"A Science of Uncertainty": Bioethics, Narrative Competence, and Turning to the "What If" of Fiction

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Vincent Lam's 2006 Giller Prize-winning collection of short stories, *Bloodletting and Miraculous Cures*, opens with an epigraph from the late-nineteenth-century Canadian medical pioneer William Osler (1849-1919): "medicine is a science of uncertainty and an art of probability" (qtd. in Bean 74). It is not surprising that Lam, a creative writer and emergency room physician himself, turned to Osler for the epigraph to this series of "what if" stories. Osler, like Lam, was well aware of the significant role that stories play for both patients and doctors in the practice of medicine. Osler's *The Principles and Practice of Medicine* (1892) served internationally as a core medical textbook until the 1940s. More broadly, however, Osler is remembered for transforming the North American medical curriculum by introducing the residency system into medical schools. In order to illustrate the variety of conditions that a physician and patient might face, his medical pedagogy hinged on taking students out of lecture halls and into the wards for bedside observation. For Osler, each patient had a story to tell, and the doctor's job was to decipher, interpret, and act upon the information gathered, as uncertain as such a process might be. In a lecture delivered at McGill University in 1894 entitled "Teaching and Thinking," Osler explained that one reason for the pervasiveness of medical "uncertainty," or doubt, was "the increasing variability in the manifestations of any one disease," and another was the singularity of patients (130). For Osler, teaching students to recognize the concept of variability was "the fundamental difficulty in the education of the physician" (348). By turning to patients to tell their own histories in a pedagogical setting, he hoped to train future doctors in the art of interpretation. For Lam, as it was for Osler, the doctor is at once the audience, witness, critic, collaborator, and storyteller.

Osler's approach to teaching medical students through observation and listening seems to be experiencing a renaissance with recent developments in narrative medicine. This approach to medicine draws on literary studies to emphasize the development of "narrative competence" or "the capacity to recognize, absorb, metabolize, interpret, and be moved by stories of illness" (Charon, "What" 1265). According to the founding director of the Program in Narrative Medicine at Columbia University, Rita Charon, narrative medicine is simply "medicine practiced by someone who knows what to do with stories" ("What" 1265). For Charon, the concept of narrative medicine, at least in part, came out of her recognition of the need to learn how to "tolerate ambiguity and uncertainty as the [patient's] story unfolded" (*Honoring* 4). In this article, I build on existing discussions of narrative competence in a clinical setting by exploring how productive it can be to turn to works of fiction, particularly "what if" stories, to illuminate Osler's pedagogically difficult notion of medical variabilities. I also want to investigate how turning to fiction might help point to some of the shortcomings of contemporary medical practice. To do this, I consider how stories that highlight the constraints of medicine and the problems of health care augment medical pedagogy, particularly the introduction of bioethical debates. Along the way, I argue that fiction can trouble two of the core elements that seem to be at the base of narrative medicine — the doctor as good listener model and the decipherable patient model. After a discussion of the relationship between narrative medicine, bioethics, and fiction, I turn to the patient-centred novels of Kathleen Winter (*Annabel*) and Emma Donoghue (*Room*) before returning to Lam's stories about physicians (in training and after) in *Bloodletting and Miraculous Cures.* Stories like these illustrate both the strengths and the weaknesses of the medical system as they imagine the impact of medical decisions on characters over long periods of time. From both ends of the stethoscope, the stories that we read in these three texts about health care, sexualized violence, medical standardization, and problems in doctor-patient relationships elicit important dialogues about ethical dilemmas in health care and contemporary culture.

Narrative Competence and Bioethics

With the burgeoning of narrative medicine programs and the growing presence of the medical humanities in medical schools, health practitioners have increasingly recognized the power of listening to patients' stories to help with diagnosis and treatment. As Mark Ebell says in his foreword to *Integrating Narrative Medicine*, "learning to truly listen to our patients' stories is the essence of narrative medicine" (x). Indeed, the field is built on the recognition that literary studies can add to the development of narrative competence by teaching transferable skills such as the ability to decode language, to communicate effectively, to recognize parallels, to analyze efficiently, and to argue reasonably. Charon and Martha Montello make this point well as they note the necessity of teaching health-care practitioners to have the "narrative competence to follow the patient's narrative thread, to make sense of their figural language, to grasp the significance of stories told, and to imagine the illness from its conflicting perspectives" (x). At Columbia University, the Program in Narrative Medicine provides workshops for "narrative training in close reading, attentive listening, reflective writing, and bearing witness to suffering" (Charon, "What" 1265). The result for doctors, nurses, social workers, and students, Charon further notes, has been to "strengthen their therapeutic alliances with patients and deepen their abilities to adopt or identify others' perspectives" (1265). The key here is to increase a sense of affiliation and alliance between doctor and patient to produce what James Meza and Daniel Passerman call, in "The Social Practice of Healing," "a co-constructed narrative within the context of an institutionalized social framework" (viii). This merger creates "coherence between the 'inner experience' of the individual and the socially authorized version of the same story" (viii). Only after engaging in "acts of diagnostic listening," says Charon, can the doctor face the patient's narrative questions: "What is wrong with me?" "Why did this happen to me?" "What will become of me?" ("Narrative Medicine" 1899). As Lam puts it, "What happens is, [a patient] tells me the start of a story, and much of what I'm supposed to do is tell them the ending. The other thing I'm supposed to do is make the ending of the story better" (qtd. in Goddard).

However, what if the patient and the doctor consider different aspects of the story of the illness to be the most significant? What happens when a physician cannot hear what he or she is being told, does not know what to do, or does not want to hear? How far can "co-construction" of a narrative extend if the patient and the physician are at odds and do not agree on the "reinforcing social norms" that the physician chooses (Meza and Passerman viii)? Some patients might not want to adhere to social norms. Sometimes, as with changing cultural norms around gender, for instance, patients might not want their stories merged with the "socially authorized version" provided by the physician at all. How do you teach such variable moments of culture shift? Furthermore, how much does culture temper how we view bodies and illness? One answer is to turn to works of fiction that follow the course of one individual case, both before treatment and after it. *Annabel*, as I will soon discuss, is an exemplary case in point. Winter's novel challenges the desirability of social norms as it imagines the aftermath of having such norms imposed on the central character and asks what might happen if the character rebelled. More broadly, much fiction is conditional, based on the question "what if?" With a conditional phrase in a sentence, a speaker can ask about the consequences of an action and remain tentative about the answer. The same holds for "what if" stories. "What if" is a powerful place to begin discussions about the potential multidimensionality of events. A fictional story provides a space to creatively probe uncertainty, to draw out the repercussions of mistakes, to work through the consequences of actions, and to imagine different ends. By writing about hypothetical situations, a creative writer can imagine a case from multiple shifting — and potentially conflicting — points of view. Because stories allow for polyvocality and a plurality of outcomes, they are potent sites to engage debates about tough dilemmas in medicine. In the classroom, medical or literary, fiction can also help with the development of what Paulo Friere calls, in *The Pedagogy of the Oppressed*, critical consciousness, so that students learn to read both the *word* and the *world*.

Bioethicist Shannon Wooden focuses on the role fiction plays in creating empathy in her discussion of narrative medicine and bioethical pedagogy when she writes about her success in teaching students about autism through a reading of Nick Haddon's *The Curious Incident of the Dog in the Night-Time*. Wooden argues that, when the novel is "viewed as a medical narrative with features common to other accounts of illness and disability, it puts us in a position from which we must practice empathy" (276). Much of the discussion of literature in the framework of the medical humanities has been on how reading fiction, inhabiting literary landscapes, and imagining different lives can increase a reader's empathy and sense of human attachment. *The Oxford*

Handbook of Clinical Medicine, published in 2014, puts it this way: "It is at that point where art and medicine collide that doctors can re-attach themselves to the human race and re-feel those emotions that motivate or terrify our patients" (Longmore et al. 17).[1] The stories in *Bloodletting and Miraculous Cures*, *Room*, and *Annabel* sit at such a point of collision. In addition to reminding doctors of their own humanity, however, these creative works demonstrate how the human element of medicine is fallible. They showcase the problems of standardization, the possibility that a patient's story might not be decipherable, and the drawbacks of "diagnostic listening." My attention to these texts lies more in the possibilities of active reading than in the results of empathetic reading. Such active reading can aid in recognition of the variabilities of medicine, stimulate the development of narrative competence, and bring into focus important ethical debates.

In their review of Lam's book in *Philosophy, Ethics, and Humanities in Medicine*, Stephanie Nixon and Joel Baetz point out that "Lam's stories might find themselves at home in bioethics curricula as training tools. The initial step in ethical decision-making is recognition and articulation of issues as moral dilemmas in the first place. Each of his short stories is embedded with ethical quandaries that could act as a springboard for such bioethics teaching." According to the National Institute of Health's succinct definition, bioethics is a subfield of ethics relating to life sciences and biomedical knowledge whereby "ethics helps people decide how to behave and treat one another, and what kinds of communities would be good to live in." In other words, bioethics is about wrestling with the difficult questions that arise because of the variability of human bodies and human environments. Lam's "what if" stories engage bioethical issues ranging from the ethics of treating possible psychosis, to the risks of dangerous birthing procedures, to the dangers of violent prisoners in custody, to the human cost of making mistakes in medical training, and to the vulnerabilities caused by fatigue and addiction.

While Lam's stories concentrate on the perspective of doctors, it is useful to briefly consider works that address bioethical issues from the perspective of patients as well. *Annabel* and *Room* are particularly interesting because they challenge, in their own ways, the very notion of being a "patient," and in the process they raise questions about social expectations, the medical system, and the ethics of standardization. I bring together these three works set at least partially in medical institutions because each carries a kind of self-reflexivity about the medical system in such spaces. It is tempting to say that these stories and novels illustrate a continuum of representations of medicine, doctors, and health-care facilities — from the well-meaning and protective doctors in *Room*, to the imperfect doctors in Lam's stories, to the portraits of uncaring medical practitioners in *Annabel.* We see good, mediocre, and bad doctors. Ditto hospitals. However, I do not want to get stuck theme-spotting and instead want to focus on how such a range of representations can be considered in terms of bioethical encounters and pedagogical possibilities. In addition to reading Lam's stories as a series of ethical "what if" dilemmas, we could read *Room* alongside a study of the impact of confinement on the victim of repeated sexual assault and on a child unaware that his childhood is anything but ordinary. Finally, we could read *Annabel* as an "inroad to ethical inquiry," to use Wooden's phrase (276), in a classroom alongside a longitudinal study of being born "intersex" and having gender imposed as Winter thoroughly maligns the notion of compulsory gender behaviour. In the process of narrating "what if" stories about the variability of patients, doctors, and medicine, these three authors present ethical dilemmas about communal health and individual care.

Annabel

What if a baby were born in rural Labrador in the late 1960s with both male and female genitalia? What if the child's father chose one gender identity for the baby and a doctor surgically and pharmacologically reinforced that choice? What would the repercussions of that secret decision be over the next twenty years? Such questions guide *Annabel.* The novel follows the baby, christened Wayne and referred to by the male pronoun throughout the story, as he grows into adulthood. It also follows his shadow self, Annabel. Throughout, Winter carefully weighs the male gender expectations of Wayne's trapper father with the possibilities of gender fluidity briefly entertained by his mother and later pursued by Wayne. As he ages, the novel explores his own sense of gender discomfort. He becomes aware of the girl inside only when he is rushed to the hospital at age twelve to have pent-up menstrual blood drained. Wayne spends the novel resisting his father's early choice, both before he learns his secret and, more generatively, after. Winter shows "acts of diagnostic listening" going very wrong as *Annabel* imaginatively animates the impact of a medical decision imposed on a "patient" in infancy. In this novel, poor diagnostic listening is due to an inability to listen beyond cultural expectation. The novel succeeds in illustrating the deep flaws of standardized treatment.

The early decision of Wayne's father, Treadway, to raise the baby as a boy is supported by medical testing and reinforced by procedural interpretation of the results. The novel unfolds by exploring what Treadway refuses to imagine — "the harm in store for a child who was neither a son nor a daughter but both" (27). While the father decides how to "erase the frightening ambiguity in their child," the mother, Jacinta, "envisioned living with it as it was" (28). When she takes the baby to the hospital, we see the doctor turn the "frightening ambiguity" of "its" genitals into quantifiable fact or at least something "believable" (50). Thus, in the late-1960s setting of the novel, Winter probes how members of the medical profession were the keepers of societal values in their seemingly objective decision making.

> "You think," she said, "a child's sex needs to be believable. You think my child — the way he is now, the way she is — is unbelievable? Like something in a science fiction horror movie? And you want to make her believable. Like a real human."
>
> "We want to give him a chance. As soon as possible after birth."
>
> "Have you done it before?"
>
> "True hermaphroditism happens, Mrs. Blake, one in eighty-three thousand births. I haven't done this before. But what we are doing today is the normal medical response."
>
> "Normal?"
>
> "And I think it's the most compassionate one. We try to decide the true sex of the child."
>
> "The true one and not the false one." (50)

The vocabulary of standardization is volleyed here between the doctor and the resisting mother: "believable," "real," "normal," "true," "false." The difference is that the uncertainty of the mother's response and the verbal repetition do not register with the doctor. He repeats the language of standardization in order to render it natural. Furthermore, Winter's careful choice of pronouns in this scene (with Jacinta employing "she" and "he" and the doctor resolutely using "he") suggests his predetermined reading of the phalometer to come. The doctor does not hear the hesitation in the mother's voice. Unable to listen to her questions, he typifies poor narrative competence at this juncture.

> "We use this phalometer." He picked up a tiny silver bar from the trolley. It had black numbers on it.
>
> "It's a tiny ruler."
>
> "It is. See?" He pointed to a mark three-quarters of the way down the phalometer. "If the penis reaches or exceeds this length, we consider it a real penis. If it doesn't meet this measurement, it is considered a clitoris." . . . "Penis size at birth is the primary criterion for assigning a gender."
>
> "Measure her then." . . .
>
> "It is the necessary length. . . ." Dr. Ho showed her the gauge. "It barely grazes one and a half centimeters."
>
> "I can't even see the numbers. They're so tiny."
>
> "This baby can be raised as male."
>
> Jacinta was silent. Then, quietly: "That's what his father wants." (50-52)

In this scene, the child's body is limited in signification to the size of the penis, which becomes a definitional object with which to quantify identity. Most striking here is Jacinta's acquiescent use of "his" in the final line, linking the child with the doctor and the absent father. The ruler ostensibly distances Dr. Ho from responsibility for the impact of the decision. It is not for him to consider the impact of such a measurement on the child. A case study might end here at a reading of the phalometer. This is precisely, however, where the novel begins. From here on, compulsory models of behaviour are imposed on Wayne by his father, his community, and the medical system, and they are shown to be egregiously inappropriate and often deeply painful for Wayne.

Unlike in *Room*, the hospital in *Annabel* is a location of neither guarded safety nor respect. For Wayne, it is a space that lacks empathy and individual understanding. Throughout the novel, he is treated as a teaching tool known as "the patient," and we repeatedly see his vehement reaction against such a configuration. Winter exposes the pain of being discussed as a biomedical body and the profound discomfort that comes from not being recognized beyond what is viewed as a medical condition. She provides a harsh portrait of interchangeable doctors, more curious than caring, and criticizes hospitals as places ruled by the binary logic that the novel slowly works to undo. Attracted to the symmetry of bridges and synchronized swimming, Wayne cannot abide the asymmetry of the hospital, where he is without agency, autonomy, or individuality. It is a place of violence — of pills, lies, and difficult treatments for a blood disorder constructed to mask his "condition." The medical staff do not hear his voice in pain or pleasure. When Wayne grows up, he moves to St. John's, where he hopes he can live as himself, a combination of both genders. Unfortunately, the city is not a place of peace. Winter is careful to show how gender non-conformity was unwelcome in 1980s Newfoundland. This comes to a crisis point when Wayne is attacked and raped by several men spewing homophobic comments as they molest him with a broken bottle. Given his history with medical institutions, Wayne refuses to go to the hospital or police for help because he would have to tell his story over and over again. By choosing silence for her character over the demands of traumatic repetition necessary for medical intervention (as we see with Ma in *Room*), Winter powerfully exposes a fissure in the hospital system. The hospital is a place of bad listeners in this novel. So while storytelling can be liberating — as it is in many contexts — here it is the opposite. The novel delivers tentative answers to its guiding "what if" questions, and in the process it details a stark and ultimately moving account of "patient" variability.

Room

What if a child were born in captivity, the son of a woman kidnapped and the man who held her hostage? What if, when the boy turned five, he was able to escape and rescue himself and his mother? What would their rehabilitation be like, and what kind of world would they meet? These are the questions that drive *Room*. Donoghue's novel is narrated by five-year-old Jack. His mother, known in the novel only as Ma, has been kidnapped and locked in an eleven-square-foot Room for seven years. Room is always capitalized because, for the narrator, there is only one. (Indeed, Jack signals the singularity of objects in Room by referring to most nouns without articles — Bed, Lamp, Tooth, Ma). The novel tells the story of their everyday lives in Room and how they must go through "unlying" and "dying" before they can get to the point of "living." We follow the slow process of their rehabilitation in a psychiatric institution as they try to adapt to the world "Outside." *Room* is different from other fictionalized captivity and survival narratives in that the confinement story and the suspenseful tale of escape take up less than half of the novel. The remainder follows them through the process of treatment, toward self-reliance, and ultimately concludes with reintegration in the community. Their time in rehabilitation raises significant bioethical questions about patient sovereignty, medical responsibility, and safety. Throughout the novel, Donoghue illustrates the crucial distinction between victim and survivor. Although she demonstrates how the language of trauma is limited in an institutional setting for survivors of sexual abuse, she empowers her characters by having them fight to retain control over their stories. Because the young boy does not have the language to describe his experiences in conventional terms, and because Ma refuses to adhere to a victim script and be defined by her kidnapping, the two former captives remain somewhat indecipherable to the doctors, nurses, media, and family around them. Ma declines to tell her mother "every detail" of her time in Room because, as she says, "I'd rather not have you thinking about that stuff every time you look at me, OK" (198). Indeed, a key lesson in the novel comes when a television interviewer tries to impose a story of suffering on Ma and we witness her get it dangerously wrong.

The doctor "lucky enough" to be on call the night that Ma and Jack are brought in to the hospital is charged with helping them to tell their stories and re-engage with the world (182). The medical staff on hand, on the whole, are respectful, thoughtful, and caring. Yet they are not without flaws. Although Donoghue's novel is less overtly concerned with exposing the inner workings of the medical system than Lam's collection, for instance, it still scrutinizes medical omniscience, curiosity, and control. Gently critical of the doctors' curiosity, however, Donoghue is highly critical of the media and their ghoulish hunger for consumable narratives of violence. As a patient who resists, Ma maintains tight control over her narrative. Within the novel, she refuses to have her story be viewed as a paradigmatic case of sexual abuse, confinement, and violence. Nowhere is this more evident than when Ma lashes out at a TV interviewer who tries to turn her into a victim, a "beacon of hope," a "talisman of goodness," and a martyr (235). Incredulous, Ma responds, "Is she allowed to ask me such stupid questions?" (236). Throughout the interview, Donoghue makes Ma an ill fit for the sanctified role into which she is thrust: she had an abortion at eighteen; she says "ya know" and "like"; she has a social conscience. She exclaims, "I'm not a saint"

(235). Establishing that she is not exceptional, Ma argues, "before — I was so ordinary, I wasn't even, you know, vegetarian. I never had a goth phase" (232). Twisting her words, the interviewer responds, "now you are an extraordinary woman with an extraordinary story to tell" (232). Ma answers insistent comments about her heroism with "all I did was I survived, and I did a pretty good job of raising Jack. A good enough job" (235). The interviewer performs the attentive diagnostic listener pose and is ridiculed in the story because of it. With her puffy hair and smug demeanour, she is a hyperbolized portrait of earnestness and insatiable curiosity. In an online chat with readers of the *New Yorker*, Donoghue explains her choice to ridicule the interviewer's combination of "that unnerving mixture of the saccharine and the judgmental" because, as she says, "it seems that we set up these Suffering Girls only to bludgeon them off their pedestals" (qtd. in Halford). The scene satirizes voyeurism, sensationalism, sentimentalism, and faux grief, as well as a desire for scandal. By placing her book outside the genre of captivity narratives, Donoghue seems to warn her readers not to consume the story at hand as greedily or voyeuristically as the interviewer does. The extended interview scene, set in the safety of the hospital, is a particularly productive place to turn for bioethical debate because it raises the question of audience expectation and how to witness a painful story. Donoghue satirizes the television host's sensationalism, but the warning is there for a medical team and family as well: do not assume understanding and knowledge based on presumptions of experience.

Room is a horrific story of human confinement, sexual brutality, and monstrosity, but it is also an eminently "readable" book that raises important questions about how easily consumable a traumatic story can be. One could argue that, by writing a fictional account of confinement and rehabilitation, Donoghue can imagine the possible impact of kidnapping, confinement, rape, and assault on a woman without exposing a real case to scrutiny or breaking the limits of medical confidentiality. However, *Room* raised questions before its publication about whether Donoghue was indeed exploiting an actual story. The author acknowledges that the spark for the novel came from learning about the 2008 case of a five-year-old Austrian boy named Felix Fritzl, who was born in captivity and had never seen the outside world when he was rescued. She notes that, though she was first inspired by the Fritzl case, she researched many cases of children raised in captivity and drew widely on them for psychological background for her characters (see Crown). As Donoghue argues, "I knew that by sticking to the child's-eye perspective there'd be nothing voyeuristic about it" because, she maintains, "the book has some really serious questions to ask" (qtd. in Crown). Some of those questions concern the ethics of representation and lines around exploitation, sensationalism, and voyeurism that should be asked of any narrative of trauma and survival of violence. The questions that a literary critic might ask in this context concern how much a writer can write about atrocities without turning them into spectacles; why readers desire to read about such violence; when a story appropriates pain; where creative licence meets fidelity to fact; who writes for whom; and who profits. In a medical context, however, a reader might come at this story differently. How does a physician treat a case with no precedent? How far can a doctor go in "doing what is right" for a patient? Where does patient autonomy meet medical responsibility? These questions would lead a reader to approach the novel from distinct yet complementary angles and point to significant questions about the ethics of storytelling around a traumatic case.

Room raises questions about the ethics of control of Ma's body, Jack's movement, and Donoghue's refusal to present either character as a victim. When Ma and Jack are taken to the Cumberland Clinic psychiatric facility upon their escape, they are told that they will be given "all the appropriate care" (204). From the outset, however, Ma wonders how there could be care "appropriate" for her unusual case. The exchange between her and the examining doctor upon arrival at the clinic illustrates a clash between accepted protocol and individual story. It is the first of many examples of Ma refusing to see herself or her son as a "patient."

> Dr. Kendrick says, "If I could just give Jack a quick check up?"
>
> "I said no already."
>
> What does she want to give me? "Is it a toy?" I whisper to Ma.
>
> "It's unnecessary," she says to Dr. Kendrick. "Take my word for it."
>
> "We're just following the protocol for cases like this," says Dr. Clay.
>
> "Oh, you see lots of cases like this here, do you?" Ma's mad. I can hear it.

> He shakes his head. "Other trauma situations, yes, but I'll be honest with you, nothing like yours, which is why we need to get it right and give you both the best possible treatment from the start."
>
> "Jack doesn't need *treatment*, he needs some sleep." (167)

Ma's assumption while she was in Room was that, after her escape, she would have autonomy (and be "free as a bird," as she later states with irony) (191). However, she quickly realizes that some decisions remain out of her hands. Rather than vilify the doctor for lacking humanity or being overly bound to protocol at this point, Donoghue follows this scene with a discussion of why adhering to protocol is necessary for the forthcoming lawsuit against the captor. When the violated body is subject to legal dispute, the doctor takes on a further role of authorized witness. The link between justice and good listening is key here since medicine and law are interwoven, and both are established to protect Ma and Jack, reasonably beyond their control.

In the context of *Room*, it is useful to ask how an institution can provide a safe space for treating a variety of patients with a range of specific needs. In her descriptions of the confining spaces of the psychiatric institution, Donoghue subtly parallels the space of Room itself. Safety is shown to be highly constructed, and it is quickly deconstructed by Jack, who finds much to fear in the quotidian operations of the institution and its administrators. Through the first-person narrative voice of the child, Donoghue defamiliarizes the operations of the rehabilitation centre and the safety that it represents. She resists metaphorical readings by creating a five-year-old narrator with the inability to speak figuratively. Still, Jack is rendered as a cultural outsider learning to adapt to societal expectations and localized standards of citizenship introduced to him by the medical staff of the institution working in conjunction with his new family. Counterintuitively for the doctors and family members whom he meets outside Room, Jack longs for the familiarity and security of the space and objects in Room. Only once does another character recognize this, and that is when a nurse named Noreen asks him if he is homesick, to which Ma replies with fury that "Room wasn't a *home*, it was a soundproofed cell" (207). For Jack, however, Room was not horrific: it was his childhood home. In spite of Ma's anger, the nurse is able to separate the experiences of the mother from those of the child and recognize his distinct relationship to the place of his childhood. Noreen is the most compelling portrait of narrative competence in the novel. She listens to

Jack, deciphers his intentions, considers his needs, and responds appropriately. Although the medical staff cannot decode all of the stories of life inside Room, they are still shown to facilitate rehabilitation through some effective forms of doctor-patient communication, including art therapy, puppet therapy, talking therapy, and role playing. *Room* would be a powerful springboard for bioethical debate because Donoghue tells a story of confinement and its legacy with humanity, credibility, and ferocity, all in the voice of a five-year-old child.

Bloodletting and Miraculous Cures

From the epigraph forward, Lam greys medical education, humanizes medical practitioners, and challenges the possibility of objective medical knowledge. We join characters on the wards and witness their making and unmaking as physicians. *Bloodletting* follows four main characters over the course of a decade from their attempts to get into medical school to working, exhausted, in an emergency room: Ming is a pragmatist, Fitzgerald is a romantic alcoholic, Sri is an empathetic sentimentalist, and Chen is a practical mediator. The doctors at the heart of the stories provide us with four variable approaches to medicine and health care.

Although each story in *Bloodletting* is a "what if" story that highlights a bioethical quandary, for reasons of space I will touch here on only a few. "Take All of Murphy" is set in an anatomy class in which the attitudes of each character toward a cadaver come into conflict. The story leads us to ask several questions about how one treats a body donated to science: impersonally and clinically, as Ming does by referring to it only as "the cadaver," or personally, as Sri does by calling him Murphy, "a dignified but comfortable name" (40). Is the cadaver an object or a subject? Is it better to empty the body of history, culture, and beliefs, or should such things be recognized and protected? Does educational use value trump culture, and how can one best show respect for the individual? Such questions come to the fore when the students unwrap the cadaver's arm and discover tattoos that begin to tell his story. The doctors-in-training find the words *Golden* and *Flash*, the RCAF symbol, and a series of small airplanes just above the elbow (41). Most significantly, the students argue over whether or not to cut through a "rich and delicate crucifix" accompanied by biblical scripture, "*The Lord Keeps Me*, Mark 16," tattooed on the cadaver's arm (42). "You should respect a man's symbols," says Sri in response to Ming's insistence that they adhere to the manual's instructions for dissection to expose the bicipital groove that lies directly under the cross (43). The symbolic value of the crucifix needs to be respected, for Sri, regardless of whether it is a symbol of his "people" or not, as Ming narrowly implies. Sri tries to be the doctor who listens to the patient's body as he reads the signs of history and humanity written on Murphy's arm. The question the story seems to ask is to what end? Is this sentimentality or respect? In her analysis of this scene, Cynthia Sugars argues that "Sri's response is human — perhaps not rational, as Ming would say — but human" (260). Such a recognition of the humanity of the doctor as well as the cadaver helps the reader to empathize with what Sugars sees as Sri's "inner conflict" rather than "Ming's detachment" (260). But the story takes us beyond empathy to ethical debate. While Sri is respectful of the cadaver's history, Ming argues for the greater good of knowing about the bicipital groove over honouring a dead man's code. It is up to a third party to break the impasse. Chen, the mediator, finds a solution that will appease both of his classmates: "Why don't you cut around. . . . Then dissect the subcutaneous layer? It'll be the same" (43). By having students debate what to do with a cadaver's tattoos, Lam illustrates that even in training doctors approach their patients with variability. By providing a solution that will appease them all, Lam also breaks a wall of objectivity that might be there with a more scientific approach to an anatomy lesson. As Nixon and Baetz note, "This is the first of many instances whereby cut-and-dry rules collide with real-world situations."

"Contact Tracing" is a story from later in the collection, long after the students have become doctors, but cut-and-dry rules still collide. Based on Lam's experiences as a physician during the 2003 outbreak of severe acute respiratory syndrome (SARS) in Toronto, the story raises two key bioethical questions. How far does the doctrine of duty to care stretch? Should health professionals be ready to risk their own health for that of others? The story asks, simply, what happens in a hospital if there is an epidemic? With the outbreak of SARS in the story, both doctors and nurses reassess their relationships with the health-care system. This story is about the moral positioning of medical practitioners and their responses as professionals and, eventually for some, as patients. It productively pits individual against communal concerns and makes the reader consider the protection of one against many. The story asks what choices health-care workers might really face during a pandemic.

Following the SARS outbreak, Lam co-wrote the non-fictional book *The Flu Pandemic and You: A Canadian Guide* (Lam and Lee). Written "with cool heads and great professional expertise," according to the book's promotional material, it is an "essential survival guide — both to pandemic influenza and to the hype surrounding it." "Contact Tracing," however, shows a far less certain version of SARS and health professionals. Lam explains how the SARS crisis confronted front-line health-care workers "with a kind of vulnerability that we had not previously experienced" (qtd. in Goddard). Such vulnerability is virtually absent from the non-fictional book on the flu but comes through clearly in the story. In "Contact Tracing," personal danger shatters any sense of medical invincibility. When asked in a book club "Author Interview" whether he thought that readers would "look at the health professionals they interact with differently" after reading *Bloodletting*, Lam replied, "Some people will read this book and feel worried about the human limitations of health care providers. Others will read it and feel more comfortable to know some of the human nuances of those who care for them." I am reminded again of Osler when he argued that doctors need to approach medicine with what he called an air of "imperturbability" and an impression of mental "equanimity" (the "cool heads" above). Significantly, however, in a valedictory address to the University of Pennsylvania graduating medical class of 1889, Osler emphasized that imperturbability and equanimity are only "airs" — both of which are vital to building the confidence of the patient but risky if believed by the physician (4).

In "Contact Tracing," two of the doctors whom we have followed since before medical school become patients quarantined with SARS symptoms themselves after exposure to an undiagnosed SARS patient. It is not until they are conversing between glass walls as patients that Chen and Fitzgerald recognize that they forgot that imperturbability should only be an air. They are then able to recognize their own limitations as doctors:

> "When did we forget what it meant to die?"
> "Probably at night."
> "Yeah, it would have been late." (288)

They also tell each other stories about the times that they failed as doctors, like when Fitzgerald chose not to respond to a man passed out in a park and when Chen chose to wait for several hours to call a woman's family after the woman died so that he could get some sleep. These stories are not the subjects of bioethical debate in the story. The doctors feel guilt over their actions, and relief in telling of them, but they also accept them as human acts compelled by exhaustion and disinterest. "Contact Tracing" productively shows several sides of the flu epidemic that could well supplement the facts and figures approach of *The Flu Pandemic and You*.

The polyvocal and fluid form of this story also augments the multifaceted nature of the flu epidemic. Lam juxtaposes briefs, present throughout the story in italics, "from the files of the World Health Organization" (WHO), with statements issued by the director general of the WHO, and Public Health announcements with the fictional consultation notes of a character named Dr. Zenkie, a nurse's story, and the conversations between Chen and Fitzgerald. By placing the verifiable information and people from the historical events around SARS beside fictional responses, Lam self-reflexively illustrates the impact of the flu epidemic on the medical system. Such creative juxtaposition traverses a false divide between knowledge and imagination. As with historiographic metafiction, the story fills in gaps in the official historical record. That said, Lam also leaves essential breaks in the narrative. We do not know in the story, for instance, if the doctors survive the outbreak. "Contact Tracing" is not formally innovative — it is typically postmodern in its use of aporias, analepis, and non-linear formation — but it is effective nonetheless in illustrating how uncertainty and ethical conflict can exist in medical situations well beyond individual diagnosis. Lam's stories point to some of the ethical concerns raised in medical schools, in hospitals, and among health-care workers themselves.

Conclusion

I end with a brief consideration of another story in *Bloodletting and Miraculous Cures*. "An Insistent Tide" is less successful than the other stories in terms of literary merit but might be more useful in a bioethics medical classroom. The story follows a character named Janice into labour and asks what would happen if an anaesthetist were unavailable when an emergency Caesarian section was required. The story points to the improbability of an "ideal" birth plan as it depicts the medicalization of labour and the use of technological interventions. It also raises significant questions about the ethics of delivery, a baby's rights, and the rights and responsibilities of the mother. The problem, from a literary standpoint, is that the writing veers into purple prose when Lam describes the pain of labour and childbirth in the context of maternal sacrifice. The story begins with Janice dreaming of ocean tides washing over her as we learn that her water has broken. The wave and water imagery recurs as the discomfort of labour and the pain of delivery wash over her. The implication seems to be that the pain of labour goes away if the woman just shuts her eyes hard enough. As Lam writes about the woman's dangerously dilating body, he renders pain poetically. No other suffering in the book is as gendered, and none is rendered as prettily. As a literary critic, I balk at the aestheticization of the woman's body in pain and think about how Lam participates in a long history of rendering hurt women in metaphorical terms. Crossing disciplinary lines, such gender criticism could be used in a medical classroom to lead to important discussions about gendered and potentially dangerous attitudes in medicine. Indeed, a course in the subject could be designed around reading this story together with *Annabel* and *Room*. In addition to the skills recognized by narrative medicine programs, the problematic content of some stories and a literary critical lens could certainly add to the development of narrative competence.

Yet the flaws in "An Insistent Tide" lead me to a few caveats about turning to fiction for medical classroom study. It is necessary to recognize that a story always comes with the limitations of its author (in terms of bias, perspective, and knowledge) and with the restrictions of the form (it is limited and immutable). Although a story can act as a springboard to bioethical inquiry, it is necessary to remember that it is a creative work of fiction and not a case history. Even if it is efficacious to turn to fiction in a medical humanities classroom, that is not likely why the story was conceived, composed, and published. Furthermore, from my position as a teacher of English literature in a neoliberal university, I am concerned about trends toward finding use value in literature and instrumentalizing art. I even worry that my argument here could be misinterpreted as a step along the road to selling the study of fiction and repositioning the humanities as worthwhile in a university system geared to STEM (science, technology, engineering, and math) subjects, and I can see the dangers in such an appropriation of literature. So I want to caution against reading fiction only teleologically. That said, I firmly believe that the study of literature *is* useful and relevant. Here, studying the works of Lam, Donoghue, and Winter, we see imaginative spaces where vital ethical questions can be asked and where accepted norms and standards can profitably be challenged.

On the hardcover edition of *Bloodletting and Miraculous Cures*, Lam is quoted as saying, "I wanted to write about the reality that doing good and trying to help others is not simple. It is ethically complicated and sometimes involves a reality that can only be expressed by telling a story." He is not alone in this sentiment. Doctor-writers (and there have been many, from Anton Chekov to Khaled Hosseini to Kevin Patterson) have long noted the possibilities of linking medicine and storytelling. The idea that with stories authors have the freedom to engage the complex ethical issues of health care apart from other forms of medical discourse is really what drives this article. Sometimes reality can only be expressed in a story. Since the field's inception, narrative medicine programs have been indebted to literary studies for the development of empathy, communication skills, and narrative competence. It is time to turn to fiction to join the "science of uncertainty" with the art of "what if."

AUTHOR'S NOTE

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NOTES

[1] Since 2010, McMaster University's DeGroote School of Medicine has included an art component in its medical program. "The Art of Seeing," a course on mental health and behavioural science, brings together the visual arts and medical training. Catherine Thompson describes the course's merits: "taking part in art courses can significantly improve doctors' observational skills, encourage them to be more humane, understanding and sympathetic when dealing with patients, improve their ability to express themselves, and help them better understand death, disability and mental illness."

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