

# Narrative Ethics in Health Care Chaplaincy

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## **Introduction: Situating Narrative Ethics within the Theory of Ethics**

In this paper, I will introduce narrative ethics as an appropriate approach to address medical ethics in health care chaplaincy. For this particular field within medical ethics, I consider narrative ethics appropriate because of the specific role and function of the health care chaplain or pastoral care worker within the medical team: his or her function is not, strictly speaking, to interact with the patient in a *medical* sense but rather to bridge the medical world of doctors and nurses in their diagnostic, therapeutic and nursing dimensions with the everyday and everybody's world where the question of how to 'live one's life well' within the web of relations is not at all centered around illness, suffering and dying. In the medical world, however, these dimensions of human life play an overwhelmingly big role – and the health care chaplain, among others, tries to help the patient in 'making sense' of this experience against the backdrop of the ordinary life. Furthermore, ideally he or she relates the medical team's views to the diverse existential, social, cultural, religious, and other contexts that play into their actions and decisions. Respect for the other presupposes the acknowledgment of one's own partial perspective, and the readiness to discover the views, backgrounds, and values of others.

Health care chaplains are in a unique position to bridge the two worlds because they interact with the patient by way of non-medical rituals and communicative inter-action. No doubt – many religious traditions regard precisely these religious & spiritual actions

as a way of *healing* and therefore as an appropriate way to respond to illness and disease. This traditional understanding of the religious role in medicine is recently becoming attractive again;<sup>1</sup> however, this is not the focus of my paper. Rather, I want to leave the medical action – understood in the narrow sense of modern medicine – in the hands of doctors and nurses, and focus on the integrative and spiritual role of the health care chaplain.

For all times in history, narratives have played an important part as way and mode of expressing one's emotions and experiences about fear of illness and the struggle against, or coping with the crises accompanying them. The experiencing of the death of a beloved person through illness, rituals of mourning and remembrance are important practices across all cultures, very often part of the religious and cultural traditions alike. Taken in a very broad sense of the form of *creative reflection*: 'everyday stories', works of art in literary or non-literary modes, poetry, sculptures, plays, blogs, video clips, or movies, narratives represent a specific way to approach the existential reality, and their *form* entails the ethical claim that this is the *appropriate* mode to deal with the experiential dimension of human reality. Narratives address and represent values, convictions, virtues, and norms that inform our actions. Narratives show the response to a given situation that demands communication, including the examination of the ethical conflicts that may be part of the situation.

And yet, *narrative ethics* is an ambiguous term: Some use it to demonstrate that narratives themselves are the appropriate form of reflection upon the existential dimensions of human life. They will turn to narratives in order to explore the moral landscape: how do people respond to illness? How do stories – or novels, soaps, films, movies, etc. – reflect upon responsible actions, addressing the patient, his or her family or friends, or even the medical team which itself is directly or indirectly representing an institution with

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<sup>1</sup> Cf. the articles of Walter Moczynski and Barbara Braun in this volume.

its own rules and constraints?<sup>2</sup> If narrative ethics is understood in this way, it sometimes claims to replace ethical argumentation. The latter is too abstract, too remote from the actual narrative setting, and therefore ignores important factors that play into ethical deliberation. Narrative *ethics* in this version will, for example, search for ways of ‘creative imagination’, work with metaphors and narratives when speaking with patients and/or the medical team, in order to grasp this concrete and experiential dimension. Religious traditions offer a multitude of metaphors, narratives, and images that are meant to distance us from our ‘ordinary thinking’ for a while, in order to open our horizons and gain insights that enable us to see ourselves as part of a bigger ‘story’. This is especially true for illness narratives, prayers, psalms, stories of healing, or mourning, and the relation between life and death, and so on. Health care chaplains are like ‘prophets’ of a particular language in the clinical setting: adding to the language of science this narrative-poetic-imaginative language that creates a space for all agents’ individuality and personal history, his or her fears, hopes, and dreams. This language is not to be spoken to the patient only: it is a language that should have a certain space because it enables the agents to explore the experiential ethical dimension within the medical sphere. In this sense of narrative ethics, narratives are a *medium of ethical reflection*.

There is, however, a second understanding of narrative ethics that emphasizes the reception part more than the construction part: here, the examination, analysis, and interpretation of the narratives are related to the philosophical and theological reflection on morality. How are ethical questions dealt with in a written story, a poem, a film, or a movie? How are media debates constructed,

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<sup>2</sup> Medial T.V. series are popular as fields of exploring the world of illness in their personal, professional, and institutional settings. One should not forget, however, that they are constructed as entertainment, and are staged according to these aesthetic and functional demands. See below for some further thoughts.

what role do stories play in argumentations, etc.? In this understanding, narrative ethics becomes a critic *of* the narratives; it will examine whether, from an ethical point of view that is informed by the historical and contemporary theoretical discourse on ethics, a narrative is 'good enough' to grasp the complexity of a problem; it will confront the narrated points of view with other views: for example, a Mafia ethics (or rather: morality that is reflected in a 'Mafia ethics' as theoretical construct) is still a morality that can be presented in a very attractive way of paternalistic care and responsibility for the common good of a given population – from an ethical point of view, however the question of freedom and compulsion, violence, or of camouflage of self-interest and power, is crucial for the critical questioning of this kind of ethics.

Narrative ethics in this receptive-analytical sense is as complex as the narrative in the constructive sense; its object, however, is not the experiential sphere itself but the narratives that articulate them, sometimes close to everyday language and communication, sometimes artful as in works of art and literature. The former are part of the medical communication, the latter part of the social construction of medicine by way of art and, as in the case of documentaries and films, media. Here, narratives are not the medium *of* ethical reflection, but they are a medium *for* ethical reflection. Health care chaplains who certainly have a strong affinity to narrative ethics in the first sense, and who are by way of their profession well-prepared to deal with it, also have a certain competence in analyzing narratives. They are not, however, better prepared than others to critically analyze narratives with consideration of the *ethical* dimension unless they are continuously educated and trained in ethics itself. The approach we take in our project therefore aims at enabling health care workers to deal with ethical questions that may arise in the medical setting of a hospital or hospice in an informed way; we use more than one method of medical ethics but consider narrative ethics as particularly close to their communicative work.

Different approaches are needed for the different contexts and the different actions.

- a) We need, for example, a set of ethical principles as constitutive rules for the moral sphere, such as respect of and for the dignity and freedom of a person. These are not 'empty' or 'abstract' principles, since they are partly based upon a sense for the freedom and autonomy of a person, and partly based upon a sense for his or her well-being as the basis of the capabilities humans should have the chance to develop.<sup>3</sup> The effect of successful (reflexive or constitutive) justifications of moral claims is a set of human *rights* we are all *obliged* to respect so that the other, as the 'claim-holder', can survive, and can live well.<sup>4</sup>
- b) In addition to a foundational, principle-based approach to morality, we also need *virtue ethics*. Virtue ethics is meant to explore the 'dispositions' that are necessary to be acquired by persons, in order to learn how to live up to the normative claims that we may all have signed up to abstractly, and to

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<sup>3</sup> There are two strong foundational ethical theories that argue for the connection of freedom and well-being, albeit in different ways: one is the justification of moral claims by Alan Gewirth (1978), the other is the capabilities approach introduced by Amartya Sen (1999) and Martha Nussbaum (1993; 2001). In another context I have argued that narrative ethics is not to be construed independent of these (or comparable) foundational theories but rather complementary to them. Cf. (Haker 1999).

<sup>4</sup> This normative basis of morality is by no means trivial; it is, however, necessary to explicate and defend the arguments that function as *constitutive* basis of the moral sphere, i.e. as a normatively binding. Here, however, it is not the time and space to present the argument. For an approach that combines the concern for normativity and the practical identity of persons in the Kantian tradition, cf. Korsgaard (1996).

learn how to act according to our ideals. From the Aristotelian ethics onwards, virtue ethics has been part of ethics and up to a few decades ago, medical ethics was construed along the line of the ‘responsible doctor’ or the ‘responsible nurse’. With the rise of modern ethics, virtue ethics was pushed to the background over against the question of how to justify moral claims at all. In the German philosophical context, for example, Kantian ethics, which was most influential in the development of modern ethics, was not only followed and taken further by the Hegelian political ethics, but also by the German Classicists concern for the character. The most famous authors of German Classicism, Goethe, Schiller, or Hoelderlin, responded to Kant in their aesthetic-ethical novels, in their dramas and their poetry.

Today, virtue ethics is being revised as a necessary part of ethics, without claiming that it could replace foundational ethics. Whereas this is concerned with questions of justification of certain actions to be considered morally *right*, virtue ethics is concerned with moral *goodness*, the development and maintenance of convictions and values that make the identity of a person.<sup>5</sup>

- c) In addition to these two major approaches, we need a strong *social and political ethics* in order to reflect upon our common social goals, the limits of consensus, the necessity of tolerance, pluralism and the difficulty to act in solidarity with others; we must reflect upon justice and injustice. Over against a static natural law tradition that acknowledges human reasoning but still roots it in a metaphysical order, aimed at the construction of a stabile moral and political order, we must learn to understand that moral reasoning – albeit not relativistic – is historically rooted. We cannot grasp this embeddedness of our

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<sup>5</sup> For further studies on the relation of convictions, values and identity that inform my own approach, cf. Ricœur (1996); Taylor (1989) for a prominent virtue ethics approach Foot (2002).

reasoning in history entirely but we can acknowledge that the historical, cultural and social situating of ourselves (Benhabib) has a considerable influence on our claims to moral truth, our moral being and our moral agency. In addition to these foundational question of morality as such, social ethics that is concerned with structural and institutional questions, addresses the medical institutions, political frameworks and health policies on the different levels, and confronts them with the question of justice (Daniels 1985).

- d) Confronted with dilemmatic situations, people look for advice. As professionals in the medical sphere, we need situated moral judgment that is connected to *casuistic reasoning*. In a given situation where patients themselves, nurses, physicians, or family members are to decide responsibly – and sometimes act on behalf of others, our knowledge and competency must include moral knowledge and moral competency.

We will not acquire this ethical competency by merely learning to list the core principles of medical ethics, i.e. autonomy, maleficence, beneficence, and justice, unless we learn to understand *why* Beauchamp and Childress came to address them in the first place, and *what exactly their status is* in medical ethics or bioethics. We will not be able to justify our moral judgment in a given situation unless we know what a rational argument should look like, and how it transcends our *necessary* but not *sufficient* emotional response or intuition. The more we learn about hermeneutics, i.e. the interpretation that is necessary to understand the actions, value backgrounds of our own, the patients', nurses' and doctors' personal convictions, the better we can respond to the codes they send us in their conversations. Given the more recent developments in clinical ethics, health care chaplains need to develop a specific moral competency about the institutional setting of medicine. Ethical education is aimed at enabling health care chaplains to play an active role in clinical ethics committee sessions or in consultations that take place *in between* fixed spheres.

Therefore, I will start my essay with a short exemplary – not representative – reconstruction of several approaches to bioethics; these are not exhaustive for the field but should be studied by any health care chaplain. I will then go a step further and introduce some facets of the narrative approach to medical ethics, in view of health care chaplaincy.

## 1. Approaches to Bio(medical) Ethics

Many current approaches within medical ethics & Bioethics draw upon the rich history of moral theory. The most successful approach is the “*principle-based approach*” of Beauchamp and Childress. It has accompanied the rise of bio(medical) ethics since the 1980s, and the ever-actualized editions reflect the theoretical development of the field. In each new edition, the authors respond to their critics and thereby embrace new methodological developments. The approach combines two traditionally distinct traditions, namely deontological Kantian ethics and teleological Utilitarianism. According to the authors, in the more or less pragmatic and decision-oriented bioethical reflection, four core principles should lead the ethical analysis, and any chaplain in a health care setting working on ethical questions will need to know them:

1. Autonomy (of patients should be respected);
2. Non-maleficence (should guide physicians as negative principle, stemming from their own professional tradition: “do no harm”);
3. Beneficence (should guide physicians as a positive principle, also stemming from the tradition of medical ethics: “the well-being of the patient is of highest priority” or “*salus aegroti suprema lex*”);
4. Justice (should guide public health policies: namely equality and fairness with respect to the

distribution of goods, stemming from the reasoning of public health ethics).

This “all-embracing” approach does not argue so much for its rational or reasonable basis but rather reflects upon ‘common’ and ‘shared beliefs’ which are taken up in order to be ‘applied’ to the field of medicine. Its advantage for medical ethics is the integration of several medical-ethical and foundational approaches; its weakness, however, is the unclear relation between the principles, and the ‘coherential’ justification that may be ‘evident’ in a certain (Western) culture, but cannot claim to be coherent with moral insights in other cultures or traditions. Nevertheless, the principle of autonomy as respect for the patients’ will and interests has been very important in the development of modern medical ethics: with the turn to patients’ rights, the paternalism that had been dominant for centuries could be overcome. In clinical trials, the principles of non-maleficence and beneficence have been used as criterion for the balance of benefits, risks and burden that may be acceptable in view of the prospects of medical innovation. The principle of justice responded to the debate on scarce resources and situations of triage that doctors are confronted with. In sum: the four principles of bioethics have a historical origin in the US-American modern medicine at a certain time, and they reflect the Western tradition of ethical reasoning, which Beauchamp and Childress adjusted to the medical context in a rather pragmatic way. With these limitations in mind, the great impact and merit of their work for medical ethics can be acknowledged. Other ethical approaches have not been as successful in medical and bioethics as the principlism; nevertheless, they play a major role in the young discipline and have triggered an ongoing debate. Here, I can only give a few examples of this debate – in an educational setting, however, health care chaplains need to know the different approaches in order to situate their own ethical reasoning and tradition.

H.T. Engelhardt’s attempt to address the present-day moral pluralism by founding bioethics on the two formal principles of (respect for) autonomy and beneficence, has been broadly re-

ceived. In contrast to Beauchamp and Childress, Engelhardt acknowledges the moral pluralism of contemporary culture(s) and the failure of any attempt to found ethics on substantial shared values. He leaves these to distinct communities with contradicting moral standards, united only in the will to *solve conflicts between moral strangers peacefully*. Health care chaplaincy could learn from this approach how important it is to acknowledge moral pluralism, in order to situate their religious tradition in an inter-religious and inter-cultural context.

Another approach often referred to in bioethics is the preference-utilitarian ‘practical ethics’ by Peter Singer that in another variant is also represented by John Harris. He claims that the interests or preferences persons articulate need to be respected by others. However, not everyone we are concerned with in bioethics is a person in the strict sense of the word. Their interests must be assumed. In certain extreme cases, Singer argues, the interest to live will be countered by the – assumed – interest not to live under given conditions. In the case, for example, of a newborn child with severe handicaps, the (general) respect for a person cannot be applied to this human being; also in other cases the traditional distinction between human beings and higher mammals will undermine the moral status of the latter. Although Singer’s approach provoked a lot of discussion, the practical impact of his “anti-speciesism” approach should not be under-estimated. Health care chaplains must be informed about this debate and be aware about the anthropological bases ethical approaches have.

Casuistry has been introduced by several authors as a method of decision-making, initiated by the historical study by A. Jonsen and S. Toulmin and taken up by several ethicists, stemming from different philosophical and religious traditions. In the Jewish-Christian tradition, casuistry offers a toolbox of so-called middle principles, such as: consider the circumstances, distinguish between main effects and side effects, do not overstretch duties but see them in relation to the needs and abilities, etc. If concerned with every-day ethical decision-making, it is useful to know of this

tradition in order to draw upon it knowingly (and not only intuitively).

Feminist bioethics has emphasized that moral judgment must not be gender-discriminating and theories in bioethics must be seen against the philosophical backdrop of undermining ways of reasoning that were considered 'female' (Donchin 1999; Haker 2003; Kittay 1999). Liberal contract theory, analogies to strict legal argumentation, and quasi-mathematical calculations of quality of life, for example, are easily considered more 'scientific' and therefore more 'rational' than communication, empathy and context-oriented moral reasoning that health care chaplaincy often make use of. A critical analysis of the disciplines and practices within medicine itself might well show how the gender-bias has been shaping the hierarchy not only between different disciplines of medicine, but also between the main professional groups, and even between the different approaches to health and illness. One striking example is Susan Sherwin's concept of relational autonomy, over against the 'atomic' concept used in traditional bioethics (Sherwin 1992). Another example is Eva Feder Kittay's care ethics approach that addresses social ethical questions of caring for persons with handicaps (Kittay 1999a).

In general, two major trends can be observed in the last decade: firstly, bioethics has turned more and more to the institutional and socio-political dimension of health; hence, the principle of justice has been elaborated against the foundational theory of justice, considered in relation to global health care and bioethics (Daniels 1985, Tong 2002). Secondly, the formerly Christian or secular bioethics has been transformed into a more diverse 'inter-religious' and 'inter-cultural' discipline, drawing attention to the diversity of patients, staff and hospitals in the US but also in the rest of the world. Partly, these developments are due to the globalization of medical research, partly they acknowledge the diverse traditions that are mirrored in the values and convictions of the persons; if the autonomy is to be respected, these traditions must

be understood and interpreted, and religious as much as cultural competency is to be developed.

At present, there are many competing approaches within the field of (bio-) medical ethics. Major debates within philosophy are echoed in the medical ethical debate; for example, when questions of political tolerance and personal choice are debated with respect to genetics, assisted suicide, or reproductive decisions, they are framed in the terminology of communitarianism and liberalism (Buchanan et al. 2001).

In addition to this broad ethical discourse, the *practice* within medicine has changed dramatically in the US as well as in Europe: we observe that medicine is more and more dominated by economic rationality; sometimes economic interests even contradict medical duties. Furthermore, ethics and law are more and more conflated with respect to the public discourse. It is still to see whether this development will undermine the beginning discourse about a “new” – but in fact “old”, more integral – way of how to deal with health, illness, vulnerability and the articulation of human experiences by way of narratives.

To conclude this short excursus into bioethical methodological discourse, one can say that there is broad dissatisfaction within bioethics with the ‘application’ of the above-mentioned “Georgetown” principles, as well as with casuistry that leaves everything to the situation of the clinic. For many, narrative ethics has become an attractive solution for the limits of principlism and the mere return to an Aristotelian virtue ethics respectively. Already a decade ago, John Arras stated this attraction for bioethics:

“The field of bioethics is beginning to take its own narrative turn. Long dominated by the aspirations to objectivity and universality as embodied in its dominant ‘Principlist’ paradigm, bioethics is now witnessing an explosion of interest in narrative and storytelling as alternative ways of structuring and evaluating the experiences of patients, physicians, and other health care professionals” (Arras 1997: 66).

Authors such as David Morris even argue that by now the biological model of health and illness, as well as the bioethical model of a reduced rationality (reduced to argumentation only) is transformed to a 'postmodern', constructive model of an interaction between biology and culture (Morris 2000). He gives two striking examples for this: firstly, the neurological research more and more distances itself from a Cartesian model that separates the body from the soul, and instead emphasizes the reciprocal interaction between the physical and the mental sphere. Thereby, it secondly opens up to cultural interpretations of phenomena like pain that is experienced differently by men and women, American and Chinese, and perhaps even Buddhist and Christians. In medical ethics, the rise of narrative ethics also means a new concern for the constructs of reality, and hence a new concern (and perhaps curiosity) to transcend one's own perspective in favor of listening to the perception and interpretation of the perspectives, metaphors and narratives of others.

As I have argued elsewhere more extensively (Haker 2007), I am convinced that narrative ethics cannot and should not function as an overall ethical approach within medical ethics. It should, however, have a prominent place in the field, precisely for the reasons Arras has given: narrative competency and narrative analysis are ways to understand and structure the experience of all persons making up the context of medicine. To this I want to add in this paper, that health care chaplains are in a prominent position to *develop* this competency, to *focus* on it in their own work with the patients and the medical professionals, and to *educate* others in the medical team with respect to their narrative competency.

However, in our work as an American-German task force aimed at the development of a new approach to medical ethics in health care chaplaincy, a group consisting of hospital and hospice chaplains, medical ethicists, theologians and psychologists, we could neither find much research nor a comprehensive educational tool for *any* ethics in health care chaplaincy as a particular approach, similar to medical ethics as nursing ethics. Hence, narra-

tive ethics needs to be developed further, drawing on the works of others (and our own work) either in medical ethics (doctor-patient relationship, nursing ethics) or in the foundational reflection on ethics as such.<sup>6</sup>

## 2. The Role of Narrative Ethics in Health Care Chaplaincy

Health care chaplains are one group of professionals ‘working’ with patients mainly via communication. This communication concerns several dimensions of health and illness, of human personhood and personal relationships, of the bond between the self and the other, of responsibility, emotions, imagination, fear of loss and hope of (re-)gaining time and life. It also involves questions of making sense of one’s life, of the personal relation towards religion, transcendence, and/or spirituality. Health care chaplains are the ones who depend on the net of communication within the system of a hospital or institution most urgently, and they can shape the ways and structures of this communication between all participants.

Communication is to be analyzed and reflected upon by all health care workers; it is not exclusively part of ethics but in this discipline it is one dimension among others. Ethics is understood as the reflection upon actions and practices and their internal

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<sup>6</sup> See bibliography for some references. I have worked on the status of narrativity within ethical analysis in Haker (1999), referring primarily to Paul Ricoeur, Martha Nussbaum, Dietmar Mieth, and Walter Benjamin’s critical hermeneutics. In this work, however, I was more interested in the relation of an “ethics of the good life” and “normative ethics”, and of the self’s moral identity and the question of responsibility at a particular (biographical *and* political) time in his or her life. In other works (Haker 2006; 2007), I have taken this approach further and taken bioethics as a field where narrative ethics should be elaborated further.

teleological and normative structure, upon personal values and commitments, upon social norms and beliefs shared in different communities, and upon institutional frameworks that guarantee the protection of rights. In the above-mentioned contemporary approaches to medical ethics, however, ethical reflection rarely considers the forms of communication, for which I use the broad term of engaging in and with 'narratives'. Narrative Ethics attempts to fill this gap and to overcome the methodological reductionism within bioethics.

While in recent years the concern for narrative ethics has been articulated by several authors (cf. bibliography), and the first steps have been taken to elaborate the different perspectives to a major approach, no special attention has been given to the work of health care chaplaincy. This comes at a surprise given the fact that health care chaplains are the professionals who are in the unique position with respect to the patients they see, with their professional role demanding of them to have *the time and task to listen* to the different narratives and stories told in the medical setting. Furthermore, health care chaplains or pastoral care workers have stories to tell themselves. They need to be deliberate about them in order to respect the other and respond to their needs at the same time. Most of health care chaplains' work, I hold, is about the construction and interpretation of stories they hear – either by the patients or by other professionals who tell them about patients.

Health care chaplains may offer their interpretation to a patient, or open a story to another sequel. They may offer their interpretation of certain behavior to the medical staff and contextualize it; e.g. in the case of denial to end treatment, it could be that a religious belief is in the background of this judgment: maybe it is God who takes the life, not man, and making decisions actively that will result in the death of oneself or a close relative, then may seem to contradict or even betray this faith.

Furthermore, health care chaplains are, or perhaps *should* participate in decision-making processes insofar as 'their' patients are concerned. Health care chaplains often serve on Clinical Ethics

Committees. Here, it is assumed that they have an ethical competence that should help them to frame an event to a 'case' so that there is an open 'end' to be decided upon. In this way, health care chaplains do not only hear stories from patients but also tell them in bringing them to the clinical ethics committee.

In the following, I will explore a little further how narrative ethics can be used as an educational tool for the development of narrative-ethical competency in the work of health care chaplains.

Three dimensions, in my view, are essential to narrative medical ethics: the relation of identity and narratives; hermeneutics within ethics; and the relation of literary, film & media theory and ethics. I will argue that Health Care Chaplains need to be better equipped to further elaborate and implement these and other aspects of narrative ethics into the overall reflection on medical ethics.

### ***Narrative ethics and identity***

In medical ethics, the question of narratives and identity is mostly linked to the patient and his or her experience of illness (Frank 1995; 2000; Lindemann Nelson 1997; 2002; Charon 2002). This is certainly appropriate, because the patient's identity is questioned more than anyone else's identity. However, it may well be the case that health care chaplains need to develop narrative competency with respect to the medical professionals, too. This is more and more the case when doctors act under the pressure of the budget: they need to make responsible decisions in view of scarce resources; sometimes, they may be torn in their self-understanding as a doctor, and need to be listened to. Sometimes, nurses may be challenged by the patient or the family, especially in cases where they themselves are addressed in disrespect. Nevertheless, the pa-

tient is the center of the face-to-face conversation of health care chaplains, and their struggle with their identity is of utmost importance.

To use the drama as metaphor, we can say that patients enter the “scene” of illness with a past, coming from a particular culture, social context and position, they belong to a class, a race, a gender – and very often to a religion – that categorizes them explicitly or implicitly the moment they encounter a doctor as a patient. Patients begin to tell their stories already in the forms they have to fill in a hospital, however fragmented it may appear; their identity is brought *onto the stage*: presented, questioned or newly constructed with every diagnosis and every treatment they undergo. Many *spectators* watch them *performing* their personal drama – watch them *living their life* at a particular moment, or watch how the drama is being unfolded by the actions of others upon oneself.

The drama of transforming into and then *being* a patient can be described as a crisis, because illness reveals a side of human existence that can be easily forgotten, ignored, or even repressed in other phases: if it is the human condition to endure the tension between potency and fragility, between teleology and contingency, between sovereignty and vulnerability, and making the best of it, then illness certainly creates an imbalance with the weight on weakness, frailty, vulnerability and dependency.

Modern medicine focuses on medical information, on technological tools and on the care patients need in order to help them through their experience. Within the narrow framework of medicine, it is *good enough* to apply the *best standard of treatment* that is available at a given time. Why then should it not be good enough ethically to act according to the *best interest standard* that takes into consideration the patient’s autonomy, his or her competency to know best what will help him or her (and if s/he is not the agent yet, or not anymore, then his or her relatives or friends will certainly act in his/her best interest)? Why complicate matters further by referring to ‘the drama of life’, the human condition, his-

torical or social categories such as race, or gender, in order to understand the identity better?

Some respond to these nagging questions that are raised in defense of the modern technology-oriented medicine and a particular modern, liberal ethics: In this narrow approach, the patient is not taken serious as a ‘whole’ person – the turn to narratives try to overcome this shortcoming that is deeply felt by patients and the health care professionals alike. My understanding of narrative ethics goes a little further, linking the illness experience to the struggle of (and for) identity that always takes place, but is particularly extreme in the case of illness. The experience of falling ill, albeit being a ‘passive experience’, still needs expression, articulation and interpretation, hence turning the event-character into active appropriation. Articulated experience is but another word for a narrative, a story, a metaphor or an image that sometimes entails the life-story in a nutshell.<sup>7</sup> It must be heard, and interpreted as what it is: the attempt to make sense of an experience that has shaken a person’s balance, at one point less, at another more, depending *not* on the seriousness of a diagnosis or medical result, but on the effect on a person’s identity. Considered from this perspective, it is in fact not good enough to ask about the ‘interests’ a patient has, because the whole concept of ‘interest’ stems from the

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<sup>7</sup> An impressive initiative can be found in the work with Aids-patients: the “memory books” that HIV/Aids patients are encouraged to make (quite a few of them illiterate, placing objects that are important for them into the ‘book’ or ‘basket’) are meant to help individuals to cope with their future death – and to secure that their children or families have something to remember them. The attempt to grapple with one’s identity is kept in these memory books – but in addition to this, they are addressed to concrete others: to sons, daughters, husband or wives, or mothers and fathers. Nowhere else have I seen an approach within medicine that takes the relation of illness & death and narratives as serious as in this initiative (Smith 2007).

economic interaction of a customer or contract partner enforcing their interests. Rather, the challenge will be to give the patient a helping hand in the process of his or her illness: to understand it, integrate it, and cope with whatever consequence it may have for him or herself and for him or her relevant others.

It is the chaplains' professional task to help the patient (or his/her relevant others) through a difficult situation, often accompanied by an identity crisis and existential questions how to integrate and appropriate the experience into one's biography. This support entails active listening and opening the space for this identity-oriented dimension; offering (religious) interpretations or religious rituals such as prayers, blessing, sacraments, and other traditions. These acts may – or should – pave the way to the spiritual dimension that is important for many people, especially in the situations of disturbance, and it may – or should – create a common space where the individual situation of a person is linked to the situations of others, through words, prayers, or stories.

### ***Hermeneutics within Ethics***

I use the term *hermeneutics within ethics* to reflect upon story-telling and narrative as *necessary* part of ethical reasoning. In order to understand this, let us turn for a moment to narratives in the stricter sense, as stories presented in works of art. Like their more 'authentic' counterparts in everyday story-telling, modern narratives do not always follow the Aristotelian *Poetic*. Apart from the totality of beginning, middle, and end, Aristotle argued that stories should *represent* the real world; the Greek word for this representation being 'mimesis'. Stories, according to Aristotle, should not represent historical events (this is the task of historical narratives, making truth claims about the past); but rather they should present their 'mythos', i.e. the story, in the mode of likelihood or probab-

ity: the story, this means, should be *possible* to have happened, characters should be ‘like us’, and the language and construction ‘beautiful’ in the sense of immanent order, teleology, and consistency. The truth of the narrative then is not the concurrence with the empirical reality but rather with the experiential reality that is individual, particular, and only in this individuality and particularity universal.<sup>8</sup>

Today’s literary theory has moved away from the Aristotelian theory of mimesis, and transformed it to a more constructive theory of narration, followed by a hermeneutic act of interpretation called de-construction. While being one of the most important theories of 20<sup>th</sup> century hermeneutics, Hans Georg Gadamer’s hermeneutics has not remained uncriticized: In order to make understanding possible, Gadamer assumed a common horizon of sense between the story-teller (or artist), the work of art, and the reader or recipient, that is activated by the act of reception. This sense, although being activated in the interpretation, still alludes to an over-arching ontological reality that is not constructed but rather reconstructed. Today, hermeneutics, however, would more easily and more radically give up the common ground between the story-teller, story and the recipient, and emphasize the ‘otherness’ and irritation of expectation and understanding – Derrida’s deconstruction theory, for example, partly turns to this difference rather than to the commonality that might presuppose the text (Derrida 1978). Furthermore, the constructive dimension of reception by which reality is newly created, is emphasized.

In a bridge between Aristotelian or classical and contemporary (postmodern and poststructural) hermeneutics, Paul Ricoeur’s concept of a threefold mimesis considers representation neither as an imitation of a presupposed ‘reality’, nor as merely imagined construction that has no root in the experienced and empirical world of action. Rather, the construction that takes place in the represen-

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<sup>8</sup> For an ethical analysis of Aristotelian poetic cf. Nussbaum (2001, 2<sup>nd</sup> edition), and Ricoeur (1996).

tation has a pre-narrative or pre-figurative background in the *praxis*, and reception re-figures the con-figuration (the story) in and for the praxis. To quote an example of the debate on euthanasia to which I will come back below: The movie *Million Dollar Baby* takes its 'plot' from the actual praxis of patients who wish to die but who cannot manage to commit suicide because of their state of illness. The actual construction of the story needs the narrative analysis mentioned above. The impression of the story, however, re-enters the practice of dying in a given situation and context, and may result in a changing practice, such as the broader acceptance of a living will.

The value of narratives in works of art lies in their resistance to abstraction and the subjection of experience to an apparently logically consistent order. Literature achieves its own mode of articulation by strengthening the voice of an alternative, experiential reality that not only has its own rationality, but is characterised by its bewildering concreteness, its orientation towards emotion and subjectivity and particularity. Narratives are therefore to be taken seriously as both a *medium of ethical reflection and a medium by which the moral sphere is revealed*. However, the possible distance of a story from the empirical reality is a point worth considering – take, for example, the metaphor of the journey for the process of dying, or the selective construction of reality in soap operas as much as in movies. By way of this distance the experience of imagination emerges. Insofar as works of art stimulate *moral* imagination, and insofar as they reflect the question of the pursuit of individual and social life as much as the question of rights and social justice, narratives of whatever kind are an indispensable element of ethical reflection. Last but not least, literature stems from its own time, it relates to historical events, to the language of a certain time, to its metaphors and forms – even though its mimesis of reality is of a 'poietic' nature. Thus, commitment to literary commentary and critical interpretation involves expert hermeneutic skill on the part of the interpreter.

The task of ethical theory in relation to literature – for which I would rather use the term literary ethics in contrast to narrative ethics – consists of both a *commentary* on the text, and of a *critique* of the ethics depicted in literature. The concepts of commentary and critique stem from the literary theory of Walter Benjamin, who used these two terms to describe both contemplative and sympathetic interpretation on the one hand, and the “dissecting-destructive” aspect of interpretation on the other. Benjamin’s theory is closely linked to the aim of deconstruction in current literary theory, although he leaves open the status of representation of the experiential reality. Ethics may be well-advised to turn to literature as one of the *sources of articulation, interpretation, and beliefs* from which ethical reflections cannot and should not be separated.

Notwithstanding these specific features, there are limits in this kind of ethical reflection that also need to be considered. Literature concerns itself with concreteness and particularities. It makes no claims to universality, but shows what is *meaningful* about human reality. It is clear that literature makes reference to general human problems and questions. It does so, however, by posing questions about the appropriateness of desires, about the range of activity and living, about the interaction between the individual and the social sphere, beings or nature, about the place of humans in history or in the cosmos, etc. But its answers are necessarily embedded within the aesthetic form. In telling stories, literature attempts to display to the reader its view of reality and make it appear plausible, and this happens even though an author has a wide range of possibilities for dissemination of the plot, interaction with the reader, or interruption of one perspective by expanding a story to multiple perspectives.<sup>9</sup> The very structure of narration leaves the ethical judgment about the story or plot (or fragments of these) to the reader. Accordingly, a literary text does

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<sup>9</sup> William Faulkner is one of the most famous writers making use of this technique.

not *argue* on behalf of the values or the hierarchy of goods represented within it – for example, by posing a truth claim. A literary text asserts no claim to the complete representation of an ethically relevant perspective. Once again, ethics is subsumed under an aesthetic conception and form, even when it contributes to both the form and content of the text. *Morality or the “ethical” in literature is necessarily a function of the aesthetic.* This needs to be considered in all ethical interpretations. The hermeneutics of ethics lead back to the second main form of reflection, namely argumentation and justification of moral claims for actions, because stories of art do not carry with them the criterion for morally right actions.

### ***Narrative Ethics and Literary & Media Theory***

*Literary Theory and Media Theory* provide valuable tools for the education of health care chaplains: they inform us *how* to analyze narratives: what story, or fragment of a story, is told, in what way, with what code, by whom, to whom? What are the implicit or explicit narratological implications of the stories?

For example, a patient may use a code to let the minister know that she knows she will die. Imagine she says: “I so much want to see the mountains again. I know it is a long journey that I have before me.” This is not a story in the Aristotelian poietic sense, with a beginning, a middle, and an end, rather it is a fragment of a story; and yet it can be analyzed as an abridged, indirect narrative of the patient’s death. Ethically speaking, it *should* be understood as a code, as speech act telling something that cannot be addressed otherwise. The first sentence is a particular desire; if it were followed by a sentence such as: “I know I will not be able to see my beloved mountains again”, the patient would have addressed nothing else than the lament that she dies. The second sentence, how-

ever, expresses a kind of acknowledgment that the journey before her now is difficult, different, but still is a journey that she links to past journeys of her life, particular to the ones into the mountains that are so important for her self that she will miss them desperately in the future. With this link, the patient articulates fear and hope at the same time, because she does not know what to expect, and also realizes that this future will put an end to other possibilities she had in her life. In addressing this fragment to a minister, she has entered into communication about death as the ‘last journey’, but in a way that links this metaphor in a very specific way to her own life.<sup>10</sup>

This fragment is not in itself a ‘full-scale’ story; yet it alludes to an implicit story, connecting the process of dying to the metaphor of the ‘one way’ journey: leaving behind what one loves, but still entering a movement into the future. Analyzed as such an image, the minister may understand what the patient is doing with these words:<sup>11</sup> Communication and narrative theory (Abbott 2002; Fritz 1992) show ways how to analyze such fragments, or more elaborated stories, draws attention to the images, the implicit and explicit elements, and the things not said; narrative analysis could continue the analysis by paying attention to the listener’s/reader’s role in the story, his or her place in it as an ‘implicit listener/reader, for example.

Everyday stories or narratives are heard (and told) by every minister at the bedside of patients. Not only is active listening a skill that needs education, story-telling also belongs to these skills.

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<sup>10</sup> I have taken this example from Bolay (1996). The narrative analysis is mine, although the author quotes this and other utterances in order to show how difficult it is for a minister to listen actively to a patient dying.

<sup>11</sup> The allusion to speech act theory is deliberate, cf. Austin’s famous essay “How to do Things with Words” that is the basis for narrative ethics (Austin 1962).

Like the patients' stories, the ministers' *story-telling* is often presented as fragments. The above-mentioned Christian health care chaplain Winfried Bolay reports that he once found an image in the conversation with dying patients, an image that leaves 'loose ends' as 'loose ends' instead of burdening this phase with all kinds of pressures to solve problems and make decisions that have not been made before. Stemming from the Christian faith, the image of God is meant to take away the pressure that the 'whole life' should be sorted out, all conflicts be put to an end, all things be done and ready before one can die in peace. Quite to the contrary, Bolay states, he tries to convey that "God will wipe away the tears". In using this metaphor for the dying person's encounter with God, the health care chaplain takes up the sorrows and concerns and connects them to the image of the Christian God as a loving God with no conditions for this love, showing how God is ready at any given time to *reach out*, or even to *take over*.

Quite a different dimension must be added when we consider the role of narratives in the media, in movies, novels, blogs or documentaries. There are series like *Dr. House* or *Emergency Room*, addressing the routine of a modern American clinic; the above-mentioned movie *Million Dollar Baby*, or *The Sea Inside me*, addressing the question of euthanasia or assisted suicide in two very different social and religious cultures (US and Spain); novels of modernity such as Thomas Mann's *Magic Mountain*, Tolstoi's *Death of Ivan Ilych*, novels that are completely fictitious and still reveal much about illness and its existential side; there is the 'pillow angel' Ashley of whom we only know because of the blog her parents posted in order to justify why they do not wish their handicapped daughter to grow or enter puberty and strongly believe that this is in the girl's best interest;<sup>12</sup> or a US-*Frontline* documentary about reproductive medicine where couples with

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Cf. <http://ashleytreatment.spaces.live.com/PersonalSpace.aspx?c02owner=1> (last visited 27<sup>th</sup> Oct. 2008).

tears in their eyes consent to ‘donate’ their frozen embryos for research – these are but a few examples, but all of them certainly need another kind of analysis than the ‘real’ bedside stories health care chaplains hear from patients. And yet, these public stories, too, are the background part of the stories ministers are told by patients, doctors, or nurses, or part of the stories they themselves tell or by which their convictions and judgment are shaped.

People sometimes ask: “Why not turn to social studies instead? This source is empirically valid and representative”. Yes, we could do this, but literature’s uniqueness lies exactly in its ‘poietic’ character, in its mimesis of practice which must not be mistaken for practice itself. By posing questions in its own way, literature participates in articulating the sense and meaning of social and historical reality – even when it denies any meaning at all.

Literature plays with the world of ethical values. It can depict people and actions that would be ostracized or condemned in the moral world. Literature frequently and intentionally transgresses the boundaries of the moral world in order to bring ethical questions indirectly to light. This is actually also the case in *Million Dollar Baby* where the heroes’ friend ends her life secretly, as an illegal act depicted nevertheless as morally right. In a real medical setting, however, his behaviour would have been persecuted legally and be condemned morally – even though one might understand that assisting someone in dying is *motivated* by compassion and altruism. The point of the movie, however, is to raise the question of the value of life and the right to die. It uses narrative and rhetoric patterns, for example exaggeration, dramatization, isolation of figures instead of showing the web of relations, etc., to make its point. The film raises the ethical question whether we would wish to live in such a way, whether we could imagine such a practise as a morally right and good practise, respecting the freedom and well-being of all people. It is not only an entertaining experience but also a useful and perhaps even necessary medium to create the space that we need to reason about ethical dimensions of our life, and about certain (prospective) thoughts we might give

the end of our life. As a 'prefiguration' of our own stories, a film like *Million Dollar Baby* may influence how we perceive the world of illness *and* modern medicine.

It has become a common teaching method of medical ethics to interpret films or sections of films in order to reconstruct the plot, the intention, the argument, and the judgment that leads to a particular action. These clips add to the cases that were presented in more 'traditional' medical ethics courses (Chambers 1999). Narrative analysis goes along with this method but transcends it insofar as it emphasizes the genre, the aesthetic dimension and form of the film, the narrative structure, the selection of perspectives, music, stereotypes, etc. In doing so, it clearly transcends the merely instrumental, pedagogical use of the narratives, which are very often used to demonstrate a truth that has been found already outside of the film. In contrast, narrative ethics will attend to the specific form of narrative reflection, and deconstruct it in the interpretive act. For example, nobody working in the field of medical ethics will be able to forget the film of Terry Schiavo that her parents 'released' in the internet. Recommendations from the Catholic Church, for example, not to deprive a human being of fluids and nutrition, were closely linked to the Schiavo case.

As indicated above, Paul Ricœur has called this the *pre-figuration of a story* in the context from which it emerges; the actual story is a *con-figuration* that stems from and responds to this context, and this again enters into a *re-figuration* in the act of reception and interpretation. Reflection and reasoning in general, and moral reflection and moral reasoning, too, is embedded in this threefold process of mimesis, in the pre-judice, the (new) construction by way of a narrative, and the reception of 'reality' in the ongoing process of interpretation (that becomes part of the pre-judice again).

If people for example declare they do not want to be resuscitated (sometimes even with tattoos written on their body in order to make their desire as explicit as possible), they already respond to stories and images they have rather seen in the media than that

they have been confronted with the threatening situation themselves. These images must be understood, the fragmented stories be analyzed against the background of pre-figuration and re-figuration, and therefore the public debates about medicine followed up and reflected upon in continuous education.

In health care chaplaincy, patients & clients, nurses, doctors, the hospital & hospices administration, and pastoral care workers need to be sensitive to the way the different communicators interact. However, it is the chaplain who depends on communication only. Hence, he or she will be the one who needs to listen most carefully to the different stories, and ideally will be the one who 'mediates' the ongoing ethical reasoning in a hospital or hospice, be it in an institutionalized way or rather spontaneous.

Narrative *ethics* in this field means the professional approach of chaplains (or pastoral care workers) who engage with the questions of identity and of story-telling. They will need to 'translate' patients' stories as much as the doctor-oriented "cases" into an ethical language, i.e. into the language of good and right, values and norms, autonomy and heteronomy, tolerance and threats to individual or community identity. They will translate what is said and what is not said, and thereby put the stories into context both in a more psychological and social way and in a theoretical ethical way.

Where media narratives are concerned, chaplains & pastoral care workers must be educated to interpret their form as much as their content, so that they can help others to better understand social processes and negotiations about values and social norms. In the Information and Knowledge Society we live in, the power of images, in addition to texts, are to be interpreted, and the blurring of "real" and "fictional" stories must be considered, too.

Health care chaplains bridge the world outside and inside. They themselves, however, are by no means 'neutral' agents; rather they need to be very clear about their own background, context, status and role in the different practices. Different perspectives and in-

sights in this plural background and the multiple tasks health care chaplains are confronted with are presented in this volume. Since my own background is Christian, I will very shortly conclude with the relationship of narration and religion, and here with the only focus of my own tradition, namely Christianity.<sup>13</sup>

### **3. Conclusion: Narratives in Christian Ethics**

Religious traditions are shaped in many ways by the narratives they are based upon. They articulate and pass down experiences of human life, interpret and re-interpret them, and reflect upon them by giving them a particular religious meaning. In cultural analysis, the hermeneutic understanding is a key to the historical and intercultural setting of narratives: the way they are told reveals the way cultures are shaped, how they situate themselves among other cultures, how they shape their own identity, etc. (Bal 2001).

The imagination of *God* necessarily takes the form of narration and poetic imagination, as Richard Kearney has shown most convincingly (Kearney 1998 ; 2001), either as condensed metaphors, or as extensive narratives in the form of a story.

Illness-and healing narratives are based upon human existential experiences dealing with suffering and death, or happiness and life. For the longest time in human culture, they have been connected to religious experiences. 'God' (or the religious sphere, or holiness in the different meanings of religions) is a reference point, an addressee for personal experiences, and a specific func-

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<sup>13</sup> Cf. K. Bentele's and also Carlos Padilla's paper for further reflection on the Christian ethical approach to health care chaplaincy. The following concluding remarks cannot replace further thorough analysis. My intention here is only to show how my own tradition is deeply shaped by narratives, over against the perception that Christian ethics – and particularly Western Christian theology – is more concerned with argumentation stemming from the Greek and Mediaeval tradition.

tion with respect to the coping process. Even in the most ritualized forms, for example, in Biblical Psalms, the experiences are shaped in the form of a personal narrative.

Illness-narratives certainly play an important role in my own, the Jewish-Christian tradition: In the Hebrew Bible, the narrative figure of Job has become the symbol of suffering, resulting in a radical identity loss, shame (and being shamed by others), and personal isolation. The story of Job is, however, embedded in a major narrative about the power of 'God' over 'Satan', and in this Job is only a token in the 'game' of Good and Evil. Nevertheless, if we interpret Job's story from the hermeneutic perspective, it reveals – and at the same time disturbs – a common understanding that suffering and illness are the result of ill-behavior. The relation, however, between evil, guilt, and illness must not be ignored by health care chaplains, because they may play a role in the crisis of identity described above. The Jewish and the Christian tradition deal with the subjectivity in turning to and emphasizing the unconditional love of God who shows his solidarity in the situation of suffering, in Christianity going beyond the human experience, namely beyond death. Love as Care, and justice as structural realization of each individual's dignity are the two most important principles of Christian ethics. They are not deduced in philosophical argumentation but rather told and retold in an everlasting attempt to grasp this insight. Care and justice are the most important principles of medical ethics, too, and health care chaplains may be the ones who will promote them best on the different levels of their professional actions. Narrative ethics will be but one approach in this work. I hope to have shown that it is worthwhile to learn more about it, and complement medical ethical reflection with it.

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