Literature, Ethics, and Medical Education: An Interview with Professor Ronald Schleifer

Chen Qi & Ronald Schleifer

Abstract: Ronald Schleifer is George Lynn Cross Research Professor of English and Adjunct Professor in Medicine at the University of Oklahoma. He served as editor-in-chief of the journal *Genre: Forums of Discourse and Culture* for more than twenty years, and as interim co-editor of Configurations: *A Journal of Literature, Science, and Technology*. The author of *Pain and Suffering* (Routledge, 2014), The Chief Concern of Medicine: *The Integration of the Medical Humanities and Narrative Knowledge into Medical Practices* (co-authored with Dr. Jerry Vannatta, Michigan 2013), *Modernism and Popular Music* (Cambridge 2011), *Modernism and Time* (Cambridge 2000), and *Intangible Materialism: The Body, Scientific Knowledge, and the Power of Language* (Minnesota, 2009), most recent of more than twenty books he has written, edited, and translated, Schleifer engages in a number of research areas, including criticism and theory, twentieth-century literature, literature and medicine, semiotics, and cultural study. (His first book, *A. J. Greimas and the Nature of Meaning*, was republished by Routledge this year.) Dr. Chen Qi, when attending the 6th Conference of Ethical Literary Criticism, Comparative Literature and World Literature (Oct., 2016, Tartu, Estonia), interviewed Professor Schleifer on a wide range of issues concerning literature and ethics in medical education, such as the definition of empathy, the reading and teaching of literature and ethics to physicians, and narrative transportation theory.

Key words: literature; ethics; medical education; ethical literary criticism

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标题：医学教育中的文学与伦理学：罗纳德·施莱弗教授访谈录

内容摘要：罗纳德·施莱弗教授任教于美国俄克拉荷马大学英语系，为 George Lynn Cross 教授，医学院联合教授。他担任知名学术期刊《文类：文化与话语研究论坛》主编逾二十年，同时又是《格局：文学、科学与技术》期刊的联合编辑。近年来撰写、编辑和翻译了二十余本学术著作，包括：《痛苦与折磨》(2014),《治疗的主要目的：在医学治疗中植入人文学与叙事学》(2013，与杰瑞·瓦纳塔医生合著），《难以触及的唯物论：身体、科学知识与语言的力量》（2009），《现代主义与时间》（2000）等，研究领域广泛涉及文学批评与理论研究，二十世纪文学，文学与医学，符号学与文化研究。其第一本学术著作《A. J. 格雷马斯与意义的本质》近期将由 Routledge 出版社再版。2016 年 10 月在爱沙尼亚塔尔图大学举办的第六届文学伦理学国际研讨会上，笔者有幸对施莱弗教授进行了专访。在此访谈录中，施莱弗教授对“共情”与“叙事转移”的概念及其在医学教育中的运用提出了独到而深刻的见解。他指出对医学工作者进行文学与伦理学教育，有助于他们了解患者病痛背后的真实情况，优化正确治疗方案的制定。在施莱佛教授及其同事的努力之下，美国已将文学与伦理学教学纳入医学生的课程体系与医生职业执照考试范围之中。

关键词：文学；文学伦理学批评；医学教育

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Chen Qi (hereafter Chen): Dear Professor Schleifer, thank you for accepting our invitation to have this interview. The 6th Conference of Ethical Literary Criticism, Comparative Literature and World Literature provides us the greatest opportunity to discuss a wide range of topics concerning literature and ethics. In your speech yesterday, you introduced the functioning of vicarious experience in narrative and poetic representations of pain and other human responses to the world in the teaching of medical ethics and empathy in programs for the training of healthcare workers. Since such literary ethical education for medical students is really new to Chinese teachers and critics, would you please first introduce the present situation of this practice in America?

Ronald Schleifer (hereafter Schleifer): In the USA in the last fifteen years many medical schools have started programs in the humanities. And the major component of these programs is medical ethics. In USA, there are approximately 150 medical

schools, and a good number of them — more than half I would guess — have required courses in the humanities for medical students. In our university, for instance, the University of Oklahoma College of Medicine, students are required to take 6 hours of humanity courses. One of the options is to take a course focused on medical ethics. When I teach literature in medicine, ethics has always been an important part of the course. This is because in large part, as my paper discussed yesterday, literature is one of the most important vehicles for sensitizing people to ethical questions.

Chen: Yesterday during the question and answer section, Professor Dorothy Figueir mentioned that these programs actually have been part of the new trend for almost 30 years, but in the past, medical students did not tend to choose literary courses. What do you think are the changes that have taken place since the institutions of these programs? And what can we learn from the practice of these programs?

Schleifer: As a matter of fact, in the USA we have a national examination for medical school, which is called MCAT (the Medical College Admission Test) administered by the American Association of Medical Colleges, and two years ago the format of the examination was changed, with the addition of questions focused on the humanities and sociology and ethics. What's happening in the USA, Europe and probably all over the world is that physicians are behaving less and less sensitively towards patients, partly because they are busy, or they want to treat the patients routinely rather than individually. And another reason is that patients are becoming more knowledgeable, because of the internet. They are much more likely to be unhappy with their physicians because they think there are other sources of knowledge. So one result of the present situation is what we have been trying to do in America: that is, to train physicians to be more sensitive to their patients. For instance, one of our largest medical schools, Mount Sinai School of Medicine in New York City, has started the policy a few years ago, to accept a large proportion of students to medical school who do not take the scientific MCAT exam. They are called the "hum-med" [humanities medical students]. What they discovered, which I think is really wonderful, is that the students who have been trained in the humanities, do not do worse in their medical school courses than any of the students who trained in the sciences.

So throughout the country there is concern about sensitivity to patients and one of the things has to do with what I call "everyday ethics." A few years ago I wrote a book with a friend of mine, Doctor Jerry Vannatta. The title of the book is *The Chief Concern of Medicine*. Where the title comes from is the fact that in

USA the first thing the doctor writes down when they meet patients is what we call "the chief complaint." That is, they ask the patients what brings them in to see the doctor. In America, the doctors write down about the patients in words, so the patients might say: "I had a terrible headache for two weeks." What our book is about is adding to the protocols of the interview. The next question the doctor may ask is: "what concerns you about your symptoms?" That creates a moment very early in the interview when the doctor does not know the answer. The patient may say, "I fear I have a brain cancer" or "I am afraid I may not see my children graduate," or "I fear I may lose my job." These are the things that the doctor can't imagine. That creates a moment when the patient is helping to define what he or she means by "good health" rather than a doctor defining "health" for the patient. This process of engaging with the patient involves what we call in the book "everyday ethics." We distinguish between "neon" ethics — the "bright light" issues — of big questions of high visibility, such as abortion, euthanasia, or domestic abuse. But "everyday ethics" is just the way people behave towards one and the other on a daily basis. I mentioned in my speech yesterday in the questions and answers, that when one philosopher talks about everyday ethics she says it's like mopping the floor. It goes like this: everybody expects you to mop the floor, but nobody thanks you; and if you don't do it, everyone is annoyed. And the philosopher goes on to say: "if you are a doctor, if you come in and smile at the patient in greeting him, things will be different than if you don't." The doctors always say they are very very busy, and they are really busy. But some researchers have run an experiment, which is really remarkable in proving that tight schedule should not be an excuse for not engaging patients on a personal level. They did the experiment in one of our hospitals. They had the doctors go to visit the patients in the rooms, and each doctor spent exactly one minute with the patient. Half of them stood up and talked down to the patient; the other half sat on the bed, touched the patient and looked into their eyes. Then they asked the patients afterwards how long the doctor was there. For the standing doctors the patients said they were there for 15 seconds. And for the doctor of the second group, they said 5 minutes. So there are ways to treat patients without a large cost of time. Another group of researchers did another experiment, in which they recorded interviews between doctors and patients. Half of the doctors have been sued for malpractice at least two times, and the other doctors had not been sued. Then what they did is that they took the interview and erased all the high pitch sound, while all the low pitch sound remained. This created a sound-track where one couldn't understand the words, but was able to understand the tone of voice of the physicians. Third parties listened to these tapes, and 99% of them

were able to recognize the doctors who have been sued simply by their tone of voice. This suggested that patient disapproval of physicians was simply because the doctors are rude to the patients. That's part of "everyday ethics" that we talk about in the book.

Besides, in our book, Jerry and I talked about the three major schools of ethics. The first is "normative" ethics, which describes things that seem to be naturally ethical. Examples of this category will be the teachings of the great religions, such as "do unto others as you would have others do to you" (the Christian "golden rule") or "develop compassion" (the Buddhist Eightfold Path). In medicine we call this "principle-based ethics." The second kind of ethics stems from the English philosopher Jeremy Bentham, who said that the best way to measure ethical behavior is the greatest benefit for the greatest number. It is a very calculating ethics insofar as it bases ethical behavior on measuring outcomes. What we advocate in our book is what's called "virtue ethics." It comes from the teachings of the Greek philosopher Aristotle. It has to do with the ethics and action insofar as virtues display themselves in the everyday action of people. That's why I raised the question yesterday in the second session concerning the fact that people sometimes distinguish between "ethics" and "morality." From the point of view of "virtue ethics," there is no distinction. Morality is how you behave and ethics are the principles by which you behave. But in "virtue ethics" the principles are embodied in your behavior so the doctor who smiles is virtuous even if they don't consciously choose the "principle" of friendly behavior or "calculate" that smiling will lead to a better outcome. The sub-title of our book, "The Place of Narrative Knowledge in Medicine," emphasizes that ethics manifests itself in everyday action. There are several reasons why we find the "virtue ethics" so useful. The first reason is because it emphasizes every day "habitual" action; the second reason is because it emphasizes that ethics is central to the ordinary practices of healthcare. One of the ways we can analyze the virtuous behavior is by analyzing how narratives work. Our book is about how teaching physicians to understand narrative; it aims to develop strategies to teach healthcare workers to be more sensitive to the stories that patients tell. So that is what "virtue ethics" about in our book.

Chen: In your speech and your book as well, the "narrative transportation theory" serves as one of the references for your argument of understanding narratives. So would you explain more in details the theory and how it is applied in your research?
Schleifer: Narrative transportation is the term psychologists use to describe what I call "vicarious" experiences. I, myself think this term "transportation theory" is not

particularly good because it is a spatial metaphor even though what the vicarious experience narrative often provokes can allow us to share someone's thoughts rather than "transport" us to a new place. About ten years ago, a psychologist wrote a book about how certain experiences of narrative transport us into the situation that the narrative describes. In the last 15 years, there have been a large number of rigorous psychological studies that measure the degree to which the readers are transported to the situation a narrative describes. One of the conclusions they have come to is that "aesthetic narratives", that is to say art narratives, stories, novels, movies that are designed to be experienced as such, much more than ordinary narratives people tell one another, have developed linguistic strategies that enhance the vicarious experience of readers. Suppose a patient comes in and tells me a story: their stories have a particular purpose, namely to offer information to the doctor. Art narratives are much more effective in transporting the readers into the situation because their aim is to provoke feeling rather than convey information. Yesterday I was talking about Roddy Doyle's novel, *The Woman Who Walked into Doors*, which is about a woman who suffers physical and sexual abuse from her husband over about 17 years. It's narrated by the woman, and the language of the author, who is actually a man, used in relation to her *experiences* allows the readers, the medical students, to understand and experience the situation of domestic violence in ways that most people aren't able to. Transportation theory wants to understand — on the level of cognition and emotion — how that takes place. The argument I was making was, first, that narrative provokes a similar experience. Then because literary narrative presents itself through language it creates the situation where you can reflect on that experience to make ethical judgments about it. So in analyzing the novel I try to describe some moments in the writing where the author presents some situation which readers experience vicariously, and then provokes the reader to reflect on that vicarious experience. That reflecting allows people to make ethical judgment about the experience of the world.

Chen: In your speech, I remember you mentioned a very interesting example, which explains how the child monkeys will learn from the older monkeys in pretending fights, what you described as "play-fighting." My understanding of the example is that in the process the monkeys will learn how to behave when they grow up. Is this example for the purpose of explaining how we may teach ethics among humans?

Schleifer: First, let me introduce the theory behind the example. One of the things I talked about in my speech was the study done by a scholar who studies narrative,

Francis Steen, who analyzes films of Rhesus Macaques monkeys' play fighting. What the Rhesus monkeys do is that the older male individuals will pretend to fight with the younger individuals in the troop of the monkeys. The adult moneys do so in order to teach the younger monkeys what to expect when they have real fights. Steen analyzes the behavior of the monkeys in relation to the story of *Little Red Riding* Hood in terms of narrative structure. I myself have done a lot of works in semiotics with A. G. Greimas. One of the things Greimas offers is a structural analysis the way narrative works. The first reason I brought up that example is that Steen's argument, which I think is true, is that narrative comprehension is not a cultural phenomenon but an inherited phenomenon. It is an evolutionary adaptation. It allows us both humans and other primates to be adapted to the world by means of a *social mechanism* that allows for sharing and remembering things about the world and experience. There's pretty good evidence that small children around the age of 3 or 4 can distinguish between well-formed and ill-formed narratives that they never heard, and that's remarkable fact. They can also distinguish between grammatical and ungrammatical sentences. Greimas is interested in developing a grammar of narrative. It seems to me that we all process narrative information by means of narrative grammar. One of the things that the medical school does as a scientific training is to teach people to ignore that knowledge, the knowledge of narrative grammar. One of the things we are trying to do in studying the relation between narrative and medicine is to re-sensitize doctors to storytelling. So the purpose of the example of monkey play-fighting is to suggest that narrative understanding is a natural phenomenon. In my speech I was talking about vicarious experience and ethic education, which, I think, are built upon our ability to apprehend information in narrative form.

Chen: One of the purposes of the ethical education for the medical school students is to arouse their empathy towards their patients. While greatly involved with personal emotion, the empathy of a physician may counteract the objectivity of science. Do you think the problem of a conflict between the empathy and the objectivity of science will be the obstacle of the ethical education for the physicians?

Schleifer: First I want to clarify what we mean by empathy, which I didn't say much about in my speech. There is some controversy. Some people say empathy is sharing the feelings with somebody else. Others say empathy is comprehending or understanding the feelings of somebody else. Doctor Rita Charon, whom we interviewed for our book, offered a wonderful description of empathy. She had a

patient, a 90-year old woman who had Alzheimer's disease. So the patient could not remember very well. She thinks it is 1930 when it is 2010. Dr. Charon said that: "I can't put myself in the position of that person, but I can image what she is going through. I can imagine that she cannot use the telephone because she can't remember the numbers. She can't cook because she can't remember where the rice is. She can't leave the house because she will get lost." Then she goes on to say: "I can imagine these things, but I don't have to feel them." Empathy is that kind of empathetic imagination. Then she goes on to say: "when I can image such things I am in the position of making ethical judgment." What she should do is to help this person. Dr. Charon wonderfully notices that: "even though my patient does not remember where she is, she still feels respect." To display respect for patients is an ethical act. Part of the job of physician is to empathize under the category of understanding and to use that imaginative understanding to figure out strategies to help people. So that is my understanding of empathy, and that's why we try to teach the students. I talked in my speech that one of the functions of Roddy Doyle's novel, *The Woman Who Walked into Doors*, is to teach people that women, who are battered by their husbands, can be understood more fully. Many people, most properly almost everywhere, especially in America because of our traditions, ask themselves why abused women would keep themselves in that position; why they won't just leave. When you read that novel you learn why. That's the kind of imaginative understanding, at the heart of empathy, that Dr. Charon describes.

Chen: Your explanation of empathy reminds me of the teachers, who are more likely to do their job better if they have children at home.

Schleifer: Even if they are not a parent, they know parents, because they have parents. So they can image being a parent. Part of empathy is that one need not have an experience in order to imaginatively understand it. So you do not have to be a parent to imagine what a good parent is, because we've all being children.

Chen: During the questioning and answering after your speech, other scholars mentioned the problem of the sincerity of the first-person narrative. Do you think the first person narrative is reliable in the story?

Schleifer: There are two facets of ethical education from literature. The first is the experience, and the second is the judgment of the experience. Reliability only focuses on the judgment part. In other words, when Paula, the protagonist and the first person narrator in Doyle's novel, describes how it feels to be beaten by her husband, somebody she lives with, that narration creates feelings. We

might say her judgments of those feelings are unreliable, but we can't say that the feelings themselves are not reliable. So the reliability of the judgment is not a problem. Some authors create unreliable narrators in order to stimulate judgment on the reader. Other authors think they can stimulate ethic judgment with reliable narratives. But for the purpose of teaching people to reflect on the experiences that they didn't have but that they can imagine, it doesn't matter whether the narratives are reliable or not.

Chen: The novel, *The Woman Who Walked into Doors*, serves as both the reading material for your medical students and the object of analysis in your speech and paper. The novel tells the struggle and survival of an abused wife. My understanding of domestic abuse is that it is an interactive relationship instead of a one-direction assault, because the victim might not be able to find a safe place or physically and mentally strong enough to get rid of the relationship forever. Do you agree? And do you think medical students and doctors will be aware of such relationships?

Schleifer: Yes, I think so, to some degree. The novel is about the lower class family in Ireland, but in the USA — and in Ireland, too, I suspect — abuse is not confined to any social class. There is domestic abuse in the middle class and the upper class as well. It's primarily but not exclusively abuse by men against women. There are relationships that women abuse their husbands or their partners. Now in our country, many communities are creating safe places for victims of abuse. But it is very difficult, for lots of reasons, not least of which are our social services are not as good as they could be. But when you say that people are not strong enough or do not have enough character to leave, one of the things we learn from reading Roddy Doyle's book is that those judgmental categories are not particularly useful when healthcare workers encounter victims of domestic abuse. It is true that Paula is not strong enough to leave her husband, but the point of reading that novel is not to judge her strength or weakness. It is to allow physicians to recognize a situation they might otherwise ignore. In the novel, all Paula's doctors ignore her. I think I mentioned an example from my physician friend Jerry Vannatta in my last week's class. Jerry told me that, just after he read this book, he had one of his patients come in with a bruise on her eye. By the way the patient was a middle class woman; she was not a working class woman as Paula is in the novel. She said that she had a car accident. She had her head hit on the steering wheel. Jerry said earlier in his career he would just take her word, but this time he looked at her and said "that bruise couldn't be made by steering wheel. It looks like made by a fist." And

the patient started to cry, and said her husband, who was also Jerry's patient, had hit her and regularly beat her. What Jerry said to her is fascinating to me. He said to her: "I don't know what's going on, but you don't deserve that." Nothing happened immediately when Jerry said that. But it turns out a few months later his patient got divorced, and moved to California from Oklahoma, and ended up working in the program to help battered women. What we teach students is that when you are in the position of authority as doctors are — and teachers as well — you don't have to worry that everything you say has an immediate effect. This woman heard somebody whom she respected said she didn't deserve this kind of behavior. It allowed her to think about herself in a new way over time and reflect upon her experience, just as novels often compel us to reflect upon experience. That's what I said in my speech that ethics are always future oriented. It is about what will happen in the future. People are never too young to be treated with respect. This includes Dr. Charon's elderly patient and Dr. Vannatta respectfully telling his patient his truthful judgment about her facial bruise. I tell my students that even small children need to save face, so you can discipline people without humiliate them. The respect we show one another is not something that happens on one day. It happens over time.

Chen: Do you know anything about ethics teaching to medical students in China?
Schleifer: No. I wish I did. But right now I have a visiting scholar in my medicine classroom from China. She is writing the paper about developing a curriculum to teach Chinese medical students literature. We in America have much to learn from the experience and traditions of Chinese medicine. I look forward to it.

Chen: Did the visiting scholar mention that Chinese doctors are working under great pressure, as they often have to treat more than a hundred patients a day. It will be very difficult for them to keep emotionally stable and patient with their patients. The relationship between the doctors and patients is tense. Sometimes patients may accuse the doctors of malpractice even though it does not exist. In some circumstance, they even physically attack the doctor.
Schleifer: I know very little about this. But my point is that it doesn't cost a lot of time to treat people respectfully, with a smile, looking them in the eyes. But a hundred patients a day is really a great burden, because our doctors are busy when they have 25 patients a day. It is a great difference. I wish I can know more about the Chinese ethical education in medical practice in the future.

Chen: The last question is about this conference. Do you find any particular topic more interesting or inspiring?

Schleifer: I've been enjoying the conference. I've been introduced to Professor Nie Zhenzhao, who is writing the book of ethics in literature; I am looking forward to reading that book. The tradition of ethics in China has a lot to teach us in the West. Yesterday's talk by Prof. Wang Songlin is about the five Confucian virtues. I've wrote them down because when I go home I want to teach these to American students. We have a lot to learn from the Chinese, ethics especially. Yesterday's talk by Prof. Wang Songlin was also about Thomas Carlyle and how much he learned in 1837 from the Chinese wisdom of tradition. I know our medical school students can learn a lot from that as well.

Chen: Thank you once again, Professor Schleifer, for taking this interview.

Schleifer: Thank you, Ms. Chen, for the wonderful questions.

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