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Stories of values. Value of stories. An alliance of ethics, literature and medical humanities

Paolo Marino Cattorini
Department of Biotechnology and Life Sciences, Insubria University, Varese, Italy

Abstract. In order to rethink the scopes, methodology and teaching criteria of healthcare professions, we have to take some theoretical steps: exploring the phenomenology of illness, recognizing the narrative dimension of medical enterprise and of clinical ethics, opening a fruitful dialogue with art criticism, underlining the mutual duties of the therapeutic covenant, and considering the cinema as a test bench for the medical humanities (history of medicine included). The inner weaving between facts and values, biological data and shared decisions in the sphere of the healing endeavour finds its roots in the ancient importance assigned, since the Greek thought, to the relationship between cases and theories, story-telling and conceptual reasoning.

Key words: ethics, narrative, art criticism, medical humanities

Schools of Medicine and Bodies of Illness

What does it mean to become a physician? What kind of compassion can a patient expect a healthcare professional to show? How does the profession interweave the role of specialized technician with those of caring ally and successful institutional manager? What cultural destiny awaits the hybrid character of a biomedical expert involved in delicate communication with a suffering patient? Hasn't it become naïve to recommend that the history of medicine (of all the medical humanities) be considered one of the core competences of a surgeon or hygienist?

The philosopher Nietzsche, in the Preface of his second *Untimely Meditation* (1874) about the use and abuse (disadvantages) of history for life (1), courageously declared that we do need history, but that we do not need it in the same way as that with which a spoilt idler cultivates the useless garden of ornamental knowledge. *Leben* (life) and *Historie* (history) are not destined to ignore or harm one another, because we require history (according to Nietzsche) for life and action, and not as a comfortable escape from moral problems, or an egotistical excuse for bad deeds or passive negligence; we only desire to use history insofar as it serves living. Otherwise, atrophies and degeneration will weaken the cultural arena and they will paralyse the debate about pluralistic values. If the eyes are simply turned back to the past, if historians do not train and teach an anti-dogmatic awareness, then we risk repurposing old rusty solutions to new puzzles, particularly to moral dilemmas never seen before. Unfortunately, even in the current third millennium of biomedical development, there are several symptoms of the dissociation between living experience, history and technicalities. What kind of *Nachteil* (detriment, abuse, damage, disadvantage) is now being perpetrated?

The ethical and humanistic training of the physician, nurse and other operators in the healthcare field still presents some embarrassing shortcomings and, in certain contexts, appears to lack theoretical foundation (2). Where the model of a naturalistic training is in force (which defines the physician as a technician, an expert on the biological phenomena of the body), it is impossible to understand the practical dimension of clinical decision-making, or to grasp the requirement (expressed in widespread and concerned forms by public opinion), for the healthcare worker to honour a basic *promise.*

Which one? The promise to act as the *ally* of those suffering, using theoretical know-how, operational skills and technical abilities to promote the *best interest* of the patient, establishing as mature and equal a relationship with the latter as possible, in order to accompany the sick person in deciding on which tactics to engage to combat the threat of the illness. The actions performed to help people are not reduced to a trade, in the sense of a manual or cognitive activity repeated impersonally, but instead constitute a *profession*, which commits the expert, in relation to all of society, to *look after* its weaker members, by promoting fundamental values (the health, life, freedom, autonomy of the citizens), communicating carefully and preventing dangerous conflicts of interests (economic, career or power-related).

This article briefly underlines the actual (but frequently hidden) relationship between clinical ethics, literary criticism and medical humanities. Moreover, it reminds us of the privileged role assigned to medicine, since the beginning of the Greek thought, as a paradigm of a practice and a knowledge requiring certain interpretative virtues that we now hold in high esteem as *core competences* of the *humanistic consultation in a healthcare setting*. Medical humanities, as inherent elements of the clinical enterprise, have a central role in establishing and enforcing a person-centred approach in the healthcare decisions, policies and institutions. The common framework and the deep commitment of these disciplines (medical law, literature, history, anthropology, moral studies, and so on) focus on the human dimensions of health problems; they use interdisciplinary approaches (instead of restricting and overspecializing the field of inquiry); they employ case studies and practical reasoning to deal with new dilemmas; they develop concrete problem solving skills (and not just the abilities to analyse language and present a coherent logical argument); they recognize the value-laden premises of professional behaviour and require rational justification of the moral judgments expressed by the stakeholders; they foster the discernment of individual, unique and unrepeatable idiographic situations and of personal episodes or deeds (3).

If medicine once saved the life of ethics (4), now the time might be right to launch a second rescue operation. *Medical humanities* (history of medicine included) should stop applying (i.e. dropping from above) their own particular conceptual repertoire, and merely trying to measure this top-down exercise against the demands of some general theories. Instead, they should reverse the approach to practical items, by *learning from clinical casuistry* and from its perennial concern for the specific circumstances and for the original contexts in which suffering is experienced in unpredictable ways: «So understood, appeals to theory – whether in neurophysiology or molecular biochemistry, philosophical ethics or moral theology – are helpful only to the extent that they throw incidental light on particular cases. The argument for seeing this approach as typical of activities like medicine and navigation was stated more than two thousand years ago, in Aristotle's *Nicomachean Ethics* » (5).

The contemporary importance of humanities in medical settings does not simply imply an epistemological turning, but it also represents a crucial factor in thinking about a new kind of *teaching* and in building a new course of *training*, which could prepare healthcare professionals for clinical encounters with ill people made of flesh and blood, and not with anonymous tokens of some broken mind/body apparatus, as marvellously depicted by the atlas of Pathology or by the treatise of mental disorders.

Are today's Medical Schools ready to adopt this new teaching approach? What role will *humanistic subjects* play in the curriculum of studies? What importance will these core anthropological competences have for indicating the criteria for the recruitment, evaluation and selection of future professionals? On what *body* will the students study and practice? On the corpse of the autopsy rooms? On the drawings of the anatomy papers? Or on the living patient's body (*Leib*, as German phenomenological philosophy calls it), subject to the troubles and expectations of a sick person, who is moved by specific fears and original desires, desires that must be intercepted, listened to, interpreted and taken into consideration when making and communicating the diagnosis/prognosis and when proposing or deciding on the treatment to implement?

The *traditional distinction*, order and ranking of the basic disciplines, skills and attitudes, which are taught during the University programmes, have to be reconsidered, after the convincing bioethical plea to take care of a human being, rather than merely

studying, measuring and repairing damaged biological mechanisms. Just in order to decide whether a subject is preliminary, preparatory, propaedeutic to another matter, you need to take a reasoned position about the scopes of medicine (6) and about the ways, in which perception, interpretation and judgment of medical data interweave in the daily clinical enterprise. The *naturalistic bias* recommends the following steps to students or resident pupils: first learn the handbook figures or formulas; then try to recognize them in laboratory compounds or in microscope specimens; next see the whole body as a balanced ensemble of biochemical reactions or a self-changing architecture of inner circuits and gears; finally remember to consider the human (generally speaking, the psychological) nuances of such a body, before communicating a diagnosis and before proposing and hopefully sharing a treatment solution.

Is this the real experience of living our body, of understanding the illness and of healing a psycho-physical wound? Histology deals with the tissues of the body, but its manuals are drafted based on an *abstraction*, which describes and documents – in a snapshot, in a videotape or in a graphic reproduction used for teaching purposes – the evolution of a group of cells, but detaching them from the organism as a whole which, for as long as it is alive, is constantly in movement, regulates itself and modifies itself in response to the stimuli of its environment and is affected by thoughts and emotions. By surrendering to the blandishments of bio-reductionism, we risk misunderstanding the *human story of a body*, its complex unity, its exposure to the world of linguistic meaning (even a wrong word can make someone fall ill).

Illness and Disease. Clinician and Technician

To understand the many meanings of the body studied by medicine, we recall the thoughts of Sartre on the three ways in which *pain* (in this case, pain in the eyes) is felt (7). Firstly, pain is experienced as a strange vibration of the conscience, which has a practical relationship with the world: there is something not right in the way in which I am reading. Pain is an alteration of the gesture of reading, with which I am interacting with the world. The words of the book seem to shake and detach themselves with difficulty from the undifferentiated background of the page. I waver myself, because *I am the eyes*, I "exist" them.

Only later on, by reflecting on what is happening within my conscience, can I localise the source of discomfort pain and feel a sort of *psychic object* (the pain), which has its own identity and duration, its own bodily position and a temporal evolution. There is an internal presence that wounds me and that I learn to recognize: the pain is here, under my eyelids.

The *physical and anatomical awareness* is the third stage and it comes about via the mediation of the body of others. The body of others speaks, it tells me things, it reveals me to myself, it studies me as if I were something that can be objectified. In this way I learn that *I have a biological body*, an eyeball, an irritated conjunctiva. I know that I am a person who has sick eyes. Those "are" no longer my eyes. I "have" them. I have a sick eye that needs a more accurate diagnosis and a remedy. I *have a disease*, which others have made me be aware of and that they can diagnose. It is present for others, even when I am not aware of it (7).

The medical treatise (that is, the knowledge about psycho-physical disorders) derives from a further reading, from a re-interpretation, from a not completely innocent translation of the spontaneous living experience, which the clinician encounters in a patient and classifies by symptoms, signs and other examinations. The *care-givers*, who deals with an illness, inquire about the genesis of the inconvenience ("don't you feel well?") and focus their attention on a decision ("I recommend that you take this medicine, which will make you feel better"). The art of a clinician, as Canguilhem wrote, has a *practical foundation*: it is not a science or an applied technique but an exchange of promises that responds to the appeal of those who are suffering (8) and who are searching for a sense of their troubled feelings, for a meaningful interpersonal communication and for a shared decision together with a trustworthy companion.

Therefore, the interpretation of the medical action as a *technical performance* and the classification of the relationship between doctor and patient as a mere legal contract, as a negotiable trade, as a supply of services or as a mechanical repair, have overshadowed the

true identity of the caring endeavour of treatment as *covenant* (9). Accordingly, Medical Schools should reformulate their *curriculum studiorum,* basing it on and having it start from the ethical perception of the pact, which is in play. Constant references should be made to this source of "value", while the biological "facts" are being studied and the students are trained to embark upon their career (10, 11). Analogously the continuous education that takes place in the field of medicine, namely the permanent training that those involved in the healthcare sector are obliged to undergo, should also pursue the desire to perfect the *humanistic qualities and skills* of the professionals as one of its main objectives.

History and Interpretation in Medicine and Narrative Ethics

If the Medical Humanities (and the History of Medicine among them) are nowadays correctly considered necessary ingredients of professional education, this is due (at least partially) to the *role of narration* in medical practice. Clinical medicine is narrative by nature, as it is structured on the practice of listening to stories of illnesses, understanding and developing them, imagining that they might have a worthy, happy solution, and suggesting a plot of worthy, appropriate course of treatment (12). In particular, clinical ethics (now, fortunately considered an essential element of healthcare) creates an intrinsic relationship with stories. Just as the doctor, in his own way, is a *story-teller*, likewise, those who practice ethics (not just the philosopher but all healthcare operators, when they wonder about the moral significance of their practices) need a story. Only *within a story* does the meaning of a *therapeutic action* gain *significance*; only against the backdrop of a "story of the origins" do the words, concepts, arguments that we use to justify a proposal of care and which the ethical theories tie together in systematic structures of thought make sense. Let us take a closer look at some of these steps (13, 14).

In order to make a decision (to identify the proportionate medical intervention, to decide whether and how we want to have a child, to fairly allocate sanitary resources), we must intertwine small and large plots. The *small plots* are our biographies, interwoven fabrics of excited ideas and cognitive passions, of conquests and failures, of plans and unfinished toils. The *large plots* are visions of a good life, paradigmatic stories, myths (religious or secular) that tell us of the beginning and the destiny of the world, of our human role in the cosmos and in society, of the interest that some god may perhaps hold for us.

Without this weave, without placing the sense of an action in the sequence of the days which we spend under the sun, and without considering our existence in the design of a "legendary" story that ensures our efforts make sense, no moral judgement can be made. On the contrary, it is not even possible to understand the moral significance of an action, because the same material gesture (caressing a child, turning off an artificial ventilator, removing an organ from a corpse) can have different *meanings* and deserve a different evaluation (of commendation or condemnation) depending on the historical context, the intentions and the experiences of the agents involved, the consequences for the person and for others, and the attitude (of empathy, predation, trust or deceit) which that gesture symbolically embodies.

Narrating in order to judge. By tackling real or fictitious clinical events, we have been urged to consider *clinical bioethics as literary criticism* (15). The former (bioethics) investigates the moral value of a deed made by a doctor or by a member of the staff (a "nice" gesture, or an ill-done, graceless one, we could say in aesthetic terms) and justifies the reasons for its evaluation in terms of principle, rules and theories. The latter (literary criticism) critically perceives the importance of a work (a "good novel", is the expression used to describe a novel that has been written well, using an ethical adjective) and backs this up, placing it in a historical framework, indicating the motives for its originality and expressing more clearly the qualities that its users can perceive and appreciate.

The two interpretative practises are *halfway between life and philosophy*: art criticism does not replace, but on the contrary promotes the vital encounter between book and reader or film and viewer; criticism refers to aesthetics (that is, to philosophy) in order to reconstruct with valid reasons the ideas of beauty, which the novel writer or movie director have followed or

opposed. Similarly, the consultation in clinical ethics helps the subjects, who are experiencing a dilemma, to deepen and express their personal point of view, by listening and critically thematising the many situational variables (desires, tendencies, preferences, meanings, consequences). Those who "apply" ethics to medicine resort to moral philosophy as they do to the repertoire of conceptual systems, as the arena which hosts the eternal confrontation between visions of good, prescriptive rules and models of reasoning (16, 17). Between sensitive intuition and logical analysis, between emotional perception and conceptual argumentation, a partnership is established.

In this sense, narrative is not a *tool* of medicine or of ethics. On the contrary, we are, as moral agents (and from time to time care-givers, historians, readers), tools of the narrative, because our experience is led by icons of goodness and by models of a worthy life. We *are the stories we believe in*. We continuously face these exemplary events with the *plot* of our actual life, with the fears and hopes lit by the experience of suffering, of receiving treatment, of healing. Between principles and stories, between rules and cases, between syllogism and symbols, between theories and narrative there is the same synergy, the same exchange of truths, which has existed since the dawn of Greek philosophy between *lógos* and *mŷthos*, between concept and image, between logical reasoning and creative yarning, between critical essay and dramatic piece.

The stories are not "tools" of the intellect, as they live within us, surround, infect and attract (or disgust) us, before we realise it. Their episodes and characters cannot be fully grasped, neither can they be interpreted in one unambiguous fashion, and they are not affected by our efforts to control or definitively complete them. Instead, they leave us the duty to think about them, to *return and reflect* on them (18), asking ourselves: what is it about this matter that convinces us and what instead disappoints us? How should the story continue in order to ensure coherence and why? What image of happiness is promoted or betrayed by a film-director's decision (in the literary realm) or, similarly (in the clinical domain), by undergoing a treatment, by refusing an operation, by donating an organ to be transplanted? Why does a potential decision seem inadequate, incoherent or even contradictory at the very same moment when it is proposed to us, by some expert, as the best option?

The so-called *application* of the theory to a concrete case is therefore not only headed in one direction, as this kind of application leads us to *bounce back* from reality to principles. Theory is perfected and corrected by applying it to real dilemmas (19). Stories are the testing bench on which to measure the pertinence, effectiveness, elasticity, universality, wealth, explanatory power, in short, to measure the properties to which each serious theory lays claim. And the fact that the stories are considered a measure and a criterion for verifying theories is proof that the two subjects belong to a *same nature*. Theory clarifies but does not dissolve the complexities of life, it sheds useful light on a particular conflict but fails to replace (by imposing a deductive syllogism) the wisdom needed to make decisions and the aptitude for interpreting required (since the *Nicomachean Ethics*, as we have said) in activities such as medicine, sailing or situational ethics.

The Physician's Covenant and the Narrative Pact

Eloquent proof of the connection between medicine and story telling lies in the analogy that exists between therapeutic covenant and narrative pact. By *therapeutic convenant* we mean the exchange of promises between the two main players in a treatment: the health workers promise that they will be on the sufferers' side; that they will keep them informed and involve them in the decisions to be made, that they will seek updated information and act with diligence, expertise and caution (20). At the first signs and actions which document this intention, the patient responds, giving them credit and expressing, on his part, the will to communicate his ailments with sincerity, to overcome the understandable reserve linked to the intimacy of the situations, to faithfully follow the advice given (subject to having freely agreed to the treatments proposed, having been fully informed about them and being competently responsible for giving his consent), not to damage other people and so on. Once this agreement of mutual beneficence in trust has been established, the partners, as proper allies, together face unexpected occurrences and challenges and sign more

detailed agreements (often also in writing: the so-called consent forms) for the more, delicate, invasive, risky procedures (21).

It is remarkable that, while some bioethicists recommend a narrative approach to decision-making, on the other side of culture, literary experts have defended *ethical criticism* as an approach to literary texts (22). This is not a moralistic, bigoted or, even worse, censuring intrusion into the experience of choosing and reading a book. Instead, it is the interest shown by literary criticism for the moral and existential implications of works. Indeed, each reader reasons (often unconsciously) in moral-philosophical terms, each time that they express, defend or discuss their opinion about a novel or a film. When we loyally interpret a work, we may *classify it* as faulty, mediocre, of little moral substance, or even misleading, false, poisoning, comparing it with other texts which reproduce a wider and a more coherent picture of a social universe, which rebuild the ethical complexities of an existential context more faithfully (think about a novel of education focused on the discomfort experienced by adolescents), and which therefore seem to invite the reader to explore the subject more truthfully, an experience in which the latter expects to participate together with, and thanks to, the author.

And this is the crux of the matter, the element that interests us most. There is a *pact* that the author (movie director or book writer) makes with the user (viewer or reader).The first step with which we enter a work coincides with the trusting consent with which we abandon ourselves to the text and follow the proposed plot until – hopefully – its conclusion. *We believe,* in order to understand. We suspend our disbelief with a conscious act of will (a willing suspension of disbelief, as Coleridge said) and slip into the personal, emotionally warm encounter with someone and something, which promise to make us *taste a revelation*, that we need (23). This *encounter* with a different vision of the world from ours generates, both on an ethical and aesthetic level, opportunities for dialogue, interaction, confrontation, disapproval. The quality and the destiny of the relationship cannot be foreseen and understood *a priori*, and so create the need for a "line of credit" to be opened: what am I being asked for, what am I receiving from and what am I being shown by the person speaking to me? What kind of friendship, what kind of companionship is the author offering us? «Instead of asking whether this book, poem, play, movie, or TV drama will turn me towards virtue or vice tomorrow, we now will ask what kind of company it offers me today» (24). We have consciously used the term "taste": indeed we find ourselves dealing with an experience that touches on a level which is *theoretical and practical*, cognitive and emotional, descriptive and normative (25). And it is an integral experience, in the sense that it wholly involves the partners. Integral for us, who run risks when we are reading a text. Integral for the work, which deserves to be employed and evaluated for its form and its contents, for *how* it tells the story and for *what* it says. And indeed the relationship between form and content is one of the elements which engage us and expect us to state an opinion, which deserve the surest confirmation of our approval from the very outset, or reawaken a more suspicious and critical view of the clues of a possible act of deceit, hatched by the text against us.

Based on the analogy between therapeutic covenant and narrative pact, it is not surprising that mention has been made of the *duties* of the allies. The author or director has various responsibilities: towards the viewer to whom he proposes a brand new vision, towards the work that he is producing, towards the events and characters, that become the fabric of the text and towards himself as witness and narrator. The reader or *viewer* also has duties: towards himself as a fair interpreter, towards the author (whose message he is receiving and using), towards the plot, which he is required to "complete" with imagination, to co-write and co-direct (as well as praise or criticise from the outside).

In other words, he who responds to the *invitation of a literary work,* comes into action as accomplice and covenanter; he takes on that story and allows it the opportunity to invade his time and his thoughts, identifying himself in the plot, yet at the same time reserving the possibility to express his own justified motivation and even to withdraw his approval and interrupt the reading/viewing. Stepping into a movie (as either a director or a viewer) is very similar to entering the moral fabric of our own life and expressing an ethical evaluation of it (26). Shooting a film, editing it and show-

ing it resembles the process during which *we imagine* a worthy future or an happy ending to our personal story, interpret the significance of a past choice or a present dilemma, and direct the interaction between the characters of our inner cast. The word "decide" comes from the Latin for "to cut" and in film terminology editing is called *cutting*. In order to live, we must make choices and in order to make choices we must dream and compose a dramatic development, excluding, surrendering and cutting out other chances.

Cinema and its manifold ethical meanings

«A modern Plato would compare his Cave to an underground cinema, where the audience watch the play of shadows thrown by the film passing before a light at their backs» (27). Several contemporary philosophers have actually defined the experience of watching a good movie as an enlightening immersion into a sea of ethical truths and as a liberating upheaval of the whole personal vision, as a sort of getting out of an obscure cave (28).

Therefore a recent pedagogic trend has stressed the importance of cinema for education in medical humanities. Watching and commenting motion pictures, with the supervision of a teacher or a critic, undoubtedly offers students several opportunities. Fictitious plots *directly involve the viewer* in cases with a complex structure in terms of cognition, emotions and values; they urge him to imagine in concrete forms a fairer model of the relationship between doctor and patient and of how healthcare is organised; they train him to interpret the words and gestures of an episode of suffering or healing with greater sensitivity, they force him to publicly display and discuss rationally understandable and coherent motives when justifying a choice of behaviour.

Despite these educational virtues, we have challenged the above-mentioned "tool-like nature" of cinema in teaching contexts and discouraged a simplistic view of its utility in so-called narrative based medicine and in narrative ethics. One of the reasons for our concern is that the *meaning* of a film is neither univocal nor easy to grasp. Consequently, it is an illusion to introduce a movie as a bewitching automatic formula of educating students in order to endow them with greater wisdom or cause them to reach a higher level of maturity, by using literary instruments, techniques and stratagems to obtain moral results that could be foreseen and planned in advance. Any work of art reveals fragments of truth that could explode, infect and modify our soul in unexpected manner. A well done movie certainly urges the audience to make its own free, moral decision, but the diverse, bizarre, even contradictory outcomes of this choice, which vary from person to person, depend upon the rich, complex, many-sided nuances of what is shown on the screen.

A film is about at least three things. First of all it is about a *theme,* which often, (in our case) has to do with ethical issues related to health. The film links facts and people, natural events and cultural occurrences, coincidences and meditated choices. And it links them in a single pattern of human interest which invites us to investigate it and draw our own conclusions, using our imagination to complete that work which "The End" of the film inexorably leaves wide open (29, 30).

For instance, we know something more about medicine, by watching a medical film. The film *Concussion* (USA 2015, directed by Peter Landesman, with Will Smith, Alec Baldwin, Arliss Howard, Paul Reiser, Gugu Mbatha Raw) proposes the true story of a Nigerian pathologist, who worked in Pittsburgh, Pennsylvania, in September 2002. His name is Bennet Omalu. The corpse of an American football player arrives on his autopsy table. The man was 50 years old, had been retired for 12 years and seemed to have suffered from Parkinson's disease and depression. Omalu wants to know the whole story, so he carries out full physical and biochemical tests and believes that he has discovered a sentinel event of chronic post-traumatic encephalopathy. This will subject him to a great deal of criticism…The film is about professional independence, the moral duties of sports medicine, the complicity between sport business, company interests and the role of science. The viewer gains knowledge and develops sharper abilities to understand and judge all of this matter.

Every film is also then about the author. The story continuously leaves us clues about the outlook that has imagined and then created the plot, experiencing the intriguing, unpredictable task of photographing,

filming, cutting, editing and then wrapping up a work, so that it can be delivered to whoever will use it. But what counts most, it is the *implied author*, that the reader/viewer infers from the narrated sequences, that is from the way a literary work is composed. This implicit author, this author-implied-in-the-text doesn't coincide with the real director (in flesh and blood), who has experienced the exciting, dangerous, intriguing phases of shooting the film, by consciously following some personal artistic intentions. The implied author is the figure who actually divides the narrative power into one or more voices, eyes or outlooks (which speak or open visual perspectives), and then into main and minor characters. In other words, the text itself displays the kind of thinking subject, who, by addressing a certain type of viewer/reader (the "implicit" user-in-the-text), gives a rhythm, a light, a music, an atmosphere, a unity (or a calculated discontinuity) to the sequences and in the end decides exactly when to finish it all. The film is the story of an outlook that changes in contact with the event being described, an event that has as many passive characteristics (as it is moulded by the film maker), as active ones, because the script has impressed the director or the producer, charmed them, and so demands obedience, invites them to "live it", to "look at it more closely", to discover its truth. Let's return to *Concussion*. The film by Landesman is composed of full close-ups, of *details*, and the viewer becomes a pathologist, who identifies the moral effects of those underlying, deceitful traumas that no amount of brain-washing or neurosurgery can now remove. The eye of the narrator does not promise a course of treatment but stubbornly documents the development of a diagnostic conjecture. The director asks us to enter his narrative perspective, which resembles the solution of a puzzle. The director has believed in the truth of a story (like in the case of Omalu: a clinical hypothesis, which has then become a scientific article and then been reported by magazines) and now wants us to go down the same incredulous pathway, placing our bets on a theory that might seem mad, unrealistic, presumptuous, unproven, naïve, but which in the end could prove to be illuminating.

Finally, cinema is about the general experience of *making films* and *going to the cinema*. Each film talks about the art that has produced it and refers to the infinite network of plots, which interweave, generate new scripts, enhance one another with ancient frames and altogether build an "other" world, the aesthetic world, in which all of us, set designers or viewers, decide (at least for a short time) to live, as it promises to bring justice in our personal dilemmas, doubts, traumas and suspicions.

In whatever form this may occur today (the classic cinema theatre; the Dvd shown in unofficial venues; viewing in streaming; the ultra-private screening on a tablet), the visual text offers us the opportunity to take part in a joint action, a shared exploration, a pact (as we have called it) which links a user to a producer of moving images, establishing an unexpected attraction between the two allies. The *story reigns* over both partners, as it chooses them (director and viewer), enchants, tricks, trains, deceives, transforms and credits them as the interpreters of a truth that occurs through them.

Language is about language, wrote Barthes (31). Cinema is always *about cinema* as a moral experience and finds inspiration in the theme discussed and the style of the narrator, to show us what happens in the time/space of our viewing. "The war film is about the strange peace that reigns between the viewers; the film *noir* is about the inevitable end of the show; the psycho-thriller tells us what the crime just perpetrated by the screen is; films about employment are about that specific job one does when one goes to the cinema" (29). «The film *Concussion* which (on the first level) tells the story of sports illnesses and which (on the second level) portrays an illness of the vision (the narrator's inability to acquire a complete perspective of many facts and characters in a controversial event), is (on a third level) about the *cinema as an illness*, as the guilty detachment from life, as the dangerous reaction to the real events, as a way of painfully bashing your head against opponents that push against you as you move, as a dream that is risked beyond the limits of the known, as the contamination of possible plots that are capable of shaking our certainties and making us doubt (32). Plots that also (we hope) might suggest a way that will get us out of our predicament.

The habit of Omalu who, before every autopsy, speaks to the inanimate body and asks it for help, is

an allusion to cinema: let me find what I am looking for, let me know the truth. Doctor Omalu knows that the time for saying ones goodbyes is long; that the effort of grieving is tiring; that the survivors hold a silent dialogue with the dead; and that in the autopsy room, death enjoys helping life. But cinema also speaks with the shadows and with moving images (like Omalu with his corpses) and asks for their assistance: help me to cut, to understand, to set free the truth that you are hiding within you».

The Body as a Text

It is now time to draw some short concluding remarks. We have shown in this paper that the alliance between Ethics, Literature and Medical Humanities is based on an indissoluble interweaving of *narrative and values*. No story can be narrated from a neutral, value-free point of view, and the task of medical humanities is to discover, interpret and discuss the idea of good life, which shines through the clinical records, the patients' diaries, the historical studies, the case reports. On the other hand, clinicians and ethicists (who deal with values: the value of health, the value of a just action) listen to stories, image, expand, compare, suggest, criticize, evaluate and even re-tell stories. Without narrating the beginning, course and prognosis of an illness, no medical step or decision can be proposed or taken for the sake of the consenting patient. Without saying what is happening to some moral agents, whose roles are placed in unique historical plots and contexts, no ethical evaluation can be pronounced and justified about their intentions, plans or deeds. Our living body itself, in times of illness or care, is nothing but a text, with a malaise which has to be understood and healed by referring to the narrative impasse and to the conflicting values which have wounded its moral fibre (33).

References

1. Nietzsche F. Untimely Meditations. Cambridge: Cambridge University Press; 1997: 57-124.
2. Cattorini PM. Cin-Etica: la bioetica al cinema. Diritti civili, responsabilità professionale e scopi della medicina. Introduzione. Santarcangelo di Romagna: Maggioli; 2017: 9-29.
3. Kopelman LM. Bioethics and Humanities: What Makes Us One Field? Journal of Medicine and Philosophy 1998; 23(4): 356-68.
4. Toulmin S. How Medicine Saved the Life of Ethics. In De Marco JP, Fox RM (Eds.). New Directions in Ethics. The Challenge of Applied Ethics. New York: Routledge and Kegan Paul; 1986: 265-81.
5. Toulmin S. Casuistry and Clinical Ethics. In: DuBose ER, Hamel R, O'Connell LJ (Eds.). A Matter of Principles? Ferment in U.S. Bioethics. Valley Forge: Trinity University Press; 1994: 311.
6. Mori M (Ed.). Gli scopi della medicina: nuove priorità, Notizie di Politeia 1997; 13(45).
7. Sartre JP. L'essere e il nulla. Milano: Il Saggiatore; 4th ed. 1980: 411-43.
8. Canguilhem G. Il normale e il patologico. Torino: Einaudi; 1998: 166-88.
9. Cattorini PM. Malattia e alleanza. Considerazioni etiche sull'esperienza del soffrire e la domanda di cura. Firenze: Angelo Pontecorboli Editore; 2010.
10. Cattorini PM. Bioetica. Metodo ed elementi di base per affrontare problemi clinici. Milano: Elsevier, 4th ed. 2011.
11. Cattorini PM. L'etica medica va al cinema. Bollettino Ordine MediciCeO Milano 2014; 2: 44-6.
12. Cattorini PM. Narrative Medicine. An Ethical Reappraisal. Medicina e Morale 2015; 2: 245-66.
13. Cattorini PM. Un buon racconto. Etica, teologia, narrazione. Bologna: Ed. Dehoniane; 2007.
14. Cattorini PM. Estetica nell'etica. La forma di un'esistenza degna. Bologna: Ed. Dehoniane; 2010.
15. Cattorini PM. Clinical Ethics as Applied Aesthetics. Journal of Aesthetic Education 2014; 48(2): 16-35.
16. Cattorini PM. Bioetica clinica e consulenza filosofica. Milano: Apogeo; 2008.
17. Cattorini PM: Consulenza in bioetica clinica. Una proposta. Medicina e Morale 2015; 6: 941-58.
18. Grampa G. Dalla simbolica alla poetica. In: Melchiorre V (Ed.). Icona dell'invisibile. Milano: Vita e Pensiero; 1981:183-220.
19. Cattorini PM. Dalle storie alle teorie: applicare l'etica alla medicina. Etica per le professioni 2009; 3: 95-102.
20. May WF. The Physician's Covenant: Images of the healer in medical ethics. Philadelphia: Westminster Press; 1983.
21. Pellegrino ED, Thomasma DC. For the patient's good. The restoration of beneficence in the health care. New York: Oxford University Press; 1988.
22. Cattorini PM. Etica e critica letteraria. La lezione di Wayne C. Booth. Rivista di Storia della Medicina 2010; 20(1-2): 61- 98.
23. Rosa G. Il patto narrativo. Milano: Il Saggiatore; 2008.
24. Booth WC. The Company We Keep: An Ethics of Fiction. Berkeley-Los Angeles: University California Press; 1998: 169.
25. Nussbaum MC. Upheavals of Thought: the intelligence of emotions. Cambridge: Cambridge University Press, 2001.
26. Cattorini PM. Movies on Bioethics. A Double Review and

Some Steps Forward. The Journal of Aesthetic Education 2012; 46(2): 111-21.
27. MacDonald Cornford F. The Republic of Plato. London: Oxford University Press; 1941: 228.
28. Fariña JJM, Solbakk JH (Eds). (Bio)ética y cine. Tragedia griega y acontencimiento del cuerpo. Buenos Aires: Letra Viva; 2012.
29. Cattorini PM. L'occhio che uccide. Criminologi al cinema, Milano: Franco Angeli; 2006: 51.
30. Cattorini PM. Doing Justice to Bioethics: The Role of Cinema. Eubios Journal of Asian and International Bioethics 2013; 23(4): 147-54.
31. Barthes R. Critica e verità. Torino: Einaudi; 2002.
32. Cattorini PM. Bioetica e cinema. Racconti di malattia e dilemmi morali, Milano: Franco Angeli; 2ª ed. 2006.
33. Cattorini PM. Cura. Padova: Il messaggero; 2014.

Correspondence:
Paolo Marino Cattorini
Department of Biotechnology and Life Sciences,
Insubria University, Varese, Italy
E-mail: paolo.cattorini@uninsubria.it