

A Narrative Ethics of Care

Jens Erik Paulsen

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Abstract If ethics of care deals with the nature of relationships, attentiveness, and understanding particular others, narrativity ought to play a central part. Sometimes, caring simply amounts to working with narratives. In the article I claim that narrativity can even be said to be native to an ethics of care. Through an example, I demonstrate how a narrative ethics of care can discern and grasp some moral problems better than the standard theoretical outlooks.

Keywords Care · Caring · Consent · Ethics · Ethics of narrative ethics · Jehovah's Witness · Transfusion

There are many ways to reason about morality. In the past few decades the focus of the academic literature has mainly been on the goodness and rightness of *agency*, under the labels 'consequentialism' and 'deontology', respectively. In contrast, existentialism, feminist reasoning and modern virtue ethics emphasise character, identity, relations, and the *context* of agency. Ethics of care is a product of this philosophical turn. Here, efforts are made to elaborate on the meaning and impact of caring in various settings, from parental care to caring within professional life. The focus is on how to care *for* the particular other or others, not on caring *about* things or issues, even moral issues.¹ Is ethics of care just an addendum to traditional ethics,

¹ The caring *for*/caring *about* distinction is Joan Tronto's [8]. Seyla Benhabib labels a similar distinction 'Concrete Other'/'Generalized Other' [2].

J. E. Paulsen (✉)

Section for Medical Ethics, Department of General Practice and Community Medicine,
University of Oslo, PO Box 1130, Blindern, 0318 Oslo, Norway
e-mail: jenseriopaulsen@hotmail.com

or is it a distinct perspective that helps us to discern and evaluate moral phenomena to which ethics has hitherto been blind?

According to some commentators, proper caring is different, indeed “immune” from just following abstract principles (Tronto: 346). So what is caring? Does caring describe substantially what one does to another, or does it describe—adverbially—the *manner* in which things are done? Joan Tronto writes that “[c]aring implies some kind of on-going responsibility and commitment”, which makes us willing to, among other things, “expend energy toward the object of care” (ibid, 347). As caring involves a commitment, caring has an object, hence caring is relational, and since the object in question is a human being, caring involves an understanding of and a response to the other’s needs and expectations, strengths and inhibitions, as well as the context of his or her particular situation. Understanding here means forming a coherent opinion, an articulate belief about where this person is coming from and where she would like to be going. Establishing the *narrative* of the other requires conversation, listening, interpretation, what other commentators have referred to as *attentiveness* to and *knowledge* of the other’s needs (ibid, p. 349). Caring is not, however, simply catering to every whim and woe of the other, it may also consist in mindful guidance of a patient, or in setting limits for a child, an attempt at influencing the life-story of the other. There is also the question of what one’s caring does to oneself, and to outsiders excluded from one’s caring. In what sense should caring be altruistic? An ethics of care must deal with these difficult questions.

The aim here is not to address all these topics, but to argue that caring involves working with narratives, and demonstrate how this can be done. A narrative approach, I will claim, is *native* to an ethics of care. Furthermore, a narrative ethics of care generates insights and an ability to discern phenomena that other forms of ethics either lack, or would be hard pressed to incorporate. The vehicle I will use for discussing these matters in this article is a dramatic case taken from a health care setting.

A Painful Case: Jack & Jill

Jack (35), a college teacher and a father of two children aged 5 and 13 years, has been a Jehovah’s Witness as long as he can remember. His wife died 3 years ago in an accident. She was not a Jehovah’s Witness. His youngest child has accompanied him to religious meetings, but the 13-year-old has never been a part of the Jehovah’s Witness community. Jack is home from work today. He’s in pain. The family doctor came to see him, and suspected that Jack suffered from appendicitis. He has referred Jack to the nearby university clinic. Jack insisted on going there by taxi, not ambulance.

In the pre-operation consultation with Jill, an experienced surgeon, Jack appears anxious. He has never been admitted to a hospital ward before. At the end of the consultation he mentions that he is a Jehovah’s Witness. Surgeon Jill assures Jack that the procedure is low-risk, that she has never even considered blood transfusion during appendectomy. Jack appears to calm down. He adds that he has a standard

declaration from the Jehovah's Witness community signed by two of the elders. He forgot to bring it, though—"I guess what will be, will be", he says with a faint smile. Jill says it makes no difference: "I would only be interested in *your* signature anyway. So it is not really required. We'll respect your point of view. Anyway, soon you'll be on the mend..." She goes on to explain what will happen to him. "I guess what will be, will be", he repeats. They part cordially, and soon Jack is prepared for the operation.

During the procedure Jill punctures an artery by accident. Jack loses blood at an alarming rate. Jill hesitates and her team soon questions her indecisiveness. Jill informs them that the patient is a Jehovah's Witness. Startled looks are exchanged, instruments are monitored. "It's my call," Jill says, "We're losing the patient." They start with blood transfusion. Despite this and other life-saving measures, Jack dies on the operating table.

Surgeon Jill is upset and even considers omitting from the journal that Jack received blood. She is not quite sure that her hesitation was decisive for the fatal outcome. But it certainly didn't help. *Am I in denial?* She curses the Jehovah's Witness policy for a minute, pities Jack's children, blames herself. *But such things do happen!* Not misconduct, just...plain bad luck. She always knew things like this could happen. Medical errors are commonplace, but fatal errors... If she had only asked him properly in advance... The two kids—where are they now? Why on earth do they refuse transfusion? Why did I even bother?

The Narrative Approach

Is the surgeon to blame in this case, or was she simply unlucky? Did she *care* properly for Jack, or is proper caring impossible given the Jehovah's Witness standpoint? How does one retrieve an informed consent—or at least some kind of understanding—under such circumstances? Obviously, Jill cared for Jack's well-being. She discussed the matter with him, she understood where he was coming from, and she respected his view. She made it easy for him to stand his ground. Not that she for her life would *really* understand it. But right before an operation is not the time to challenge religious beliefs. The best way of caring for Jack was simply to make him feel at ease. If the operation had gone as planned, her conduct would never have been questioned. On the contrary, Jack would shortly have been out of the hospital, grateful to the surgeon who removed his pain and respected his standpoint to boot. The first impression is therefore that Jill's conduct was impeccable, but ethics is about thinking at least twice.

A narrative ethicist works with stories rather than facts, rules and principles. Here I will follow Abbott's approach loosely [1]. We will therefore first identify and discuss the relevant background stories, or "master narratives", in order to provide context for the situation at hand. Next, we will evaluate the core narrative (i.e. the Jack & Jill case) from two perspectives, so as to broaden our understanding of what happens. Finally, we will focus on closure, that is, discuss different courses of action and the endings they entail, and which will have the greatest acceptability.

Master Narratives

‘Blood’ is a rich notion, signalling kinship and conflict, holiness and impurity; sometimes life itself. It holds the power to turn faces pale, or to arouse people. Blood stains stories of crime and stories of love. Massive loss of blood follows in the wake of violence, sickness and suffering, and ultimately leads to loss of life. But the story of how doctors have *compensated* for blood loss is long and interesting, too. Not only because it adds to the drama already present, but because it introduces a novel set of problems. As Jack and Jill seem to hold different views on blood transfusion, we need to study the master narratives that allow for this difference of opinion.² Without knowing their opinions, it is difficult to know what is at stake. Let us have a look at the mainstream view first.

After William Harvey successfully demonstrated heart-driven blood circulation in 1648, scientific attempts to transfer blood between animals or humans were soon made. Although some degree of success is recorded, the characteristics of blood were not well understood. Only after Karl Landsteiner’s description of different blood groups began receiving attention in 1909, did direct blood transfusion become a standard therapeutic means. During WW1, techniques for storing and transfusing blood were developed and refined. With anticoagulants and refrigeration, blood could now be stored for days, and blood banks became a possibility. Hospitals could access blood given by anonymous donors. Needless to say, blood banks revolutionised medical practice. Today, components of blood are stored, and much research is put into creating artificial blood products. Blood transfusion is considered as a safe and efficient way of increasing blood volume or the oxygen-carrying capacity of blood during or after surgery. Transfusion saves patients every day. Therefore, surgeon Jill always keeps a unit or two of blood handy when operating. Not that she always needs it. Sometimes it is just a precaution; to counteract the unforeseen. And quite often, Jill gives the patient a unit for boosting the number of red blood cells after an intervention. She believes this to be beneficial for patient recovery. This is what cheating athletes do to increase their performance. Jill does the same in the name of the good.

However, there is a flop side to the coin. The quality control, here as elsewhere, is not perfect. Blood transfusion introduces the risk of side-effects. Most of the time as mild allergic reactions, but sometimes side-effects can be lethal. The chance, however, of contracting hepatitis or HIV infection through blood transfusion is one in two million units. So most people think the benefits outweigh the costs by many orders of magnitude. However, that is not to deny that sometimes the patient would be better off by *not* being given blood. Maybe better techniques or advance planning would lessen the need for blood transfusion, thus minimising the risk of side-effects and shortage of blood. That blood transfusion is an asset is indisputable, but whether today’s practice is *optimal* remains a question.

² Several master narratives are relevant to this case—the role of the clinic, paternalism and autonomy, law and medicine, to mention a few. The most important stories in our connection deal with blood transfusion. This is where Jack and Jill’s opinions diverge. What the one considers to be the master narrative, the other may consider as a deviant narrative.

Jehovah's Witnesses know that transfusions save lives, but they contest that lives *ought* to be saved in this manner. Blood is a sacred substance and not some commodity. In the Scripture the Lord bans "eating blood", a statement that the Watchtower Society—the authority for Jehovah's Witnesses—interprets as including the practice of blood transfusion. The ban on eating blood is stated several times in the Old Testament. For instance, in Leviticus 7:26 it is written that "You are not to eat any blood, either of bird or animal, in any of your dwellings." And later, in Leviticus 17:10, the vengeful Lord claims that "And any man from the house of Israel, or from the aliens who sojourn among them, who eats any blood, I will set My face against that person who eats blood and will cut him off from among his people." Similar passages are found in Acts (15:19–20) and in Deuteronomy (12:23–25), where the Lord identifies blood with life: "Only be sure not to eat the blood, for the blood is the life, and you shall not eat the life with the flesh."

Few non-Witnesses would drink the blood of another human being. Analogously, Witnesses claim that blood transfusion is out of the question. However, some have pointed out that the Old Testament hardly addresses modern blood transfusion. You do not really *eat* through the cardiovascular system.³ Consequently the ban on blood transfusion rests on a misunderstanding. But if 'eating' is interpreted broadly, for instance as 'assimilating a substance', the Watchtower society's standpoint still makes sense. And face it, if you should not eat blood, then you are certainly not to take it intravenously! Blood is life itself and should not be transferred from one person to another—like some commodity. It is the secret of life. Therefore, Jehovah's Witnesses deny themselves some life-saving interventions. This is sometimes hard to accept for health care workers, for surgeons that have to let perfectly saveable patients die. It is no doubt hard for the patients themselves. But some things are more important than living—to deny blood transfusions seems to be the ultimate test of faith. This is where the true believers can be separated from those who put themselves first.⁴

The ban on blood transfusion seems to be written in stone, but as with the mainstream story, exceptions and reservations can be found. This is not surprising as the stakes are high, and the risks and benefits are matters of faith, although the Watchtower seems to emphasise the medical benefits of not receiving blood on their homepage. Jehovah's Witnesses want modern health services. Therefore, they "accept—and vigorously pursue—medical alternatives to blood". "Jehovah's Witnesses actively seek the best in medical treatment," said Dr. Richard K. Spence, when director of surgery at a New York hospital. "As a group, they are the best educated consumers the surgeon will ever encounter" [6]. The Watchtower society's position may thus help in developing health services. However, advanced techniques and methods seldom apply to emergency situations involving massive loss of blood.

³ See for instance, Geisler and Howe [4], p. 434].

⁴ In most countries, this sacrifice can only be made by adults, but from a point of view of the Watchtower society the ban is valid for minors as well. Glaringly, this was the message of the magazine *Awake!* when it pictured "Youths Who Put God First" on the cover of the May 22, 1994 edition. The cover pictured youths who had followed the Watchtower's interpretation, and died after denying blood transfusion.

It would certainly be tough to expel a Witness from the religious community on the grounds that he or she received blood as a last measure. Being too hard on the ‘sinner’ would certainly contradict other teachings of the Bible. Today, those who receive blood are not disfellowshipped if the Witness claims weakness of will after the fact. In light of less absolutist view on blood products, this seems reasonable. In the new millennium, the Watchtower society accepts the use of blood products like albumin, EPO, haemoglobin and blood serums to some degree, and makes this a matter of conscience for each Witness: “[w]hen it comes to fractions of any of the primary components, each Christian, after careful and prayerful meditation, must conscientiously decide for himself” [7, pp. 29–31]. With the latest inclusions to the list, the society accepts every component of blood, but not whole blood. Given the consequences this policy has had, it is perhaps no surprise that the end point of this slippery-slope is hard for many Witnesses to accept. In the past the Watchtower has taken a similar stand on other medical practices, only to abandon its position later. This was the case with vaccines, which were held to be “a direct violation of the everlasting covenant that God made with Noah after the flood” [5, p. 293].

The Jehovah’s Witness story is, in other words, not as absolutist as it may seem at the first glance. But the views of the authorities and actual practices may differ. The central authority is weaker than local social control. Jack may be a fundamentalist on this issue, it may even be his chance to prove himself to himself and to his community—even to his children. Doubts and discussions about blood transfusion exist among Jehovah’s Witnesses, but overemphasising the ambiguities may lead us to ‘overread’ the Jehovah’s Witness master narrative. Similarly, disregarding the differing opinions within the milieu would represent a form of ‘underreading’.⁵ These are the two most important pitfalls in explaining the context of the case.

This example shows that master narratives are not stereotypes, but complex and sometimes amorphous. Knowledge of these complexities provides us with a repertoire of possibilities and angles for discussing relevant matters.

Readings of the Core Case

The core case about Jack and Jill is easier to handle because it involves few people. But it is also more difficult because Jack is dead and we cannot know what he his motives and thoughts—or even if he had a stable opinion at all. We can investigate Jill’s, but her memory may be coloured by the tragic outcome. We will never know the whole truth. What we can do as ethicists is indicate what could have been different. We will consider this by taking the core case as reconstructed above. In order to gain understanding we have to consider the story from three points of view: an intentional (stated overtly), symptomatic (e.g. what is not said), and adaptive (e.g. imagining other possible trajectories).

An *intentional* reading addresses what is openly stated, and from this perspective the story seems straightforward. Surgeon Jill’s intention is to cure patient Jack. She also intends to respect her patient’s wishes and make the experience as painless as possible. Therefore, she soothes anxious patient Jack in the pre-operative

⁵ ‘Underreading’ and ‘overreading’ are Frank Kermode’s terms. See [1].

consultation, and she responds readily to his signalling of religious conviction. She is comfortable that this is a correct interpretation, because the only reason Jack would bring up his religious affiliation would be in connection with a possible blood transfusion. Jack's primary intention is getting well. That is why he is seeking medical treatment. He wants the surgeon to know that he is a Jehovah's Witness, and that he possesses an advance will declaring that he does not want blood transfusion. The accident, of course, was not intended by either of the parties. Jack was anaesthetized, Jill was not reckless—she cannot quite explain why it happened. When it did, the intention to save his life proved stronger than the intention to cater to his wishes. The intentional reading renders Jill a caring physician who got unlucky.

A *symptomatic* reading emphasises what is not overtly expressed in the narrative. It aims at pointing out what is communicated indirectly, what the interlocutors will not or cannot tell. Special wordings or omissions are common markers of such suppressed information. Admittedly, this involves some degree of guesswork, and the danger of overreading is always present. We therefore need to argue our case perhaps more carefully than was the case in our intentional reading. In the conversation between Jack and Jill there are some issues that can be seen to be hinted at, understated, or implicitly understood. For instance, *why* did Jack forget his declaration? Why didn't Jack say explicitly that he didn't want a blood transfusion under any circumstances? What did his repeated statement "What will be will be" mean? And why didn't Jill raise the question of what to do in emergencies?

To address the latter question first: Would she have talked about the what-ifs to a non-Witness patient? She was completely confident that Jack would not need it, so we have no reason to believe that she would have raised the issue. But as a surgeon she knows that complications *may* occur. Good patient care implies a dose of relevant ifs and buts, without scaring the patient unnecessarily. If Jack (or any other patient) had asked her directly about the risks, we have no reason to believe that she would not have volunteered any information. The case does not really reveal whether Jack is following the traditional Jehovah's Witness line. He has signed a hypothetical contract, but he did not bring it. Maybe this simple fact should have made Jill venture into an exchange of opinion? Does he usually carry it? Admittedly, discussing the declaration could have upset Jack. Maybe Jill, subconsciously, likes to keep her options open? If we have not discussed it, then I make the decisions. Or, maybe she considers even hinting at religious views as too paternalist? Is that why she acts so confidently? She avoids a difficult discussion, while Jack's anxiety is lessened. A win-win situation. But Jack's anxiety may stem from the unfamiliarity of the hospital situation, or from being anaesthetised and brought under the knife for the first time. Introducing the Jehovah's Witness aspect might overshadow such issues, and he regrets it. Maybe he feels that there are so much at stake that he is about to reconsider his stand on blood transfusion. After all, he is a single parent. Although this is not the time to *abandon* his beliefs, maybe he wanted to discuss it with an outsider. Jill had been aware that some Witnesses accept a wide range of blood products, she might have felt that this was a topic that ought to be discussed with Jack. Maybe if she had known that quite a few patients even accept whole blood, without wanting any fuss made about it, well, maybe she

would have approached Jack differently. We all have our inconsistencies. It would perhaps have been a near-impossible discussion to initiate, given Jack's pain. Nevertheless...

Is this a gross overreading, or do we have any evidence to say that Jack has ambiguous thoughts on the issue? At first glance, he simply states that he is a Jehovah's Witness, and that he has a valid declaration. It is understandable that he has left it at home. He was in a hurry, he was anxious, he was in pain. However, saying that he left his declaration/statement "at home" *may* indicate that he did not forget it, but more or less deliberately left it. "The statement is there, I am here." He didn't say he was sorry that he forgot this piece of paper, or that he could produce it somehow, or that the hospital could call. He just mentioned it, and then Jill hurriedly assured him that "the procedure is low-risk", and that she has "never even considered blood transfusion during appendectomy". Maybe Jack feels that he cannot go further without coming close to denouncing his stand *actively*. If it is low-risk, it may not be worth problematising his religious policy. "What will be will be." Seeing him calm down, Jill ends the conversation, thereby cementing her view of him as a stereotypic Jehovah's Witness. If Jack wants to express doubts, he must explain that not all Jehovah's Witnesses are absolutist in this regard and that he, even if he has co-signed the declaration, considers survival to be more important, at least as long as he has small children... But since the surgeon has ended the conversation, this would be difficult. So understanding that the timing is all wrong, he puts his life in the hands of fate. "What will be, will be." This utterance can be seen as a giving up—I cannot speak my mind. There are at least two symptoms in the text, indicating that Jack wants to discuss "outside of the box". Is this an overreading of the original narrative? Before we discuss this topic further, let us have a closer look at the third way of reading.

In an *adaptive* reading, we alter conditions and utterances and study what difference such changes make: "What if Jill had asked...", "If Jack instead of X had said Y...", "What if this was a pre-planned procedure?" and so forth. This resembles standard scientific experimentation and enhances our understanding of the case, and why we think things matter. But it also has a normative function. We may come to agree that some type of action is right or wrong, good or bad, better or worse. In the present case we may even conclude that even with the sparse information Jill had, she should have acted differently in order to secure relevant information. Retrospective wisdom, perhaps, but the point is to learn from the experience, not to judge Jill.

Let us assume that this is a crisis for Jack, a last opportunity to revise or suspend his standpoints—he might not be fully aware that this is the case. He is only half-way to realising that he is changing. He *feels* that this is the time, but maybe he cannot *voice* this opinion all by himself, he can only manage to send some subtle signals. No freely stated informed consent at the time. No straightforward talk. He needs help. How could Jill assist him? Is it Jill's task to do so? Would it be proper care or unacceptable intrusion to even try? Is Jill justified in just repeating that Jack is a Jehovah's Witness and assuming that he is in line with the traditional view—a stereotype? Is she justified in trying to make Jack act out of character, in challenging his religious beliefs, in the name of what is most convenient for herself and her

team? Is she justified in appealing to his considerable responsibilities as a single parent? All these lines seem dissatisfactory. How can she make sure that Jack's *own* voice is heard? How should she introduce the topic and when should she stop? Let us recapitulate the first part of the conversation between Jack and Jill:

First part (0)

Jack: I have never really been to a hospital before... I've been *here* before, but never as a patient...

Jill: I know what you mean, Jack. You go about your everyday life, and suddenly you are a patient... The good news is that we won't keep you long. We do this operation all the time. You'll be back teaching in no time. We've already given you some intravenous antibiotics to avoid further complications. We will soon introduce general anaesthesia so that you won't notice a thing. I will then find your appendix and make sure it won't bother you again. Then I'll stitch you up. Then we'll talk some more. It has been a pretty painful day, I guess?

Jack: Yes, of that I can assure you. I would do almost anything to make this pain go away. I'm glad that you, you seem to know your business... You, you know that I am a Jehovah's Witness?

Second part (0):

Jill: As I said, this procedure is routine... low-risk. I have never even considered blood transfusion during appendectomy, so you should be alright.

Jack: Right. Uh, I have a declaration signed by two of the elders. But, uh, I forgot to bring it... What will be, will be...

Jill: Don't let that bother you, Jack. I would only be interested in *your* signature anyway. So it is not really required. We'll respect your point of view. Anyway, soon you'll be on the mend...

Jack: Yes, I guess what will be, will be (he smiles faintly).

(They exchange smiles and Jill leaves the room)

Let us consider some other paths the story could have taken:

Second part (1): *Jill thinks Jack's forgetfulness is a sign that he accepts blood transfusions:*

Jill: Since you brought it up like that, does that mean that you are flexible with regard to religion on this point... Or more precisely, blood transfusion...

Jack: No, no, I've been a Jehovah's Witness all my life, I'm not copping out now.

Jill: And no exceptions are allowed, right?

Jack: Right.

Jill: Thanks. I'm glad you told me. You'll be just fine, Jack!

The accident happens, but Jill never considers blood transfusion. She is not comfortable with the situation, but she feels that it was Jack's conviction that killed him.

Second part (2): *Jill is familiar with Jack's master narrative and tries to make him reconsider:*

Jill: Keeping some blood units handy makes it easier for us—and it's safer for you. It's how I prefer to work. It's prudent, I think. I know this is difficult for you, but I also know that the WTS is changing its attitude. In some years I guess we would not be having this discussion. After all, vaccines pose no problem anymore. I know that you've got a lot to live for—and I understand it perfectly if you don't want to take any unnecessary risks... Ok... It's your call of course. I'll follow your guidelines.

Jack: I don't know what to do... It'll be okay...

Jill: Ok. I will use my best judgement. Don't worry, Jack. You'll be out in no time!

The accident happens, but Jack lives. He files a complaint afterwards. He says that Jill forced her values upon him at a difficult moment, and that his life is ruined.

Second part (3): *Jill scouts the territory, pressuring Jack mildly:*

Jill: Jack, although appendectomy is a straight-forward intervention, you know that there is, as always, a slight risk that something unforeseen can happen... Given the circumstances, I know I have to bring this up with you...

Jack: [nods]

Jill: (she leaves ample time for Jack to speak) I know, or at least I think I know where you're coming from, and I fully respect it. In some regards your stand makes us improve our medical services. That is a good thing. However, in case something unforeseen happens during the operation, I will use my best judgment. Is that ok with you?

Jack: [Nods again, almost imperceptibly]

Jill: I'm sorry I needed to raise the issue. As I said, this is a routine operation. You'll be just fine, Jack...

The accident happens, but Jill is better prepared. Maybe there is no happy ending to be had, but in all these alternative endings some nagging doubts are at least eliminated. Therefore, they probably represent better courses of action than the original one, which left Jill uncertain of how to act in an emergency. Are these narratives also examples of better *caring* than the original case? I would venture to say yes, with the possible exception of (1). The way she asks him seems too direct, even provocative, unless strong non-verbal signs indicated that this approach was acceptable. The answer she gets is equally direct. Then she secures the information

with a closed question (“and no exceptions are allowed, right?”). If caring requires us to attempt to participate in the other’s story, closure comes too soon here. One or two open questions would have mapped his opinions better. She is certainly not forming a better relationship with Jack by proceeding in this manner. Good caring requires forming a (here: professional) relationship. This is not the same as just making things easier for the other. His truthful answer is of great consequence.

In the second example Jill puts pressure on Jack through her interpretation of the validity of his master narrative. After doing so, she says that she will try not to influence his choice at all. One may well argue that this is exactly what she tries to do in the first place. She saves his life, so from the perspective of medical care (and her Hippocratic Oath) she does the prudent thing. Given the circumstances, Jack will probably not be expelled from his religious community, and Jill must probably assume blame for what happened. She will probably not receive anything but a mild warning from her superiors. Rigging the scene so that she will be the one to blame may not be the worst kind of caring, at least not if Jack learns to live with the wrong done to him. Moreover, the seriousness of the situation may justify a no-nonsense approach.

The third scenario differs from the last one in that issues are merely hinted at. Does Jill go too far in leading Jack here? The ‘consent’ she obtained is hardly optimal. Is it fair to press for an opinion in this manner? Is she justified in acting upon a weak nod when Jack was able to speak? If Jack died, how would she answer if his next of kin inquired “We hope no blood transfusion took place?” Could she justify saying “yes” but that “it was Jack’s own wish”? Her caring for him is based on his silence and his nods. As was the case in (2), she should be ready to assume the blame if necessary, but there is nothing that indicates that she does not take care of his interests. After all, Jack has no death wish—he calls for the doctor and accepts surgery. Of course, Jill also takes care of her own interests—she is there to save lives. That is why she chose to become a physician, and it is what she has sworn to do. It is against her reflexes and professional pride not to do everything she can to save lives. In addition, she feels safer—a better surgeon—if there are no constraints present. She knows that Jack is against blood transfusion, but not how strongly. She also knows that what is a question of either-or on paper, may be negotiable in practice. She knows that people change when they are experiencing crises. As Rita Charon writes:

Old family secrets, long-time troubling issues, deeply felt but unexpressed emotions – all muted or somehow removed from the surface of daily lives over the years – often become visible and expressed in ways that they are at no other time during our lives. *Serious illness can be, and often is, a time of profound change in the lives of patients and those closest to them* [3, p. x].

It is part of being a carer for a human being in crisis to inquire into such matters, but how? Maybe she is too blunt in (2), too cautious in (3).

A Narrative Ethics of Care

As mentioned in the introduction, there is an ongoing discussion about whether ethics of care is an ethical theory in its own right or simply an addendum to

traditional theories. Providing a definite answer to this question is perhaps not so important. If some line of ethical reasoning works, i.e. produces useful insights and perspectives, we ought to develop it further. No ethical theory can claim to excel in every aspect of morality. Ethics of care is a relatively new branch of ethics and all its features have not been firmly established and developed. Here, I claim a narrative aspect is one such central feature. It may even be seen as a defining feature. But such a claim hinges on the idea that narrative reasoning is somehow intrinsic to ethics of care, and not simply a tool that can be used for any old theory.

If consequentialism or deontology had been our point of departure we would most likely have overlooked the issues troubling surgeon Jill. Performing Benthamite felicific calculus [9, p. 19ff] or asking Jack to rank his preferences would simply not have been very helpful. We would, somehow, have had to ask Jack to estimate the weight of his religious and parental obligations, in addition to those he holds towards himself. This might well not be a question without a definite answer. The manner in which such questions are posed has an effect on the answer. Going for a signed testimony under the circumstances fares little better than Jill's assumption that Jack is completely in line with Jehovah's Witness policy on this issue, because he considers himself a Jehovah's Witness.

A similar critique can be raised with regard to deontology. Checking out the universalisability of the maxims of Jill's actions would have fared little better than the Benthamite attempt. Jill *is* doing her duty. Patient autonomy *is* well taken care of, right up to the point where she has to make decisions on a shaky foundation. Potentially, both consequentialism and deontology may justify Jill's actions. These theories would be perfect if Jack's views and opinions were written in stone—coherent, consistent, stable. My claim is that we would do even better if we could allow for greater complexity. The problem is that in order to become privy to Jack's complex attitudes and sensitive information—knowing when to withdraw and when to proceed—Jill must form a professional, trusting relationship with Jack. If not, she will not be granted access to his “sensitive” information. Jack must trust that Jill will act in his best interests and must entrust her with the necessary information. In the original narrative, the conversation stopped short of real understanding. Jill might have been right, but she can never know for sure. Caring as mere stereotypical assumption is not good enough. In alternatives (2) and (3), Jill at least came closer. Proper caring requires communicative skills, the ability to scrutinise and contextualise the narratives of the other (e.g. the patient), to catch the drift of the other's life story. This may amount to “merely” being able to apply some conversational techniques, but in practice it requires the (ethical) skill of putting oneself in the place of the other, of filling in the blanks where the other cannot or will not speak, and of securing this information, somehow. To be able to imagine acceptable trajectories. It also requires a keen sense of one's own motives and interests.

An additional feature ties the narrative approach to caring, and thus also to an ethics of care. Narratives are not only therapeutic *means*, they are often *therapy itself*. Listening to the other, and demonstrating the willingness and ability to facilitate, mirror, interpret and understand the words and narratives of the other, are often in themselves therapeutic activities and a direct expressions of caring. It is simply difficult to imagine caring without the carer understanding the spoken or

broken narrative of the other. As narrativity and narrative skills are thus inseparable from caring, an *ethics* of care must have the resources to receive, evaluate—even create—narrative elements. Through tracing the relevant “master narratives”, reading the intentions, the symptoms, and evaluating alternative (adaptive) endings of the Jack and Jill story, we have seen one way of doing ethics of care narratively. A narrative approach is, of course, helpful to other methods of ethics, too, but it is a intrinsic part of an ethics of care. Or so I claim.

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