Confessions

Confessions:
Confounding Narrative and Ethics

Edited by

Eleanor Milligan and Emma Woodley

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Confessions: Confounding Narrative and Ethics,
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INTRODUCTION

To confess, in the general sense of the word, is to acknowledge, avow, admit or concede. Confessions allude to revelations – ready and reluctant, coherent and confused – that seek to make some sense of things for the teller and the listener alike. In research that considers narratives, storytelling may be experienced as a kind of 'confession', for both the participants and the researchers. For the participants, this may be a confession of things previously unrealised or unarticulated. For the researchers, in their conversations about the problems and processes of narrative research, their own confessions merge with the confessions of others to guide, illuminate and possibly confound the research journey. As 'confessions' make sense of and shape the world around us – in the telling, the receiving, and the interpretation and re-interpretation, the range of papers within this volume seeks to make some sense of the complexities that shape the dynamic relationship between narrative, ethics and research.

The word "confounding", has a similarly inviting ambiguity in its definition that might broaden and deepen the scope of our discussions about narrative and ethics. The Oxford English Dictionary defines 'confounding' as:

- defeating utterly, bringing to ruin, destroying
- discomfiting, abashing, putting to shame
- surprising or confusing, losing presence of mind
- mixing up or mingling so that the elements become difficult to distinguish or impossible to separate

Without limiting or prescribing the interpretations that may be made from these definitions, there is an enormous richness in thinking about how the act of 'confession' may challenge, affront, surprise and indeed entangle our ability to make meaning of the ethical aspects of narrative research-both in its subject matter and processes. Could we argue that some narratives undermine ethical engagement? Or perhaps we may note that confession, in the form of story telling, can often surprise or confuse us in our analysis. Indeed, we may be invited to think, how we can tease apart

the importance of narrative as an inescapable feature of our lived realities and as a basic pre-condition of ethical engagement.

This volume invites some play around the complexity inherent in notions of "confession" and "confounding" by exploring narrative, narrative research, and vulnerability and ethics around the themes of *Narrative Method*, and *Narrative Vulnerability and Ethics*. The significance of this collection is that it intentionally highlights the place of narrative in uncovering the ethical dimensions of the human condition, in research and in social inquiry. As narratives invite an in-depth understanding of the moral world of the other, a fuller understanding of narrative research affords illumination of a range of voices that may serve the broader ethical research purpose of helping us to appreciate and understand the fullest story we can of our particular research projects. The aim of the volume is, therefore, to make explicit links between the importance of narrative, that is, the telling of stories to create shape and meaning in our lives, and ethical engagement so critical to the achievement of a good life.

SECTION ONE:

NARRATIVE METHOD

CHAPTER ONE

CREATIVE, EXPRESSIVE ENCOUNTERS IN HEALTH ETHICS EDUCATION: ETHICS AS RELATIONAL ENGAGEMENT

ELEANOR MILLIGAN AND EMMA WOODLEY

The increasing expectation that health practitioners ought to be aware of, and responsive to, the human and ethical dimensions of their practice has seen the inclusion of medical ethics units into most health care education courses. This commitment to incorporate an ethics component into health practitioner education[1] has been accompanied by the rediscovery of the traditional humanities as an appropriate pedagogical platform from which to encourage students to think about the ethical dimensions of their professional practice(McKie and Gass 2001; Pullman, Bethune, and Duke 2005; Macduff and West 2002; Weisberg and Duffin 1995; Collett and McLachan 2006; Biley and Champney- Smith 2003; Gull, O'Flynn, and Hunter 2002; Darbyshire 1994; Grant 2002; Begley 2003). Exploring an individual's illness experience through creative works – such as literature, poetry, music, biography and art – invites students to consider the unique experiences of each person, as opposed to viewing the caring response in terms of "general principles and typical patients" (Begley 2003:127).

The "humanities turn" in medical education has occurred largely in response to concerns that the scientific and technological aspects of health care have become privileged at the expense of cultivating the equally important human and caring aspects of practice. While some scepticism about the worth of incorporating the humanities into an already crowded medical curriculum exists (Edgar and Pattison 2006; Pickering 2000), and

[1] Most literature on this topic refers to medical and nursing students, although we have applied it to paramedic student in this instance.

while the capacity of the arts to provoke the "desired" insights from health care students is also questioned, the appropriateness and success of this pedagogical approach is widely advocated and considered to have a number of educational benefits (McKie and Gass 2001; Pullman, Bethune, and Duke 2005; Macduff and West 2002; Weisberg and Duffin 1995; Collett and McLachan 2006; Biley and Champney- Smith 2003; Gull, O'Flynn, and Hunter 2002; Darbyshire 1994; Grant 2002; Begley 2003). In the first instance, artistic or literary representations of the plight of the vulnerable or suffering other draw students' attention away from the singular gaze of the biomedical "microscope" towards a more multi-faceted, inter-subjective account of the illness or injury experience. Additionally, as Begley (Begley 2003:128) notes, creative representations have the power to evoke a strong emotional response in the reader, inviting empathetic understanding and relational involvement rather than detached observation. Importantly, this not only enriches students' accounts of the experience of their patients, but also encourages the cultivation of appropriate responsive dispositions such as empathy, compassion, care and nurture.

Finally, the more flexible nature of humanities education is regarded as better able to meet individual student learning needs and may lay the foundations for lifelong interests in the expressive arts. The value of this, Campo (2006:254) argues, is that practitioners who cultivate a passion for language, as well as a capacity to see beauty, will be better able to translate the wonders of medical advancement "in the most meaningful terms for their lay patients and into the larger society around us". Therefore, a heightened appreciation of the human condition (in which the "medical condition" is embedded) with all its vulnerabilities, frailties and triumphs, coupled with the capacity to articulate, interpret and explain the *meaning* of medicine in terms of a life as lived, is of tremendous significance and value in developing an appropriate ethical stance in health practitioners.

During the design and subsequent teaching of a short, first-year professional ethics unit for the paramedic students at Queensland University of Technology, we decided to embrace this turn towards the humanities as it elegantly complemented our existing approach to health care ethics education. Our aim was to design a task which re-enforced our emphasis on ethics in practice as engaged and relational in nature by encouraging the students to enrich their view of the "patient-other" they would eventually meet. By creating a supportive and collegial environment

for our students, we hoped to nurture appropriate dispositions of empathy, understanding and sensitive response to the multiple vulnerabilities of the illness experience.

The purpose of this article is to detail our experiences of using a creative-expressive task in the health care ethics classroom. While we acknowledge traditional biomedically influenced approaches to health care ethics education, we aim to strengthen the case for departing from that tradition and for embracing an engaged-ethics framework for health care practice. We have observed how this approach equips emerging health care professionals with a more appropriate ethical framework from which to respond to the realities of contemporary health care. As such, we show how setting a creative-expressive task for first-year paramedic students gives them an opportunity to rehearse an engaged, relational ethic, providing them with a hands-on and, arguably, a "hearts-on" opportunity to practise the relational and affective nature of health "care".

Prefiguring an Understanding of Ethics

According to Beauchamp and Childress (Beauchamp and Childress 2001:1) ethics is best understood as a "generic term for various ways of understanding and examining moral life." Within these "various ways" there are many conflicting and competing accounts of "ethics" based on different starting presumptions and which offer widely differing explanations of what ethics is, how it ought to be practiced and what its purpose and potential is. Clearly, the starting presumptions and understandings we have of "ethics" are critical in shaping how we attempt to "do" ethics, yet as Isaacs notes, the most fundamental question of "how ought one to understand ethics?"(Isaacs 2003) , or in this case "how ought one to teach ethics?" is largely unarticulated and simply taken for granted as collectively understood, widely accepted, and generally unproblematic. However, Beauchamp and Childress's acknowledgement of "various ways" suggests there ought to be no presumption of collective understanding.

Within the multiple definitions and prescriptions of what ethics is, the dominant account that permeates the medical and philosophical literature is that of the biomedical "theory centred", abstract, universal and generalisable application of moral principles (Urban - Walker 1993). While narrative ethics may be a well-rehearsed idea in the current literature on health care ethics education, it does not, as yet, successfully rival the more common principles-based approach made prominent by

Beauchamp and Childress (2001). These principles[2] are held as starting points of reflection and guidance when considering "cases" that present an ethical dilemma or quandary (Beauchamp and Childress 2001), and may be applied to reveal a consistent, considered and rational response to the ethical question "what ought I do?"[3]. While this notion of ethics seems to dominate collective understandings and expectations in the field of medical ethics (and, notably, in the minds of many of our students) there are significant problems with an approach which sees ethics as an epistemological quest for moral knowledge and abstract truth. Most notably perhaps, is the tendency to reduce the complex realities of ethical engagement to the sterile prescriptions of what Caplan (Caplan 1982:8) describes as "moral engineering ", in which moral theories are simply overlaid onto "the facts" to reveal a generalisable moral truth.

Margaret Urban Walker (Urban - Walker 1993) further notes that the often thin, reductionist and superficial moral debates generated from these "engineering" engagements are the inevitable consequence of defining ethics as the consistent application of intellectually-derived, code-like principles and theories. When ethics is equated to the systematic application of practical reason, pressure to dismiss potentially complicating details such as subjective experience or contextual features inevitably follows. Thus the status of moral knowledge as repeatable and universalisable is perpetuated in these sterile encounters. However, when context is lost, critical consideration of how the particularities of individual lives shape the ethical terrain are also lost, and with them the opportunity to appreciatively engage in the hermeneutic understandings that shape the moral conversation with that patient. Thus the ability to forge an informed ethical response to each individual situation is diminished by traditional approaches. A further consequence of adopting the traditional view of ethics as a detached, intellectual inquiry, is that "ethics" has become segregated as yet another expert-outsider discourse, beyond the grasp of the ordinary person who often lacks the prerequisite philosophical skills to contribute to the discussion (Urban - Walker 1993; Komesaroff 1995). As such, moral deliberation is given over to expert specialist analysis and the relationship between practitioner and patient becomes further removed.

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[2] The most commonly referred to principles of medical ethics, as proposed by Beauchamp and Childress (2001), are autonomy, beneficence, non- maleficence and justice.

[3] It should be noted that the 'I' of medical ethics literature predominantly refers to the practitioner 'I' and rarely the patient 'I'.

Our rejection of the detached ethical "expert" model is also a repudiation of a tacit assumption within traditional moral philosophy that sees the moral agent as being primarily an objective "thinker", who is detached, individualistic, rational and knowledge seeking. As Isaacs has noted, this view denies the reality of the human condition as one which is embedded in relationships and other meaningful contexts – such as language, space and time – and whose experiences are mediated through the contingencies of embodiment. Such persons or agents, Isaacs argues, ought to be seen as primarily "doers", rather than objective, detached "thinkers", who seek to actualise themselves within the constraints and opportunities afforded to them by their embodied and embedded states. This ontology applies equally to practitioners, so-called ethicists, and those they seek to serve, highlighting the relational, creative and, potentially mutually transforming nature of moral engagements.

Barry Hoffmaster notes, however, that our collective view of ethicists is that they

> "tend to leave the 'facts' of clinical medicine to the doctors; their task is then to apply elegant and compelling arguments drawn from first principles of ethics to these undisputed and indisputable facts. Unfortunately when the relationship between clinical medicine and ethics is conceived in this way, the result is a very sterile discourse"(Hoffmaster 1991:213).

Thus, the dominant "sterile discourse" that is often evident in our health care institutions and policies, is fraught with difficulties. While it remains segregated as a complex and expert discourse, it cannot facilitate the task of meaningful moral engagement. Moral understandings are always interpreted and deeply embedded in a particular time, history and context, all of which create a unique, rather than universal, basis of meaning. As individual patients and practitioners are embedded in multiple layers of connectedness and understanding each person has a unique perspective. Hence, the expectation that generic, universal principles should be presumed to equally apply to each individual is misplaced.

Arthur Caplan remarks that, "the resolution of moral issues demands more than the ability to marry moral theory with the facts" (Caplan 1982: 2). If we strive to prepare our students for the ethical realities of health care practice, as educators we have an obligation to equip them with the "more" that Caplan identifies. For us, this "more" begins with framing

moral understandings in health care practice as those existing between embodied and embedded "doers" in relationships that are shaped by the dynamics and flow of power inherent in that setting. Consequently, ethical encounters are not appraised in terms of attaining the 'hypergood'[4] of a rational outcome, but are, rather, situated *human* encounters. While these encounters are guided by the frameworks of values, principles and virtues appropriate to the caring setting, attention to the contextual particularities, and the important role of identity and individual subjectivities become important in seeking sensitive and practical outcomes. In essence, we encourage the students to see ethics as a transformative, relational and engaged endeavour in which their role is not to be an ethical "expert", but rather to be informed and sensitive interlocutors within the multiple relationships of the health care setting.

A Transformative, Relational and Engaged Ethics

In laying the groundwork for the creative task, the students were invited to consider the following features of the human condition:

- The human condition is one of being and becoming.
- The human self is embedded in multiple contexts of history, culture, language, relationships, biology, time and spiritual horizons. The unique culmination of these layers of embeddedness shape individual moral frameworks for patient and practitioner alike and defines the multiple "goods" we affirm.
- The illness experience can fracture these goods; hence illness is a time of multiple vulnerabilities.
- Vulnerability calls for a caring response from another, as Hoffmaster (2006:43) notes, "vulnerability marks the limits of individualism".
- By building self awareness, in our students, of these foundational ontological understandings of the nature of the self, they may become empowered, through exercising the nutrient and integrative power[5] of caring (May 1972), to respond empathically to the vulnerable patient other.

From these understanding, we build a philosophical foundation for the students that are appropriate to such an ontological awareness of the

[4] This is a term used by Canadian philosopher Charles Taylor.
[5] See Rollo May 'Power and Innocence' 1974.

human condition. This approach[6] adopts four broad dimensions – the *hermeneutical*, the *appreciative*, the *appraisive* and the *transformative* (Isaacs and Massey, 1994) – in which we invite students to see the ethical encounter through a number of different lenses.

The hermeneutical lens acknowledges the way different interpretive frameworks (developed from our embeddedness in history, culture, relationships etc.) will shape the way each participant will see, interpret and thus make meaning from the situation. This lens compels us to follow the broadest moral principle of respect for persons. In some ways, the hermeneutical dimension allows us to see that we are the same in that we are all meaning makers, despite our different interpretive frameworks.

The appreciative lens invites us to acknowledge the ways in which our unique and particular identities, constructed and re-constructed over our lives, may shape our experience of the encounter in different and distinctive ways. The task here is to appreciate as best we can the "otherness" of the person before us. Begley (2003) describes this as considering the plight of "the named individual standing in front of us", which opens a window into their subjective moral world.

The appraisive lens is perhaps the most familiar to medical ethics as it involves the use of those values, principles and virtues appropriate to the situation to appraise or evaluate that which is of ethical relevance to us. For instance, this lens invites us to consider principles such as beneficence, non-malfeasance, justice and care, for example, as they apply uniquely to the particular health care setting.

Finally, the transformative lens seeks a practical outcome (rather than solely an elegant theoretical analysis) that is responsive to the thick analysis afforded us by the other lenses. Importantly, these dimensions are not to be seen as linear or sequential in any way but are taught as complementary elements of an applied ethics approach, intended to deepen our understandings of the ethical considerations at play within professional health care practices.

[6] Until recently, this approach to healthcare ethics has been uncommon within Australian universities. In recent years, graduates from the program have been successful in incorporating this approach into other ethics programs in universities as well as other health care settings.

In a broad sense, this account of ethics can be considered a phenomenological, hermeneutic or "pre-modern"[7] account through its emphasis on the hermeneutics of making meaning, and its acknowledgement of the deeply entrenched and subjective nature of being. However, this description doesn't wholly capture the rich diversity of interdisciplinary influences on which this conception of ethics is built. The work of scholars such as phenomenologists Martin Heidegger, Paul Ricoeur and Maurice Merleau-Ponty, political and social philosophers such as Charles Taylor and Stephen Toulmin, identity and narrative scholars such as Jerome Bruner and Hilde Lindeman, and feminist philosophers such as Susan Sherwin, Rosemary Tong and Margaret Urban Walker all contribute in significant ways to enrich this account of a transformative, relational and engaged ethics.

By articulating a framework for ethics that foregrounds its relational, subjective, dialogical and power-directing nature, we set the scene for using a creative expressive task that invites students to engage in this way. The aim of this course, and indeed the creative composition task, was to demonstrate how the theory, principles and cases can come alive for us when we foster empathically responsive ways of relating to the patient-other, to one's colleagues and even to oneself.

Ethical Education and Education in Ethics

If our foundational understandings of ethical engagement flow from a view of the self as interpretive, embedded, engaged and relational, then these core beliefs must be reflected, not only in *what* we teach, but also in *how* we teach. Furthermore, if ethics is concerned with creating the necessary conditions for transforming, flourishing and understanding ourselves and others within the reality of particular human relationships, practices and institutions (Isaacs and Massey 1994), as educators we are morally obliged to incorporate this awareness into our pedagogical practices. Hence, while we can educate "about" ethics, we must also educate ethically. With this in mind, the teaching team made a concerted commitment to move away from a traditional, monological, transmissive approach to learning by inviting our students to approach learning as a transformative, dialogical and reciprocal encounter.

[7] A term used by Stephen Toulmin in his book Toulmin, S. (1990). *Cosmopolis. The hidden agenda of modernity*. Chicago: The University of Chicago Press.

The ethical tenor of our classes was significantly shaped by respecting our student's capacities as mature adult learners. Building on the strategies which promote adult learning as articulated by Malcolm Knowles[8] (Knowles 1990; Knowles, Holton, and Swanson 2005:93-94), the learning encounter was designed to reflect the following understandings:

- Adult learners are motivated by the 'need' to learn, thus educational opportunities must be responsive to the particular needs of each individual.
- Learning builds upon and integrates existing experiences.
- The physical environment must be comfortable, free from distractions and conducive to positive interaction between the teacher/facilitator and learner. Additionally, the adult learner must perceive a mutual trust and respect in a collaborative, cooperative partnership.
- The goals of learning are mutually defined and ultimately must be perceived as the learner's goals. Teachers can facilitate and support learning but the core responsibility and motivation rests with the adult learner.
- Adult learners must share active responsibility for what is learned. Participation breeds a sense of commitment necessary to genuinely pursue the goals of learning.
- Learning opportunities are designed in such a way that a sense of progress and success is created. Additionally, adult learners retain some control and negotiation over how progress and success are defined.

Despite these understandings and intentions, the most significant challenge in creating this environment was in coaxing the students out of their pre-conditioned expectation of passivity in the learning process. Although we were clearly rejecting the familiar (to them) mode of education as the systematic delivery of facts and content, our biggest challenge was to build trust in our students that our commitment to "partner" them in their learning journey was genuine.

[8] Knowles differentiates these characteristics as andragogical, or pertaining specifically to the different developmental and cognitive demands of adult learning, from those of pedagogical approaches developed with a child's developmental stage in mind.

Encouraging Committed, Connected Knowers

Our commitment to human ontology as that of connected, embedded and relational beings, coupled with our commitment to approach learning ethically within the classroom, saw us begin the unit by inviting our students to imagine themselves as committed, connected "knowers." We employed a distinction between *received knowers*, *subjective knowers*, *procedural knowers* and *connected knowers* – one established initially by William Perry and scholars from Wellesly College but one that became known to us through Ken Bain's (2004:43-45) research on the best college teaching in North America. In essence, these understandings of knowledge, and their corresponding approaches to learning, reflect four broad developmental stages that a learner/knower may work through. Bain noted, from his survey, that the best college teachers supported students at whatever developmental stage they were at while also seeking to inspire and equip them with the skills to reach the highest stage – the committed, connected knower.

As Bain summarises it, committed knowers approach learning independently, creatively and critically, "valuing the ideas and ways of thinking to which they are exposed and consciously and consistently trying to use them" (Bain 2004:45). However, he notes that Perry et al. broadly categorise this stage into "separate knowers," who seek a detached, somewhat adversarial, approach to ideas, and "connected knowers," who suspend dispassionate observation to see the merits of the ideas they are exposed to. Importantly, this final stage of committed, connected knowing is carried by the student into their lives beyond the classroom. As Bain notes, the pedagogical goal of encouraging committed, connected learning equips students' with the skills to become life long learners as their "ways of thinking and drawing conclusions are permanently transformed". Thus, our invitation to the students to rethink their approach to learning and consequently their approach to knowledge mirrors our invitation to them to continually *be-come* responsive, engaged, discerning and practical participants in their ethical encounters rather than simply memorising abstract moral theories and principles for later regurgitation in an exam. Learning, we believe, should change how one sees oneself in the world, and be motivated by knowledge, freedom, creativity and curiosity.

Interestingly, our invitation to the students to adopt this approach to learning was initially met with some scepticism. Used to a content-laden curriculum, many had experienced success with, been rewarded for, and

even been required to actively adopt one or other of the less sophisticated developmental learning stages. The familiar and ubiquitous question of whether a particular piece of information will be on the end-of-semester exam, for instance, reflects a willingness to stay in the "received knower" stage where students see truth as external to them and generated by outside experts and thus dedicate their time to ingesting the "correct" answers from their teachers or instructors only to regurgitate them again at assessment time; a process that de Beaugrande tellingly calls "bulimic education". Arguably, this approach to learning is not uncommon in health care education, particularly those degrees with a heavy science component. Indeed, as Nisker (Nisker 2004:295) notes, this may provide partial explanation as to why some health care students are initially attracted to "the principles-and-theories approach to ethics" as the thought processes may reflect those taught for decisive clinical decision-making.

The students' scepticism of our teaching and learning approach was also compounded by their initial discomfort in being given a creative-expressive assessment task. Again, the predominantly science-based training to which they had previously been exposed left them feeling ill-equipped to approach this "humanities" exercise and many initially expressed concerns about moving beyond their learning-style comfort zones. Their concerns were twofold: firstly, they doubted their aptitude for creative writing tasks, and secondly, they doubted the usefulness of such a task in helping them to learn (or memorise) what they needed to know to pass the ethics component of their degrees. As Bain (2004:45) notes, students can feel "resentment and hostility when they discover that truth does not reside in the heads of their teachers." However, our challenge was to provide appropriate levels of sympathy and understanding without inadvertently condemning them to the second stage of learning development, that of the "subjective knower." The risk of adopting a subjective approach to learning lies in the assumption that, because there may be competing claims to the "truth", all knowledge is therefore subjective and the "right" answer is accessible through intuition alone (Bain, 2004:42-43). The related issue of relativism often seeps into discussions of subjectivity in ethics. Our task was to avoid losing students to a relativist approach to ethical engagement while inviting them to build on some of the foundational ideas of ethics in health care practice to which we were introducing them. Their creative assignment required them to rehearse, in practice, the dispositional and cognitive aspects of their ethics education.

The Creative Composition

While poetry, art and literature is dismissed by some as extraneous to the core task of medicine (which is to "cure") (Pickering 2000), in this instance the aim of inviting students to embrace a creative mode of expression represented an extrinsic means of encouraging deeper understanding and insight into the illness experience as lived by individual patients. At their core, the humanities provide a platform from which we can articulate what it means to be human. Furthermore, the incorporation of humanities into medical education creates a rare moral space in a content-laden curriculum. In such a space the critical moral question of "what is valuable for human beings seeking to create a world where they can live and flourish?" – may be explored (Edgar and Pattison 2006).

As health practitioners of all disciplines are called upon to respond to vulnerable others, often at times of significant trauma and need, the critical capacity to relate to, make decisions for, and work with others (patients and colleagues) defines medical care as a fundamentally relational practice, and not simply one of technical or scientific medical expertise. Paradoxically, as Hoffmaster notes, "vulnerability doesn't mean much to morality because, in part it is missing from moral philosophy, yet it is our very vulnerability that creates the need for morality" (Hoffmaster 2006:41; Cassell 1991:26). Yet the human condition remains essentially one of vulnerability, particularly when experiencing illness. As relational encounters are the site of ethical interaction the aims of this course were to encourage students to develop an appropriate sense of ethical identity and commitment.

The key learning objective for this exercise was to encourage students to use their sympathetic imaginations to try and access from the inside what a patient might feel when faced with a particular human predicament. Rather than offering them typical "case" scenarios to assess against a list of bioethical principles, we provided them with five short vignettes which were crafted to move the students to respond to the plight of a patient in terms of the ruptures and challenges to their sense of holistic wellbeing and not just to the specifics of their physical wellness. Students were asked to choose one of the vignettes and to adopt the character of the patient represented there. As Nisker (2004:296) notes, writing in first person more intimately brings the reader (and, arguably the writer) closer to what the person may feel. The brief for the creative nature of the task was broad and students were encouraged to write a poem, a short

composition, a song or to create an artwork that would best reflect the needs, vulnerabilities, and feelings of this fictional "other." While many existing courses invite students to respond to and consider the narratives of others in exploring the complexities of a moral life, most do not challenge students to compose their own creative work in response to the situation presented. We found that extending students to this next level of engagement in another's story was an extremely valuable learning encounter in responding to the plight of the other, but also, importantly, in contributing to the development of the necessary ethical competencies required in their everyday professional practice. In laying the prerequisite ethical frameworks, students were equipped with the appropriate language to articulate their thoughts, but also importantly, where invited to begin constructing positive professional identities of themselves as ethically sensitive practitioners.

Despite their nervousness at such an unorthodox assessment item, we sought to support the students in a number of ways. For instance, each member of the teaching team chose a vignette and wrote their own creative piece in response to it. This was then shared with the small tutorial classes as an example of a "lay" person's attempt at such a task. Interestingly, this was a lesson for us in putting ourselves in the shoes of the students and experiencing the exposure of completing an unfamiliar writing task that was then subject to public scrutiny. Additionally, one of us experimented with playing a Victorian parlour game that Nisker (2004:296-297) has used with some success in similar circumstances. This game consisted of reading one of the vignettes and then getting the tutorial group to respond to it by getting the first student to write one line on the top of a page and then folding the paper over to conceal it before passing it onto the next person to write their line (and so on until all have written one line). When completed, the paper is then folded back out and read (with some on-the-spot editing for sense and rhythm, but not meaning) as a complete poem. This exercise was remarkably effective in demonstrating to the students how language can be evocatively, creatively and yet coherently and simply used to portray some of the realities of the human condition. Finally, the teaching team also actively sought to create a collegial, caring learning environment in which to develop a sense of trust and safety for the students. We listened respectfully to their initial anxieties and fears, communicated our belief in their abilities, set guidelines for respectful class behaviour and continued to talk through their concerns and ideas as the course progressed.

Students responded to all vignettes, many noting that the particular story chosen had resonated because of an existing experience, for example, knowledge of an elderly neighbour, or a family experience with miscarriage, reinforcing the observation that learning is mediated through prior knowledge. Importantly, though, some of the students actively chose vignettes for which they had no prior experience, thus explicitly challenging themselves to truly imagine the experience of the vulnerable who appeared, in almost every way, to be "other" to themselves. As listening is a moral act, students were invited to share their compositions with the whole group in the final tutorial of the semester, giving each person an opportunity to hear the insights of their colleagues. The compositions presented were emotional, intellectual, imaginative and transformative, displaying an insight and a humanity that students and staff later noted was energising, exciting and richly rewarding.

The Compositions

There were many outstanding examples of artwork, songs, poetry and prose to choose from, but for the purpose of this article, we have included only two poems written by students to illustrate how they responded to this invitation.

Margaret's Story

Margaret, a seventy-five year old pensioner, has been diagnosed with motor neurone disease. While she has been able to stay at home with the assistance of home care nursing services, her condition is such that she now needs to enter hospital care for the last weeks of her life. She is aware, as the ambulance officers gently carry her from her home, a home which she has lived in for the past fifty years as a wife, mother, and grandmother and neighbour that she will not be returning.

Consider her thoughts as she says goodbye to her house, her garden, her pets and her street.

Flowers
by Kiera Eades

With its beginning there was immeasurable potential and
Unknown possibility

With care and love there was growth and
It flourished,
It surpassed boundaries
It expanded, exploded and demanded attention

With age it sits proudly, royally, regally
It has fulfilled its expectations
It is content and satisfied

With time it will soon tire, wilt and expire,
Strength depleted, it will shrivel and shy
From its once glorious form

But I will not see the completion of life and
As I look for one last time at the flowers I planted,
I nurtured , I appreciated

I hope I flourished and grew as rapidly and beautifully
As my flowers have for me

I hope I stood as proudly and vibrantly
As my flowers have for me

I hope I have provided a sense of joy and wonderment
As my flowers have for me

But I know I leave a memory of unique beauty
As my flowers have for me

Fatima's story

Fatima and her husband Aziz have recently been settled in Australia as refugees from the harrowing troubles in Darfur in northern Africa. She is four months pregnant with her first child. During the night she has begun to bleed and has begun to experience painful contractions. It is now in the early hours of the morning and she is fearful that she is losing her baby. Aziz has called the emergency number for an ambulance and when they enter her bedroom Fatima is relieved to see that one of the officers is a woman who moves quickly to reassure her that they will soon have her on her way to the hospital.

How might one capture the sense of grief, aloneness and the yearning to trust that Fatima now experiences.

My Angel, My Baby
by Naomi Burstow

The couch is soaked with blood
My blood, my baby's life blood
Every minute that passes by
Its life I fear is fading

I remember the day I took that test
And discovered the news of your life
My heart was filled with such a joy
Only to be shattered in an instant

A tear slides down my cheek
For my angel baby's precious life
Was there something more I could have done?
Some more care I could have taken?

I will never touch its soft cheeks
I will never hold it in my arms
I will never rock it gently to sleep
I will never see my angel

At this moment I look up
And I see her coming towards me

Her face is kind , her eyes are soft
Her presence is a welcomed one

She gently takes my hand
And speaks words to calm my heart
We are moving to hospital
Where I will find my baby's fate

The rest of the world will not miss you my angel
They did not know of your precious life
But my love for you remains
My angel, my baby.

Conclusion

> "Although I'm not sure if any of us can teach compassion, we can, through narrative, try to conserve the compassion our students already have and pave a softer path through the hard environment trodden by health care students and professionals" (Nisker, 2004:300).

In retrospect it is perhaps not surprising that, when given the invitation and necessary supportive environment to express their moral sensitivities that students responded with insight, empathy and relational awareness. Yet the depth of understanding and compassion displayed almost universally by students took us by surprise. The emotional impact of this exercise on our students was palpable and many expressed deep appreciation after the course had finished. Unfortunately, time for an adequate debriefing and evaluation session with the students was not possible. As with many such courses, the realities of a content-laden degree program mean that insufficient time is allocated to the "softer" components of the degree thus leaving us with little time to fully explore the impacts of such an exercise. Fortunately, however, a comparison was possible between this course and the approach taken by the same teaching team in a much larger nursing ethics course. Much to our regret, an exercise of this intimacy is a logistical impossibility for the nursing cohort, who number several hundred in a year, and we are left with more orthodox teaching techniques of lectures, tutorials and examinations. Nevertheless, we have learnt that, of the two courses, the paramedic students' enthusiasm, presence, and affective response, is markedly richer than the nurses', and the tone of the paramedic tutorials make them more rewarding to teach.

While content-laden courses of health professional education are essential and build critical technical competencies, we mustn't lose sight of the fact that the medical condition is embedded in the human condition. The calibre of the work produced suggests that this exercise was extremely worthwhile in heightening ethical sensibilities to our shared human condition. It further reinforces our belief that students, when given the time to think, process and reflect upon the human condition can develop the necessary language and skills to feel and display deep empathy and ethical sensitivity. Thus students were not assessed on their level of technical artistic "expertise" but, rather, were rewarded for participation and for displaying ethical insight. This reflected our belief that while some knowledge of ethics can be learned conventionally, and assessed conventionally, such as through examination, the practising, and acquiring, of ethical sensitivities and sensibilities must be seen as part of a lifelong quest for understanding of which this is one small part. Indeed, the creative composition formed only ten percent of the final assessment of this whole unit.

As Bruner suggests, there is power in approaching science and the humanities not as polar opposites, but as complementary disciplines (Dodds 2000). The outcome of this exercise confirmed to us that ethics ought not to be taught as a rigid content driven course but, rather, ought to be seen as a rare moral space which can be used to encourage students to explore different ways of knowing. By inviting students to stretch their sympathetic imaginations we hope to have challenged them to see ethics in their paramedical practice as part of who they are and not just what they do.

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