to the patient's story. Doing so always runs the risk of inappropriately discounting the interests of the rest of the family.

All this is true of the autobiographies we tell when we are at our best. Even at our best, most of us assign ourselves the central role in our stories. Most of us are inclined to weigh benefits and burdens to ourselves more heavily than those to others. We all tend to be self-centered. But if illness makes most people more self-absorbed, self-centered, or inconsiderate, more regressed into a primitive or immature self, then the autobiographies of the seriously or chronically ill will be especially likely to shortchange the interests of others. And all of this is further reinforced by an audience of health care professionals and bioethicists who are most interested in the health-related aspects and outcomes of the story and who are all professionally committed to weighing in on the side of the sick. For these reasons, we should be especially wary of relying on a sick person's story.

But even when the interests of others are not inappropriately discounted in the story, it is still a form of oppression for any one person to tell the official story of a group—family, clan, business, team, government, or ethics consult. It is not, for example, morally sufficient if I paternally take the interests of the rest of my family into consideration, not even if I scrupulously fair in doing so. They must be allowed to speak for themselves—to define their own interests, to say how they see our present situation. Allowing others also to tell their version of the story is part of what is involved in respecting them as persons. Thus there is a basic moral criticism of exclusive attention to anyone's autobiography... with the possible exception of those who are all alone, with no family, friends, or loved ones.

The second way in which people can be oppressed by an autobiography is that they can be forced to live in someone else's story. This form of oppression grows out of the fact that we are not only passive tellers of our stories, but also active agents who are living our lives. We all attempt to live out a script. In order to continue to live our present script, we must often try to fit recalcitrant reality into our stories. One option for fitting reality into a story is, as we have seen, deception and self-deception. But as actors, we have a second option for fitting reality into our scripts. We can actively shape reality to fit the story we are telling. This is not in itself remarkable, uncommon, or morally troublesome; it is an essential feature of action, an inescapable part of forging a life.

But it can easily slide into a form of oppression: we attempt to force others to live as characters in our stories. Take the example—perhaps the caricature—of the traditional husband who "takes care of the little woman." If I am living out that style of masculinity, then I must see my wife as "the little woman"—as needing help, perhaps even as fundamentally incapable of taking care of herself.

Otherwise the story I am attempting to live out will lapse into incoherence, and a large part of my life becomes meaningless. I may, as a result, take steps to make reality conform to this perception. I take steps—normally without full awareness of what I am doing—that tend to incapacitate my wife in order that I may be the man who takes care of her. This sometimes takes truly horrific forms. Equally horrific, to mention just one more example, are attempts to create my sons in my own image, to make them "chips off the old block."

(Distance normally insulates outsiders to some extent; they are somewhat more immune than family members to this sort of oppression. But outsiders, too, can be forced to live in the stories of others. In fact, the frustration physicians and nurses feel over providing futile treatment can be a result of the professional debasement that can result when health care professionals are forced to play an assigned role in the patient's or family's preferred story.)

To the extent that I am successful in forcing, manipulating, pressuring, or badgering others to live as characters in my story, I deprive them of the opportunity to author their own stories. There is a fundamental loss of freedom and autonomy in this. It is, at bottom, to deprive the other of the opportunity to live her own life. Although illness can help to free other members of my family from this form of tyranny, it can also serve to strengthen my hand in making them serve my story. Ideally, of course, we should be creating a story together.

To summarize, the moral challenge to a narrative ethics based on patient autobiography is that it harbors two forms of oppression. First, others are silenced and often slighted if only my story about our life together is attended to. It is wrong to slight the interests of others; it is wrong to silence others even if they are not slighted as a result. Secondly, I easily wrong others by attempting to mold them to fit into my story. Others aid and abet both forms of oppression if they attend exclusively or even primarily to the story I tell about my life and the place others have in it. For these two reasons, a narrative bioethics based primarily on patient autobiography is morally as well as epistemologically flawed.

The Alternative

What is the alternative to a preoccupation with autobiographies in narrative ethics? I have already hinted at it. The alternative is to acknowledge that an autobiography is only one account of a life, a deeply fallible and often unreliable account at that. Moreover, all of us live in and tell many autobiographies. Consequently, insofar as narrative bioethics requires an accurate account of a life or an illness, we need to piece together the narrative by attending to many stories told by many tellers.Acknowledging this would involve coming to see that the patient's husband has a perfectly valid "take" on her wishes and values, on what
her life has been all about, on "what she is up to" (including what she is up to in
telling her story the way she does).

Of course, the point here is not that we are transparent to others but not to
ourselves. There are limits to others' knowledge of me, too. Other narrators also
have agendas; their stories about me also contain mistakes. Their stories are also
motivated, shaped for an intended audience, designed to impress us with the
narrator, and so on.

This is true even for those of us famous or distinguished enough to have
professional—"detached," "objective"—biographers. It is even more true of
biographers with whom we have had extended interaction. My physician, in
telling the story of my case, is also inevitably telling a story about how she prac-
tices medicine and even about who she is. And the biographers who have most
at stake in telling our stories one way rather than another are our more common
"intimate biographers"—lovers, close friends, and family members. Their self-
images and even their lives may turn dramatically on the way they tell the story
about us.

There is, then, no detached observer—value-free, motiveless, with no inten-
tions, no plans, no agenda—to tell the authoritative story! There is no authori-
tative story. Because there is no "view from nowhere," the alternative to
autobiography in narrative ethics cannot be simply a return to the physician's
privilege to tell the story of the case. Rather, we must recognize that the physi-
cian—or bioethicist—tells the story of patients in the way she does because of
the limits of her own self-knowledge and the agendas she brings to bear. The
person cannot be left out of the story she tells; the person cannot really even be
left out of the factual or scientific observations she makes about the case.

This more complex view of narrative and narrative ethics requires a new dis-
cipline of us. There may well still be a point to the traditional discipline of trying
to achieve and speak from a detached, value-free standpoint. Often we should try
to put our selves out of play in telling stories about others, or even about
ourselves. But recognizing that we all inevitably fail to achieve an objective,
detached, unmotivated account either of ourselves or of others, we need also to
learn another, rather different discipline—that of coming to recognize our own
motivations, biases, agendas, and then of stating them quite explicitly. This kind of
self-knowledge is required of a narrator—and thus of a health care profes-
sional—if her account is to be maximally reliable and morally trustworthy.

If someone has the requisites that enable her to offer an epistemically reliable
and morally trustworthy autobiography, it will be because she has long partici-
pated in a complex, multiperson process, listening to many different accounts of
her dreams, fears, plans, actions, activities, and past. She knows herself because
she continually tries out various versions of her story—biographies as well as

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autobiographies—on many audiences to check the reliability of her own view
against their responses to what she is saying about her life.

Autobiographies that are both epistemically and morally reliable are thus
derivative from biographies: it is only through having attended to many stories
about me—including the stories others tell in response to my earlier autobi-
ographies—that I can finally give a trustworthy account of my own life. Still,
self-knowledge is never complete. No one's autobiography should ever be taken
as the definitive account of her life. And none of us can completely avoid deeply
troubling and pervasive forms of oppression that often pass unnoticed in the
stories we tell.

In light of all this, we might venture a fundamental reinterpretation of
autonomy, including patient autonomy. The autonomous person is not an island
or some transparent self who has immediate knowledge of what goes on inside
herself and who clings to that in the face of everything anyone else may say. No,
an autonomous person develops an autobiography in community—in this
complex, multiperson encounter seeking the truth about her and her life with
others. On this alternative view, only those who have participated in such a
process can become autonomous. For it is only through hearing many stories
about ourselves that we can know ourselves, what our life has been . . . or even
what it means to us.

The art of weighing these many different and often conflicting stories, and of
weaving them together into a reasonably coherent though multivocal account, is
the art of the biographer. As bioethicists and clinicians we must, then, become
biographers, not simply faithful recorders of autobiographies. Listening to
multiple sources is epistemically more reliable than exclusive reliance upon any
one source. Attending to many voices is almost always morally preferable to
listening to only one. Dialogue is better than monologue.

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versions of this paper.

Notes

2. Martha Nussbaum, Poetic Justice: The Literary Imagination and Public Life (Boston: Beacon
   Press, 1995).

5. I owe this point to Edwin J. Delattre, in conversation.

6. I owe this point to William Donnelly, in conversation.


8. It should be obvious by now—if not long before—that this paper is deeply indebted to feminist epistemology. See, for example, Sandra Harding, Whose Science? Whose Knowledge? Thinking From Women's Lives (Ithaca, NY: Cornell University Press, 1991).