

The Ethics of Self-Care in Caring Professions

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ABSTRACT

The medical academy's primary ethical imperative may be to care for others, but this imperative is meaningless if divorced from the imperative to care for oneself. How can we hope to care for others if we, ourselves, are crippled by ill health, burnout, or resentment? The self-care imperative, however, is almost entirely ignored in the training of healthcare professionals. Indeed, this training opposes the introspection essential to the practice of ethical self-care. If we are to heed the self-care imperative, healthcare professionals must turn to an ethics that not only encourages, but even demands care of the self. We must turn to narrative ethics. Since narrative is central to the understanding, creation, and recreation of ourselves, we can truly care for ourselves only by attending to our self-creating stories. Narrative ethics brings these stories to our attention; so doing, it allows us to honor the self-care imperative.

Keywords: *Ethics Clinical - Ethics Medical - Narrative Medicine - Narrative Ethics - Self-Care*

L'etica della cura di sé nelle professioni di cura

Il primo imperativo della medicina accademica è quello di aver cura degli altri, ma questo imperativo è privo di senso se viene separato dall'imperativo di prendersi cura di se stessi. Come possiamo sperare di curare qualcuno se noi stessi siamo bloccati dal malessere, dal burnout o dal risentimento? L'imperativo della cura di sé, però, è pressoché ignorato nella formazione dei professionisti della salute. Di fatto, tale formazione contrasta l'introspezione, che invece è necessaria alla pratica della cura di sé. Stando all'imperativo della cura di sé, i professionisti della salute dovrebbero assumere un'etica che non soltanto incoraggi, ma addirittura esiga la cura di sé. Devono aderire, cioè, ad un'etica narrativa. Poiché la narrazione è cruciale per comprendere, creare e ricreare se stessi, si può veramente aver cura di sé soltanto se ci si prende cura delle storie che vengono costruite personalmente. L'etica narrativa le pone alla nostra attenzione, e, in tal modo, ci consente di onorare l'imperativo della cura di sé.

Parole chiave: *Etica Clinica - Etica Medica - Medicina Narrativa - Etica Narrativa - Cura di Sé*

We are ethically obligated to care for ourselves. This, I believe, is incontrovertible. Our primary ethical imperative may be to care for others, but this imperative is meaningless, empty, if divorced from the imperative to care for oneself. I must care for my hands, if I am to lift the fallen; my heart, if I am to love the lonely; my mind, if I am to cure the ill; my eyes, if I am to find the lost; and my soul, if I am to guide them home. No matter how it is conceived – philosophically, theologically, psychologically – the imperative to care for others is always already an imperative to care for myself.

Unfortunately, health care professionals are generally offered little if any instruction in the care of the self, let alone its ethical implications. In fact, what they are taught, both implicitly, by observing their instructors' behavior, and explicitly, in courses on clinical conduct, is that they are to take themselves entirely out of the equation. Their personal thoughts, feelings, embodiment simply do not matter, do not figure at all in the clinical or research equation. Yet without honest self-reflection – without turning one's attention explicitly to one's body, emotions, thinking – ethical self-care is impossible. Rather than learning to care for themselves, in ethically sound ways, students learn, in effect, that self-care is immoral.

This suppression of self-care was brought home to me in a particularly poignant way by a story written by a 4th-year medical student, Ashley, for an ethics course.¹ Ashley's story was about an experience she'd had almost two years earlier, as a third-year medical student, on the first morning of her first inpatient rotation. Early that morning, a patient named Mary was admitted to Ashley's hospital floor. Mary, who was not much older than Ashley, had been hospitalized with sepsis, caused by immune suppression from chemotherapy. Shortly after arriving on the floor, Mary developed Acute Respiratory Distress Syndrome. The entire team ran to her room, and the Chief Resident told Ashley to sit by the bed and encourage Mary to relax. For more than five hours, while residents and attendings ran in and out of the room doing everything in their power to arrest Mary's respiratory decline, Ashley held Mary's hand, repeating, over and over again, "Just breath. Relax, it's going to be okay. Breath. Please try to relax. We're all here for you. Just breath". When Mary stopped breathing, the Chief Resident pushed Ashley away from the bed, and he and the rest of the team began the code. Death was declared several minutes later. The team abruptly left the room, leaving Ashley alone with Mary's battered body. No one ever spoke to her about Mary's death.

When Ashley finished reading this story to me, she looked up and said, through her tears and without irony, "I just wish I'd been able to *do* something for Mary, like everyone else. I felt so helpless. Just useless and in the way." In the two years since Mary's death, Ashley had never shared this story with anyone at her school.

Clearly, the message Ashley had received is that she should not dwell on this traumatic experience. There was no place for her feelings, her human vulnerability. While she might not have been told explicitly to "suck it up, learn to be 'objective,' and move on", this was clearly the message – all too common in the training of health care professionals – of the "hidden" curriculum. Given the power and pervasiveness of this message, how could Ashley hope to learn to care for herself? How could she

¹ The medical student and her patient's names, along with other details of this story, have been changed to protect patient confidentiality. The medical student's story is narrated here with her permission.

face the traumas of her work – face them directly, honestly, *ethically* – if her work is utterly separate from her life, alienated from the familiar, *homely* life of her feelings, her embodiment?²

The answer, I believe, lies in Ashley's story, or rather, in her act of storytelling itself. In this act we discover an ethical alternative, an alternative that not only encourages, but even demands care of the self. We discover an ethics that "lightens the load on people," (Frank, 1995, p. 153) that is "reciprocal and reflective, [demanding] vision and courage, all the while replenishing one's store of vision and courage" (Charon & Montello, 2002, p. XII). In storytelling, we discover narrative ethics.

Stories are the primordial means through which we make sense and convey the meaning of our lives. It is this to which the philosopher Paul Ricoeur points when he speaks of "life as an activity and a passion in search of a narrative". For Ricoeur, our life is "the field of a constructive activity, by which we attempt to discover... the narrative identity which constitutes us" (Ricoeur, 1991, p. 32). Medical sociologist Arthur Frank reinforces the idea that our identities are formed through narrative when he writes that our, "very selves are perpetually recreated in stories. Stories do not simply describe the self; they are the self's medium of being" (Frank, 1995, p. 53). The power of narrative to create, express, and recreate the *unique* reality of the self – its irreducible, inassimilable particularity – has become increasingly manifest. Indeed, the primacy of narrative is acknowledged across diverse disciplines: Historians, cognitive psychologists, social scientists, theologians, psychiatrists, and literary critics" Charon and Montello note, have all "come to recognize the central role that narrative plays in the way we construct knowledge, interpret experience, and define the right and the good" (Charon & Montello, 2002, p. X).

Narrative ethics engages every level of our being, including and perhaps especially our emotional life. Looking "beyond a calculus of principle and reason", Richard Martinez writes, narrative ethics requires us "to account for the emotion so crucial to ethical action and to the ways in which stories work on us" (Martinez, 2002, p. 210).

As we saw above, Ashley could not understand the meaning of her experience at Mary's bedside until she had written and shared her story. Writing and reading her story, as I'll make clear below, allowed Ashley to re-interpret her role, to "define the right and the good," to value her experience in the context of a much broader ethical horizon, a horizon that embraced her particular, lived, emotional experience as a medical student, a young woman, a caring human being.

Narrative ethicists recommend that we learn to think *with* stories:

Not think about stories, which would be the usual phrase, but think with them. To think about a story is to reduce it to content and then analyze that content. Thinking with stories takes the story as already complete; there is no going beyond it. To think with a story is to experience it affecting one's own life and to find in that effect a certain truth of one's life. (Frank, 1995, p. 23)

² As Martha Nussbaum writes, "Our cognitive activity centrally involves emotional response. We discover what we think... partly by noticing how we feel; our investigation of our emotional geography is a major part of our search for self-knowledge" (Nussbaum, 1986, p. 15).

As Frank makes clear, the way that stories create and communicate meaning is primary and complete. There is not a more “fundamental” way of thinking that must be applied to stories in order to reveal their ethical import. On the contrary, storytelling itself is ethic’s invocation and attentive listening ethic’s response.

The first lesson of thinking with stories – Frank contends – is not to move on once the story has been heard, but to continue to live in the story, becoming in it, reflecting on who one is becoming, and gradually modifying the story. The problem is truly to listen to one’s own story, just as the problem is truly to listen to others’ stories (*Ibid.*, p. 159).

This final point of Frank’s – that to practice ethics one must truly listen to one’s own story – is key to understanding narrative’s role in the ethics of self-care. Since narrative is central to the understanding, creation, and recreation of our selves, we can truly *care* for our selves only by attending to our stories. Our needs, desires, aspirations are given both form and content – integrated and reintegrated into the continual unfolding of our selves – through the self-creating power of narrative. Narrative, Joanne Trautmann Banks writes, “inevitably expresses and transforms who we are at every level of our being.” (Trautmann Banks, 2002, p. 219)³. Through my self-story, I decide, express, and enact who I will be. I therefore take responsibility for myself through active, self-conscious engagement in the narration of my story. John Lantos writes that our ideas about right and wrong change only

by talking together about ethics, talking out loud, telling each other about our deepest convictions, our fondest and most fragile hopes, our darkest fears. By talking and telling the moral stories of our lives, we can try out new ways of thinking about the things that evoke in us complex thoughts and conflicting emotions. (Lantos, 2014, p. 43)

Storytelling’s ability to grant an individual life moral coherence is restorative, healing. This healing, however, is not just personal, but interpersonal as well. Narrative ethics recognizes that all of us, at one time or another, will become fractured, whether by illness or by professional setbacks, stress, disappointments, or even success. Narrative ethic’s recognition of this shared vulnerability undermines the modernist heroics that so effectively, and damagingly, alienates healers from ill people, from other healers, and from themselves.

Writing, reading, and discussing the story of one’s alienation, therefore, are often the first steps in overcoming it. This was certainly true for Ashley. During our discussion, we considered the role the “character” of the medical student plays in the story of Mary’s death. In this story, Ashley discovered, the student plays a much more important role than any of the doctors: Mary would have died whether or not Ashley was there, but her death would have been far less peaceful. While the importance of Ashley’s role seemed immediately obvious to me, as it would to most readers of her story, Ashley had not, previously, been encouraged to acknowledge the moral authority of her actions. On the contrary, her professional training had actively discouraged this acknowledgement. Every death, for medicine, is simply a defeat – end of story – at the hands of its worst enemy. Writing and sharing her story offered Ashley a means of memorializing Mary’s death – a means of preserving the memory, and so *placing* the meaning, of an event radically dislocated by her professional training. This was healing for Ashley. Reflecting on the story of her life, of Mary’s life, of *their lives*, Ashley heeded the imperative to care for herself.

³ As Hilde Lindemann Nelson puts it, narratives “make intelligible what we do and who we are; through them, we redefine ourselves” (Lindemann Nelson, 2002, p. 47).

Obviously, writing and relating the story of Mary's death could not possibly repair all of the psychic, and ethical, injuries Ashley suffered during her medical training. It was, however, an essential first step in what must be a continuous, ever-evolving narrative process: for Ashley, as for all health professionals, healing requires an ongoing commitment to narrative self-reflection.

I have witnessed the power of this commitment first-hand. For almost fifteen years, I have led Narrative Medicine Rounds for the family medicine inpatient team of the New York-Presbyterian hospital. We begin rounds every week by together reading aloud a short essay, story, or poem by a professional author. We then discuss the ways the author constructs and conveys meaning in her or his text. Following this discussion, I ask the team to write to a prompt, keeping in mind the narrative lessons we've learned in our discussion. When they've finished writing, the team reads their stories aloud, and we discuss them in much the same way as we discussed the opening texts.

Over time, the culture on the Family Medicine wards has shifted from one that, at best, tolerated thinking *about* stories to one that now fully welcomes thinking *with* stories. The benefits of this change are striking. One morning, for example, one of the attending physicians, Angela, asked if she could read a story to the team that she had written the previous evening. Angela has been with our program for many years, having completed her residency training at Columbia before joining our faculty. As an intern, Angela had been utterly focused on learning the medicine, the whole medicine, and nothing but the medicine. Like most interns, she was understandably resistant to anything that she felt might distract from this focus; all such distractions seemed to threaten her ability to keep her patients alive. Now, as a young attending, she is one of the faculty members most gifted at thinking with stories. I was therefore happy to set aside Hemingway's "Hills Like White Elephants," and the prompt I'd planned to use ("Write about a missed communication"), so that Angela could read the following story:

"My mother is dying" the voice says.

I must go see her. My family calls her "the fruit lady." She always brings a heavy bag of fruit, pineapples peeled ever since I told her I was too lazy to peel them. I can see her red lipstick and thick, straight, salt and pepper hair. Before the chemo, that is. There was something young and alive about her, even sexy, despite her 60 years.

"They put in a chest tube to drain the fluid and her lung collapsed. The other was full of cancer," her daughter explained. I had hoped this procedure would let her walk around without oxygen during these final few months.

I had forgotten that she had smoked many years ago, when she first complained that her throat felt tight, her heart was racing. It took a few visits to realize this was not a virus or a sour stomach. I told her right away, feeling encased in plexiglass during that conversation, trying to convey facts.

She rallied with her usual grace and we had two more years of warm, intimate visits, stories of her family and friends, bags of fruit. And now she was dying.

On the train there were lots of people shoved into the car, going home after a long day of work. What will I say to a room full of her family, even to her? What explanation can I offer them about why medicine cannot stop this process, this pain? How will I say goodbye, in Spanish, no less?

Presbyterian Hospital subway stop – so familiar, but somehow different tonight. On the way into the hospital, lots of important looking people – surely they have saved lives today. I am going to watch one end.

How does one say “goodbye” in Spanish? I racked my brain. Hasta luego, nos vemos, si “dios quiere”... what else? I seriously wonder if this is a language that does not have a word for a final goodbye.

The room is full of people. She is blue and in pain, struggling with each breath, her oxygen sat is in the 50s. I hold her hand and swallow my heart as she says, “Gracias por todo, doctora, te quiero mucho”. I whisper in her ear that I will think of her whenever I eat pineapple, that I love her too. I think she smiles.

The oncologist is gone for the day. I page the intern to double the morphine drip and cancel the CT scan that surgery requested to check the placement of the chest tube.

The subway is emptier on the way home. I feel oddly peaceful. I open the door to my apartment and see simple signs of life. Everyone looks pink and healthy. I breathe a sigh of relief. My husband is puttering around the kitchen. “How do you say goodbye in Spanish?” I ask.

He looks at me incredulously and says “Adios”.

Angela's story, I believe, highlights beautifully the benefits of a sustained, sustaining culture of ethical self-care. While these benefits are numerous, I would like to focus on the three that are most clearly in evidence in the story and in the team's response the morning it was shared: 1) attention to singularity, 2) heightened awareness of narrative temporality, 3) formation of community.

Singularity

It is narrative's focus on singularity that makes possible and structures all true moral deliberation, including deliberation about care of the self. What Arthur Frank writes about ill people applies equally to physicians and researchers: “My concern is with ill people's self-stories as moral acts, and with care as the moral action of responding to those self-stories” (Frank, 1995, p. 157). Moral activity has two sides: care given to the other in response to the other's self-story and care given to myself in response to my own self-story. By telling and attending to her unique story, Angela is called to respond to the self-care imperative.⁴ She is called to examine who she – is becoming *as a person, as a unique individual* – not as a substitutable role (“doctor,” “attending”). This examination necessarily entails asking whether her actions are good or bad for herself. As Barry Hoffmaster contends, the “crucial test of a story might be the sort of person it shapes.” (Hoffmaster, 1994, p. 1161) This test helps Angela to understand how she might care for herself and thus become the person she wants to be. Michael White writes that a person often finds herself “situated in stories that... she finds unhelpful, unsatisfying, and dead-ended, and... these stories do not sufficiently encapsulate the person's lived experience or are very significantly contradicted by important aspects of the person's lived experience” (White & Epston, 1990, p. 14). To care for oneself, therefore, one must take responsibility for one's

⁴ “The moral imperative of narrative ethics is perpetual self-reflection on the sort of person that one's story is shaping one into, entailing the requirement to change that self-story if the wrong self is being shaped.” (Frank, 1995, p. 158)

narrative situation: “[P]ersons give meaning to their lives and relationships,” White argues, “by storying their experience... [I]n interacting with others in performance of these stories, they are active in the shaping of their lives and relationships.” (*Ibid.*, p. 13)

Temporality

Angela's story, like all narratives, is a temporal configuration of events. This configuration is not strictly chronological. On the contrary, Angela begins in the story's “present” (*My mother is dying' the voice says*); flashes back to the past (*Before the chemo, that is*); returns to the present (*They put in a chest tube to drain the fluid and her lung collapsed*); moves back to a moment even further in the past (*I had forgotten that she had smoked many years ago*); narrates forward from this past to a point in the present just after the phone call (*On the train there were lots of people shoved into the car*); then narrates from this point forward through the hospital visit (*The room is full of people*), ending with the scene at home (*I open the door to my apartment and see simple signs of life*). This temporal configuration is crucial to Angela's ability to make sense both of her care for her patient and her care for herself. By bringing together events that are not contiguous in time, Angela's story sparks a flash of illumination that brings to light the meaning of her experience. As Rita Charon puts it, “we learn who we are backwards and forwards, early memories taking on sense only in the light of far later occurrences and contemporary situations interpretable only in the web of time” (Charon, 2002, p. 67). As Angela's story demonstrates, it is impossible to honor the imperative to self-care unless one attends to the narrative temporality of one's own self-telling stories.

At the end of her story, Angela returns to her home. There, she feels “peaceful”, she observes all the “signs of life,” and she “breathes a sigh of relief”. Surrounded by her loving and beloved family, she literally learns how to say goodbye to her patient. Like all good endings, this return to her home brings closure to Angela's story, a closure that gives to her experience, and so to her very self, a healing *wholeness*. Paradoxically, telling a story (her configuration *of* time) about her search for coherence (her experience *in* time) enacts the coherence for which she is searching. In Angela's case, the fruit of her story, if you will, is the story of her fruit.

Community

“Only connect,” E. M. Forster writes in the epigraph to his 1910 novel *Howards End*. (Forster, 1910) This admonition, I believe, is a vital expression of the self-care imperative. Indeed, Samuel Shem writes:

the primary motivation of human beings is the desire for connection... [T]he seeds of human misery are planted in disconnections, violations, isolation, and domination, and the core of healthy growth is the movement from isolation toward connection. (Shem, 1991, pp. 43-44).

Since the work of establishing interpersonal connections is fundamental to addressing “human misery,” ethics is nothing if not this interpersonal work: “Perhaps the greatest life-value of ethics,” writes György Lukács,

is precisely that it is a sphere where a certain kind of communion can exist, a sphere where the eternal loneliness stops. The ethical man is no longer the beginning and the end of all things, his moods are no longer the measure of the significance of everything that happens in the world. Ethics forces a sense of community upon all men. (Lukács, 1974, p. 57)

Narrative honors this centrality of community to ethics, particularly to the ethics of self-care. Angela's story beautifully illustrates the power of narrative to transcend isolation. Her story expresses and enacts a marriage between her work and home lives. Like all marriages, it is defined – as only narrative can reveal – by the web of relationships that comprise and support it. Angela's story reveals her active, self-reflective engagement in making interpersonal connections and fostering narrative coherence. She shows us how this coherence undergirds her familial and professional lives: she returns to her family to find the words to say goodbye to her patient. Yet the story itself fosters the very connections, the very coherence, which is its principal theme. Angela's is therefore both a story *about* self-care and an act *of* self-care.⁵ Yet again, Frank's reflections on illness apply to the self-care of both patients and medical academicians: "Serious illness is a loss of the 'destination and map' that had previously guided the ill person's life: ill people have to learn 'to think differently.' They learn by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared" (Frank, 1995, p. 1).

Reading her story to *this* audience, Angela fosters both the interpersonal connections narrated *in* her story (her family, her patient, her patient's family) and the interpersonal connections created *by* her story (the inpatient team). As Julia E. Connelly writes, narrative knowledge allows and encourages human connections. One shared story triggers the telling of other stories by involved listeners, facilitates memories and personal reflections on past experiences, if only silently

revealed, and creates an expanded awareness of the moment, including a recognition of the power of personal presence and connectedness. (Connelly, 2002, p. 145)

This "expanded awareness" was certainly in evidence the morning that Angela read her story. When Angela finished reading, we discussed the story's meaning and impact. Every member of the team – from third-year medical student through well-seasoned attending – was inspired to share a story from her or his own experience. In each of these stories the team discovered and created connections to all of the others, thus building upon and reinforcing the shared narrative coherence that characterizes a true community of storytellers. In opening to each other's stories, they healed the wounds of their heroic isolation.

Conclusion

To honor the self-care imperative, one must attend to one's self-telling narratives. David Morris writes that the "goal of narrative bioethics is to get the stories into the open, where we can examine their values, sift their conflicts, and explore their power to work on us" (Morris, 2002, p. 213). Opening health care professionals to their own stories is crucial to self-care. To effect this opening, ethicists

⁵ "If we assume the truth of the relational self, ethicists receive a personal dividend as they attend to one another's interpretations of the patient's story – their work contributes fundamentally to their own self-development". (Trautmann Banks, 2002, p. 224)

must contend with cultural and professional biases that work to keep these stories hidden. As Psychologist Jerome Bruner writes,

The fact of the matter is that if you look at how people actually live their lives, they do a lot of things that prevent their seeing the narrative structures that characterize their lives. Mostly, they don't look, don't pause to look. (Bruner, 2002, p. 8)

Fortunately, the native ability to see “the narrative structures” of our lives,” while underused, is not rare. This ability is almost certainly universal,⁶ and it is an ethical imperative that we employ it. We *must* pause to look, *must* bring our selves to light, *must* tell and here our own stories. Only then can we hold Mary through her terror at death's approach without losing ourselves to that terror. Only then will we have ourselves to offer, when we are called again to heal.

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⁶ Narrative capacity seems to be an innate human ability” (Hudson Jones, 2002, p. 160).

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