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Asking the Right Question about Pain: Narrative and Phronesis

Arthur W. Frank

Professor Emeritus in the Department of Sociology, University of Calgary; currently Professor II at VID Specialized University, Norway.

A project shared by humanities in medicine, bioethics, social scientific studies of medical practice, and related studies can be summarized by the following question: How can we reduce the gap between suffering caused by the body's deteriorations, whether the result of illness, disability, or aging, and the total suffering that attends these deteriorations? In approaching this question, a significant clinical, scholarly, and personal ideal is thinking with a story, as opposed to the more conventional academic and scientific approach of thinking about stories[1]. Thinking about stories is useful, and I will engage in that kind of thinking in this article; but a problem arises in what gets lost when stories are only thought about.

Like most distinctions — including my distinction above between natural and socially incurred suffering — thinking with and about stories marks a continuum, not a dichotomy, but the terms suggest real differences of interest and method. Thinking about stories implies making a story the object of the gaze of an expert who produces an analysis. Analysis requires stable objects, so the story that exists in the transitory activity of telling becomes fixed as a narrative text. Thinking with stories involves a hermeneutic of mutual engagement; a story is one aspect of a complex of nested relationships that remain in process. Thinking with stories involves taking one's own place in that process, in which all participants will continue telling stories about each other and about themselves[2].

In thinking with stories, one story necessarily leads to another, just as the attempt to define a word leads to other words that require definition. A person stops looking up subsequent definitions not because some end has been reached, but because she or he has the feel for the word that started the process — or has simply had enough. A story about thinking with stories can be crafted to provide an

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[1]I discuss thinking *with* stories in *The Wounded Storyteller*, 23-5, 158-63. 1 took the idea from personal communication with Julie Cruikshank, subsequently published in her book, *The Social Life of Stories*. David Morris expands the concept in "Narrative, Ethics, and Pain."

[2] The social scientific recognition of the ethnographer as a storyteller who is part of the story is developed in a large body of literature. See, for example, Van Maanen, *Tales of the Field*. In the philosophical literature, see MacIntyre, *After Virtue*: "Each of us being a main character in his own drama plays subordinate parts in the dramas of others, and each drama constrains the others" (213). I would add that each drama also enables the others.

illusion of closure, but at the end it would be more honest to continue on to other stories. At the end of this article I create recognizable closure by the academic device of giving the preceding process a name with a philosophical pedigree. This ending is only another sort of beginning, though the reader will probably have had enough and will appreciate my stopping.

In this article, I want to think *with* a story specifically about pain. The story is told by Vanessa Kramer as part of a speech she gave, in the mid-1990s, to a group of cancer survivors; Kramer herself was living with metastatic breast cancer. Within her own story Kramer narrates a story that her aunt told her, and here we find the nesting of stories and relationships. Kramer tells the story as a conversation with her aunt; in effect, she brings her aunt to the-meeting. Her aunt's story is in one real sense, that woman's own story. But in just as real a sense, the story serves as Kramer's medium for expressing what is happening to herself, and it offers her listeners a way of organizing their experiences. The question of whose story this is becomes complicated. Ultimately, the story seems to be no one's *own*; it exists amid all these relationships, which the story itself works to shape.

Kramer's aunt — to whom she does not give a name, so I will not name her either — has just had exploratory abdominal surgery, which discovered cancer so extensive that she was told "nothing could be done"[3]. The story, presented here as a fixed text, describes her postsurgical treatment:

> *It was late in the evening, and the staff was efficiently bustling around her* [the aunt's] *bed setting up an automatic dispenser for pain control drugs…. Everything was in place, the staff went away, and my aunt was left to ride the roller-coaster of her own thoughts, but the first time she pushed the button, the machine, to use her words, "blew up."*
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> *This event produced prompt and intense activity. "Do you know," she said, "I had six of them in there… all trying to fix the machine. They seemed to take an eternity." (When we are in great pain like this, eternity has a way of opening up under us, and over us, and to the side of us.) In the end, the machine was deemed impossible to repair, and the crowd of people left, wheeling it with them, leaving my aunt alone. "They were all totally avoiding me," she said. "It made me feel so alone, so utterly alone. I felt as though I must be the only person this had ever happened to."*
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> *After a while a nurse came in, all efficient and professional with a questionnaire. This was presumably a standard questionnaire to establish a course of pain control. My aunt said, "You'll never guess what the first question was: 'What do you perceive to be the source of your pain?'" My aunt felt as though she had been caught in an absurdist play. How could the nurse not see? There's always physical pain after this kind of surgery. There's always emotional and psychological pain when treatments fail.*
>
> *But here the thread of mortality that is within all of us, all our lives, was emerging and becoming clearly apparent in her. Everyone in the room knew it was so. But once the technology broke down, from my aunt's point of view, that particular group of health care professionals was left resourceless. As my aunt said, "No one made eye contact with me. No one reached out to touch me[4]".*

That final, poignant line — "No one reached out to touch me"— expresses the social increase to suffering. Kramer's aunt is dying, and both the physical disease processes and her sense of her life coming to an end cause suffering. My concern is how the way she is treated — the acts of omission and commission at her bedside — increase her suffering. How do the good people at the bedside, and I assume they *are* good people who went into medicine because they wanted to reduce suffering, end up acting in ways that make things worse?

[3] Kramer, "Case Story," 1. I should note that I was the editor of the series of articles in which this story appeared. I discuss Kramer's whole story in *The Renewal of Generosity*.

[4] Ibid., 1, 4.

Thinking *About* the Story

When I wrote *The Wounded Storyteller* in 1995, my purpose was to enhance the capacity of clinical professionals to listen to stories like Kramer's. To that end I proposed a typology that would give working clinicians a sense of what to listen for. Frameworks facilitate thinking *about*. Without a framework to contain it, a story can be easily dismissed as a one-off occurrence, a sad tale that has little claim on the listener. Claims can be instrumental, calling on the listener to do something, but the more consequential claims require the listener to become someone different, to understand his or her place in the world differently, because he or she now exists in a new web of relationships. When the story's claim becomes personal, thinking shifts from *about* to *with*, and the framework that enabled the initial listening can fade into the background.

The Wounded Storyteller proposes that particular illness stories weave together three recognizable types of narrative — restitution, chaos, and quest — one of which usually predominates. Kramer's aunt is in pain, and medicine promises to restore her to her previous, pain-free existence. That narrative of restitution, including the means of achieving restitution, shapes what people are able to experience at the bedside. What does not fit the narrative does not register as experience; what falls outside of narrative becomes as invisible as Kramer's aunt, who says that the staff was totally avoiding her. She seems to have dropped out of their narrative even before the story of the pain-medication machine begins; once the narrative centers on restitution, the machine becomes the central actor and the object of the staff's attention. *Their* story is that the machine serves the end of restoring the patient's pain-free existence, but really the patient is something that the machine requires, not vice versa.

The machine's breakdown is more than mechanical; it is a narrative breakdown as well. Mechanical breakdowns can be fixed with more work, but narrative breakdowns have the effect of making any further action seem impossible. No wonder the staff runs away.

Restitution stories can represent the noblest aspirations of medicine, but they cause trouble when they deny mortality. Daniel Callahan offers a fine example when he quotes a biotech CEO saying, "Death is a series of preventable diseases"[5]. What we see at the bedside of Kramer's aunt is the *narrative imperialism* of restitution; no other story is allowed into the room. That imperialism creates this absurd scene of the nurse asking a patient who has just had major surgery and has been told that she will die sooner than later from cancer what she perceives to be the source of her pain.

Asking about the perceived source of pain can be a good question. Like any tool, it is perfectly useful in the right situation. But here the question is applied indiscriminately, asked in the wrong way and at the wrong time. The nurse does not speak from her own perceptions and sensibilities. Instead, she recites a script that includes the question, "What do you perceive to be…?" She follows this script instead of attending to her patient. Medicine likes to use this word, "attending", but turns it into a noun, losing the moral significance of the verb, "to attend to," in the sense of paying close attention.

Those among the medical staff cannot see how absurd they look to the patient because they cannot imagine the story from her perspective. This lack of narrative imagination generates mutual alienation between patient and caregivers. Each appears strange to the other: the patient finds the staff absurd, and they would probably respond by saying that her reaction fails to understand their work. We can suppose that room also contained some clinicians who did imagine different narratives and did feel absurd acting as they did, but who believed they had to remain silent. They are alienated from their profession and, ultimately, from themselves.

The bedside scene totters on the edge of being a chaos story, the second general type of illness narrative. In chaos, time collapses into an eternal present — the eternal present that Kramer describes is one of acute pain. Spatial relationships also collapse. People who are living in chaos experience others coming at them, pressing in on them with demands that seem threatening. The temporal sequence of these demands is incessant: before one can be responded to, another is asserted. The world of chaos is one in which order and control are lost and have been replaced by jabbing, aggressive, continuous demands, without sequence.

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[5] Lawrence M. Fisher, "The Race to Cash in on the Genetic Code," *New York Times*, August 29, 1999, C1, quoted in Callahan, *What Price Better Health*?, 67.

Narrative seeks to redeem life and pain from chaos by creating sequence. Frank Kermode writes that narrative is the attempt to humanize time "by giving it form"[6]. In narrative form, one event seems to belong before and after others — not to happen randomly but to *make sense exactly there*. Temporal sequence implies causal priority: once narrative sequencing asserts that one thing belongs first, another thing can be deferred until later; it can wait, and the possibility that things can wait humanizes life.

Chaos stories are antinarratives in that they are told from within *dehumanized* time — time without order and thus without meaning. Fortunately, Kramer's aunt seems too wise and possessed of too good a sense of black humor to fall into true chaos. When she turns her experience into the telling of a story, and when her equally wise niece validates the story, their relationship of storytelling humanizes the chaos of what has happened to her. Through her story she reinserts herself into a humanized temporality and gives herself reassurance that she has time. Teller and listener together transform medical insensitivity into an absurdist joke. Later, when Kramer retells her aunt's story to a meeting of cancer survivors, she implicitly teaches them how to tell their own stories and keep themselves out of chaos. Stories rehearse future events as much as they recollect what is past[7]. By "rehearse," I mean that stories anticipate which narrative frameworks will be useful in shaping future events so that we can survive them.

The third kind of general illness narrative is the quest narrative in which people understand illness as a source of some insight. This insight has value not only for the person who acquires it at great cost but also for the healthy, those who live cocooned in the belief that only others exist on what Susan Sontag calls the "night-side" of life[8]. The quest narrative is animated by the belief that healthy society suffers but does not realize it is suffering. The quest aspires to bring to both ill and healthy the insight that it is an illusion to divide life into two sides, light and dark or whatever set of metaphors one chooses. The "thread of mortality," as Kramer calls it, persists, always part of life, and if people could learn to live with it instead of living in fear of recognizing it, then not only would health care be humanized but life in general might become a great deal more humane. Death is not a series of preventable illnesses; rather, life is an unpreventable death, and that is all right. In quest stories, the person who has come closest to death returns to tell us not to be afraid; death is as necessary to our renewal as sleep and winter.

This quest spreads to all who recognize the story's claim on them and who witness the story by continuing to tell it. No story is any one person's *own* because the story is always already told in a relationship. When we acknowledge that the story has a claim on us – and the pronoun has to be first person — then we cease thinking *about* the story and start to think *with* it. The analytic framework fades into the background, and one story leads to another.

Fear and Redemption in the Quest

My recent thinking about stories revolves around what I call the G twins. (I learned from *The Wounded Storyteller* that if you propose anything that looks like a typology, shape the language so that commentators will have to realize it is a trope, not a theory.) The G twins are rarely all that is going on in a story, but they are usually an important part. One G stands for the monster Grendel from the epic *Beowulf,* and the other stands for the Holy Grail. Grendel and the Grail are not types of narratives so much as they are presences or forces that pervade many narratives, taking different forms. Grendel represents what we believe can destroy us[9]. The Grail represents some force that can heal and redeem us. We fear Grendels; we desire Grails.

In the epic *Beowulf*, what animates the action is that every night Grendel creeps into the safe space of the common hall, where everyone sleeps, and carries off one of the warriors. Beowulf's quest is to

[6] Kermode, *The Sense of an Ending*, 45. See also Chambers, The Fiction of Bioethics, 81.

[7] On how stories emplot a future, see Mattingly, *Healing Dramas and Clinical Plots*. For examples that show how people use internalized stories to rehearse future courses of action, see Mead, *Mind, Self, and Society*.

[8] Sontag, *Illness as Metaphor*, 3.

[9] See Heaney's introduction to *Beowulf* for a brilliant evocation of what I am calling the Grendel force.

kill Grendel and restore safety to the hall so that the warriors can sleep in peace. The epic might be a restitution story if it ended after Beowulf's success, but it includes a second episode in which the older Beowulf is killed by a dragon. For the ancient Anglo-Saxons, any restitution was understood as provisional. At best, the hero can keep chaos at bay, and eventually that work will kill anyone. All gods have their twilight. Somewhere in almost every story is some force bringing with it the possibility that the events in the story might develop in a way that will destroy the characters. That force has to be kept away, at a distance, out of the safe space within which there ought to be light and kinship. Among those of us living in relatively secure, first-world environments, serious illness that incapacitates or kills is the Grendel that many people fear most often.

If most stories have some Grendel force, they differ crucially as to whether or not they can name their fear. Stories like *Beowulf* deal explicitly with the intruding force of loss and suffering; they give that force a name and naming humanizes feat. Other stories refuse to name the threatening force. These stories are performed in order to keep the Grendel force outside of the telling of the story and thus beyond the horizon of articulate recognition of teller and listeners. These stories are artfully constructed to prevent anyone from having to admit to anyone else what each recognizes but remains silent about; it is as if the integrity of the storytelling community depends on not naming the Grendel force. That tacit agreement to silence is what Vanessa Kramer describes going on among the professionals at her aunt's bedside.

In that postoperative setting, the questionnaire about pain perception, however valid it might be for some purposes at some other time, works as a narrative device that judges stories to be acceptable only if they do not name what they ultimately fear – mortality — and only if they speak of what they immediately fear — pain — in a language dissociated from emotions like grief. The recognition of mortality and the affect appropriate to that recognition would require a completely different storytelling scene.

The other G twin, the Holy Grail, represents some lost object that, if found by the right person, has the power to heal and to redeem. In Grail stories, some crisis animates the hero's quest to find the lost object that is the sole means to remedy the trouble. Grails take multiple forms, giving plots different shapes. A variation relevant to Kramer's story is the plot of *The Lord of the Rings*. The ring is an inverse Grail: life is good as long as the ring remains lost; as soon as it is found, it corrupts and destroys. The quest is not to find the ring but to destroy it, and that destruction will heal and redeem. In Kramer's story people invest a techno-object with powers to set things right; when their faith in this object proves misplaced, they are left vulnerable in their resourcelessness. Both *The Lord of the Rings* and the medication-machine story can be called false-Grail stories, and they can be traced back to stories of false gods and idols. The medical staff's attention to the medication machine is a form of idolatry, with Kramer as a modern Moses, coming down from the mountain to smash it.

One of the first Grail stories is the quest of Parzival, the young prince whose mother fears that if he becomes a knight, he, like his father, will be killed in battle[10]. So she raises him in perfect ignorance of who he is and of what the world is. Since parental intentions always have the opposite effect, Parzival becomes a knight, and his naïveté leads him to do things that other knights either fear to do or have the mature judgment not to do. These actions have both good and pernicious effects, and as Parzival becomes more self-reflective, he learns to recognize these effects and take responsibility for them. It is entirely too easy to imagine a contemporary retelling of Parzival as a young physician.

The best-known part of Parzival's story occurs when he arrives at the enchanted castle of the wounded king, Anfortas. Anfortas has been wounded by a boar, and the wound festers, causing him great pain. The festering wound causes a stench which the poet, Wolfram Von Eschenbach, describes in graphic terms. Everyone breathes better when Anfortas is outdoors fishing; hence he is known as the Fisher King. The presence of the Holy Grail keeps Anfortas alive, but the effect of the Grail is not benign, at least not for the king who wants most of all to be allowed to die and therefore released from pain. The Grail is not unlike the contemporary intensive care unit (ICU), in which people are sometimes kept alive, suffering, for purposes that are unclear. Unlike the ICU, the Grail's purpose is

[10] See Von Eschenbach, *Parzival*. Among the numerous contemporary retellings of Parzival, I rely especially on Paterson's *Parzival* and Clarke's *Parzival and the Stone from Heaven*.

pedagogical and redemptive, and Anfortas's suffering has a narrative coherence that will ultimately be revealed.

Anfortas's wound will heal only when someone comes to the castle and asks him the right question, quite simply, "What ails you?" It is an utterly naïve question, blessed in its naïveté, and Parzival seems to be the ideal candidate to ask it. But he fails to do so. He does not ask the question because in the education he has picked up in the course of his travels, he has been taught that the many questions he has been accustomed to asking make him seem simple and are often rude. On this occasion, Parzival takes this well-intentioned, civilizing lesson too much to heart and does not ask the question that must be asked. His inability to apply what he has been taught — his lack of sensitivity to context — is a symptom of Parzival not yet being the person who is capable of asking the right question. The enchanted castle then disappears, and Parzival has to go through his own sufferings before he can return to the castle, ask what he should have asked, and release the king. One of the healthier Christian tropes that the story presents is the idea that getting it wrong the first time is par for the course. What counts is learning from initial failure.

Here, finally, we begin to think *with* stories. Hearing Vanessa Kramer's story with Parzival in our imaginations, we see her aunt playing the role of the wounded king and all the health-care professionals in the room as candidates for the role of Parzival. When a nurse finally does ask the question of what is wrong, she asks the question wrong. Kramer reacts by asking, "How could the nurse not see?". Thinking *about* stories suggested one response: the nurse is caught in a restitution narrative that renders her blind to what Kramer sees as obvious. Thinking *with* stories suggests that the nurse, like the immature Parzival, can see perfectly well, but she cannot act on what she sees. She sees but cannot speak in a manner that is congruent with what she sees; both the wording of the question and her manner constrain what can be answered. The way she asks the question is not consequentially different — not different in its effect on the patient — from Parzival's not asking. Both the nurse and Parzival act as if they cannot see the monster in the room, and both leave the suffering person to deal with this monster alone. The nurse's problem, in the story she believes she must be part of, is that the patient's room will not magically disappear, leaving her in a dark wood to wander and to learn. It is unclear how the nurse will learn unless she hears Kramer's story and unless she is the kind of person who can hear Kramer's story.

Proximity, Distance, and Empathy

Parzival asks the right question (and asks the question right) once he takes the reality of Anfortas's suffering as a starting point. To share a common humanity means to be able to see that something is wrong but not to presume that what the observer and the suffering person perceive to be wrong are the same. A delicate balance of proximity and distance operates here: you have to ask, but how you ask depends on knowledge that is incomplete without the asking. This balance — being close enough to know but recognizing the distance that always remains — seems crucial to the practice called empathy.

The need for proximity requires the clinician to approach Kramer's aunt as another human being who is a living body. The clinician's experience of being a body allows him or her to know that, as Kramer says, of course there is pain after such a surgery, and of course there is suffering after such news. Kramer's "of course" signals this need for proximity, the aspect of empathy typically emphasized.

Proximity demands recognizing that yes, the monster is in the room and that the clinician take a stand with the patient in facing that monster. The first and crucial clinical move is to express the commitment to stay with the patient, to be there to do whatever can be done. It is an enormous defect of health-care organizations that professionals often cannot express this commitment because there are constant territorial disruptions over who stays how long and does what. This structured disruption of continuity of relational care is more than an organization problem; it is a moral failure of health care, deforming who patients and clinicians can be to and for each other.

This moral failure generates stories that work to keep the monster unmentionable, but no less present. It blocks the telling of stories that name the monster and that enable the suffering person to

feel that she or he does not face this monster alone. The beginning of not feeling alone is hearing someone else express, out loud, his or her recognition of the monster's presence.

But proximity can become unbalanced and turn to presumption if empathy fails to sustain distance. Distance is necessary to avoid projecting one's own feelings onto the other. The mature Parzival may see little more of Anfortas's suffering than he saw the first time, but he has learned not to presume to know that suffering without asking. How different might the reaction of Kramer's aunt have been if the nurse had first offered the great gift of recognition? She needed first to recognize her patient's pain and suffering and make that recognition her starting point — not to appear to be interrogating this pain. After acknowledging the limitations of what she could recognize, she could then say that in order to treat the pain, she needed Kramer's aunt to describe it in her own terms. The element of suspicion would have been avoided and space cleared for a story in which the nurse could participate. The difference between what happens and what might have happened is less about phrasing than about attitude — how the nurse presented her own body to the body of her patient. The phrasing of words counts less than the sense of relationship within which the words are spoken.

I should add one caveat, learned from watching difficult clinical scenes. If a patient is already in chaos — deep in chaos — then the professional's self-presentation risks being interpreted through the lens of that chaos. People who are experiencing multiple sorts of violence against themselves learn to see what they fear they will see. If medical communications often fail people living in chaos, it is equally true that living in chaos makes it difficult to communicate.

Because one story leads to another, our understanding of the story we are presently part of is always influenced by stories in the background. Maybe I hear an element of suspicion in the way that the nurse asks the question because of another story I have heard which comes from Bernie Carter's research on nursing care. Carter quotes from the diary of a child being treated for pain. We can hear this child as a contemporary, wounded king, captured in a system that inhibits asking the question that would begin to relieve suffering. The child describes his experience:

> *I've had pain in my stomach for nearly 2 years. It seems much longer. I found most of the doctors very helpful, however, a couple of the doctors treated me like I was faking. One doctor told me that what she was seeing on examination and what she was being told were two different things. I was 11 and knew that I was being accused of lying. This made me really angry, because it didn't help the pain (it actually got worse) and it really hurt me to be called a liar when the pain was very real*[11].

With this story in my imagination, I hear Kramer's aunt being set up for the same kind of accusation. If the answer she gives to the nurse's question does not fit the medical staff's expectation, she could have trouble getting the care she needs. People who care for other people do not test them, and too often I hear stories about patients being tested by clinicians. As the boy in Carter's story says, this makes the pain worse.

Empathy is not so much an attitude toward another person; it is primarily a response that is, in turn, responded to, and that cycle of response is dialogue. Parzival's empathy depends not on how he feels as he sees and smells Anfortas's wound. What count are Parzival's actions in relation to Anfortas: asking the right question, which requires returning to the enchanted castle, which requires becoming the person who is entitled to return. In this sequence of actions, Parzival does not act for himself alone.

Parzival's quest is interdependent with the fate of Anfortas. Any person's story depends on others who become less other as the enmeshment of stories teaches interdependence. I confess to believing that in learning this interdependence patients have a qualified advantage over clinicians. This advantage may have less to do with physical suffering and the feelings that generates (though these can count) and more to do with not having a particular institutional face that must be sustained before one's colleagues. Being suspicious is one technique of sustaining that professional face; it shows the professional's ability to judge.

The interdependence of witness is stated dearly by another child whom Carter interviews: "I know what my pain is like, but he [the physician] never wants to hear. He might be a doctor but I've got the

[11] Carter, "Pain Narratives and Narrative Practitioners," 210.

pain. *If I can't tell him, who can I tell?*"[12]. That dependence of the suffering person on the clinician embodies the Parzival aspect of any medical encounter. The dependence is really interdependence because until the clinician becomes someone willing to hear the other's pain, she or he, like Parzival when he fails to ask the question, is incomplete as a person. Whenever a clinician walks into a patient's room, Parzival encounters the wounded king all over again. If this secular yet still spiritual Grail of medicine is to bring healing and not prolong the suffering, the right question has to be asked.

I emphasize that the dialogical approach to clinical communication is neither original nor is it difficult to practice. Parzival has to unlearn the manners he has learned well but without discrimination. Asking the right clinical question often involves more unlearning than learning, and unlearning — simplifying — is difficult to write up for continuing medical education (CME) credits. The professional education system assumes that anything worth learning must be new and technically complex. Communication is turned into another procedure, practiced according to a prescribed regime. No professional credit is given for saying or learning that something is obvious, but in the story of Parzival, redemption depends on doing the obvious. The CME system, as one representative of institutional medicine, accords no value to giving people permission to act on their best instincts. We need an alternative, and this alternative needs a name.

Phronetic Practice

If what counts about any story is what those who hear it choose to do with it, and if people need to reduce the gap between suffering that seems an unavoidable part of the human condition and suffering that is compounded by the social treatment of the ill, then the final questions concern whether one can learn to ask the right question, and if so, what the appropriate pedagogy would be. Parzival apparently learns. His ordeals endow him with the quality that Aristotle calls phronesis, conventionally translated as practical wisdom[13].

Phronesis is one of the three branches of knowledge that Aristotle describes, the other two being *episteme* and *techne*. *Episteme* is concerned with universal laws; it aspires to be context invariant. Episteme sets the ideal for scientific knowledge — including evidence-based medicine — and for those branches of philosophy and social science that are concerned with rules, principles, and laws. If *episteme* is of the head, *techne* is of the hand. *Techne* invokes making; it produces objects, originally art works and what we now call technology. Surgery, as a craftwork of hands, is a form of *techne*. *Techne* teaches how to craft, and *episteme* teaches the laws that govern what is crafted, but neither form of knowledge takes us very far deciding what we *ought* to craft. For that we need *phronesis*. *Phronesis* is what Parzival needs to acquire if he is to make good use of the warrior skills (*techne*) that he picks up, perhaps too quickly. Acquiring *phronesis* takes far longer. Thinking about *phronesis* after Pascal, I am inclined, perhaps with violence to Aristotle, to think of it as being of the heart, in the sense of that which exceeds reason. *Phronesis* is the type of knowledge for which we lack any contemporary English term, which may be a bigger part of our problem than we realize: contemporary society has lost the understanding that *phronesis* is necessary to becoming a complete human. Thus, we fail to train people for it.

From the philosophical perspective of the present, *phronesis* seems to anticipate pragmatism in its interdependence of action and values. To act is to act on the basis of some value, and any value achieves specific meaning only in the unfolding of an action; actions alone enable us to know what the value means[14]. In order to learn to act in ways that exemplify our values, we need to pay attention to how different actions develop, with what consequences, and for whom. In seeing how value-based action plays out, we discover the goodness or the failure of our action. *Phronesis* thus depends not on rules or laws but on experience. A person develops *phronesis* by taking his or her values through the trials of multiple actions and by reflecting on the outcomes. Experience enables a person to know

[12] Ibid., 214 (my italics).

[13] See Aristotle, *Nicomachean Ethics*. My discussion of *phronesis* is instigated and guided by Flyvbjerg, *Making Social Science Matter*; my usage of "phronetic" as an adjective is taken from Flyvbjerg. My favorite discussion of *phronesis* as an ethical value is Vanier's *Made for Happiness*.

[14] A contemporary summation of pragmatist ethics is found in Varela, *Ethical Know-How*.

where certain courses of action are likely to lead. *Phronesis* is the opposite of acting on the basis of scripts and protocols; those are for beginners, and continuing reliance on them can doom actors to remain beginners[15].

Because *phronesis* requires experience and is expressed in action, it cannot be specified in the abstract. Is it more than a tautology (with a Greek name) to say that the wise person knows to act wisely because she or he is wise? We save phronesis from tautology when we under-stand that a story unfolds over time, with time humanizing the hero. In all quest stories, the hero spends years wandering. Parzival knows how to ask the right question only after his adventures and trials give him time and experience to reflect on his initial failure.

There are two other conditions that must be met in order for Parzival to become the kind of person who knows how to ask the right question. As well as requiring time, becoming a wise hero requires having a body that can suffer, in part because this body also knows the possibility of joy. Finally, becoming wise requires interacting with other people on whom the hero has effects that have moral consequences; reciprocally, these people affect the hero. While these three conditions could be considered essential to all stories, in the quest stories more is involved than the sum of the characters, their experiences, and their interactions. At the center of Parzival's story is the Grail, in all its power and mystery. Here I need to return to my G twins as the basis of understanding people's stories.

I regret the ungenerous observation that the idea of the Grail in many stories differs from Parzival's Grail, and this difference is one reason why his story continues to be significant for our contemporary moral development. The kind of Grail that many people imagine is more like a Goose that Lays the Golden Egg. Many people have the idea that if they could get their hands on some thing, like a winning lottery ticket, or the perfect medication, or a new surgical procedure, then their lives would be healed and redeemed[16]. Anfortas, the wounded king, has the Grail in the sense that it is there for him, but it does not heal him. More accurately, the Grail has the king, and there lies the problem of both pain and medicine: too often they have us.

The Grail can provide, but first it demands. The Grail's demand that Parzival become the person who can ask the right question is a demand for *phronesis*. Parzival must learn to discriminate what action fits the context. One aspect of his youthful naïveté is his ignorance of the demands of different contexts. Initially this lack of awareness has a comic quality, but then it turns serious: first, when Parzival fails Anfortas; and later as he learns the consequences of some of his earlier actions. Parzival must learn to know what a given context asks of him and how to choose the appropriate skills with which to meet the needs of the situation, including but not limited to his formidable skills as a warrior. Parzival, like many young physicians, is prematurely potent in *what* he can do. He needs to learn *when* and *how* to do.

Parzival can and does learn, although the course of learning does not run smoothly; it requires faith, which might be described as sustaining focus on an ideal. The Grail can be interpreted as what it is worth having faith in; it draws people into processes that require and ultimately produce faith. Parzival's story gives the rest of us faith that no matter how badly we bungle things initially, we can get it right if we sustain a belief in the moral significance of the quest to get it right. The Grail is that promise.

Thinking with stories is one kind of phronetic inquiry. The study of narratives can be used to generate epistemic knowledge, and narratology can be a form of *techne*, concerned with the making of stories. Those uses have their value, but I want to claim that the unique possibility of stories is to teach *phronesis*[17]. Let me offer a final yet always partial definition of *phronesis*. To practice *phronesis* is to train oneself to constant self-awareness as a moral actor. One form of that training is the telling of

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[15] See Flyvbjerg's discussion of the educational research of Stuart and Hubert Dreyfus in *Making Social Science Matter*, which concludes: "If people are exclusively trained in context-independent knowledge and rules, that is, the kind of knowledge which forms the basis of textbooks and computers, they will remain at the first levels of the learning process" (71).

[16] One example is cosmetic surgery; for a psychoanalytic interpretation of cosmetic surgery as the search for a lost wholeness, see Blum, *Flesh Wounds*.

[17] This claim simply arrives by a different route at the same point others have made; see, for example, Charon, "The Narrative Road to Empathy."

stories, like Vanessa Kramer's story, that highlight how people are constantly affecting each other's capacity to be carried off by some Grendel or to be redeemed by a Grail. I imagine the epic *Parzival* as a story that Parzival tells to himself, becoming able in the course of that telling to see himself at his best and his worst and in all the effects he has had on people during his life and to see how they have affected him. After telling himself this story, Parzival is able to ask the question — the right question about pain — that ends one story and begins another. This provisional ending may be as close to goodness as we are able to get.

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