THE DIALOGUE BETWEEN MEDICAL DOCTORS AND BIOETHICISTS: RETHINKING EXPERIENCE TO IMPROVE MEDICAL EDUCATION

EL DIÁLOGO ENTRE LOS MÉDICOS Y LOS BIOETICISTAS: REPENSAR LA EXPERIENCIA PARA MEJORAR LA EDUCACIÓN MÉDICA

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ABSTRACT:

Palabras clave:
Educación médica; Experiencia; Bioética; Narración; Humanidades.

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More and more seems to be necessary to find new ways of communication between medical doctors and bioethicists in order to build a shared vocabulary and to prevent conflicts: many bioethical problems seem to be caused by the lack of dialogue between them, which both seem to speak two different languages. Improving this dialogue means searching new languages and innovative forms of communication: the narration could be a really effective tool to enhance the physicians' and bioethicist's moral conscience, since it facilitates reasoning on someone's particular experience, and, ultimately, on our experience. Starting from the results of a questionnaire administered to a group of students of the Faculty of Medicine and Surgery of the University Campus Bio-Medico we present a theoretical discussion about the need for more dialogue and for a shared vocabulary in medical experiences. In this regard, we suggest as a possible solution to the conflicts among medical doctors and bioethicists, an educational strategy, i.e., humanities courses for medical students, which may help them to deeply describe their practical present (and future) experience.

RESUMEN:

Keywords:
Medical Education; Experience; Bioethics; Narration; Humanities.

Cada vez más parece ser necesario encontrar nuevas formas de comunicación entre los médicos y los bioeticistas con el fin de construir un vocabulario común para evitar conflictos: muchos problemas bioéticos se deben a la falta de diálogo entre ellos, ya que ambos parecen hablar idiomas diferentes. Mejorar este diálogo significa buscar nuevos lenguajes y formas innovadoras de comunicación: la narración podría constituir un instrumento muy eficaz para mejorar la conciencia moral de los médicos y de los bioeticistas,

dado que facilita el razonamiento sobre la experiencia de una persona en particular, y, en último término, sobre nuestra experiencia. A partir de los resultados de un cuestionario administrado a un grupo de estudiantes de la Facultad de Medicina y Cirugía de la Universidad Campus Bio-Médico presentamos una discusión teórica sobre la necesidad de un mayor diálogo y de un vocabulario común con referencia a las experiencias médicas. En este sentido, sugerimos como posible solución a los conflictos entre médicos y bioeticistas una estrategia educativa, es decir, cursos de humanidades para estudiantes de medicina, que pueden ayudarlos a describir profundamente sus experiencias prácticas presentes (y futuras).

1. Introduction. A pilot study on the dialogue between medical doctors and bioethicists

Starting from a reflection on our experience of teaching on several masters and bioethics courses in Italy, it appeared to be urgent replenishing a common fabric of experiences to share between medical doctors and bioethicists (almost all philosophers). In fact medical doctors do not understand the importance of some bioethical reflections because they fail to grasp the importance of the pragmatic relevance in strictly clinical environments. On the other hand, bioethicists tend to over-emphasize some problems, which have arisen in the purely theoretical field, and that are only of marginal importance to the physicians' work.

With the aim to highlight sources and modalities of conflict between medical doctors and bioethicists, we developed a short and easy to fill in questionnaire and administered it to a group of students of University Campus Bio-Medico (UCBM) of Rome. The survey was composed by 9 questions, addressing the issue of conflict between physicians and philosophers, with particular reference to many key-terms (person, health, disease, quality of life, human dignity, pain, suffering, care, treatment). Different items dealt with deeply felt issues as euthanasia, possible need of guide from "moral" experts, the weight of ideological convictions, the need for a technical teaching to the bioethicists. The first question simply asked to state if in the participant opinion a conflict between medicine and philosophy does exist or not, while the other eight questions did cope with aspects and features of this conflict and each of them answered by means of a 4-steps Lickert scale ("Strongly agree", "Agree", "Disagree", "Strongly disagree").

A total sample of 185 students at 1st and 2nd year of the UCBM School of Medicine and Surgery have been included in the study; we believe that medical students can be the more adequate sample to this study: even if they haven't practiced the art of medicine yet, at the end of an annual course of studies, they have already had a chance to be into hospital wards and to observe the physicians. At the same time, not being highly specialized yet, they haven't lost the benefits of a multidisciplinary education. The mean age was 20.78±1.04 (range 19-22 years). Of these, 173 (93.5%) claimed that a conflict between medical doctors and bioethicists exists. As a consequence only the answers of these students were analyzed more in depth. The answers to each multiple-choice question were analyzed with the Chi-square test, by grouping positive (agreement with the statement) and negative (disagreement with the statement) answers: results are summarized in Table 1. The choice of Chi square test was aimed to verify if an observed distribution of frequency will fit with a theoretical (and expected) distribution.

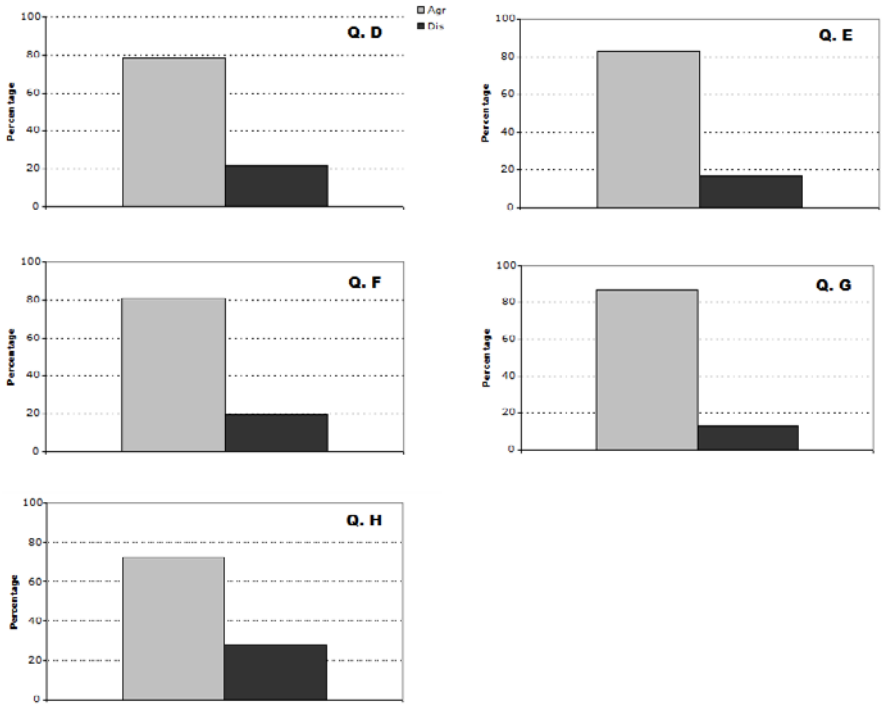
Regarding causes and reasons of such a conflict, the sample was almost equally divided between those who believed that it mainly depends by a lack of acceptance of philosophical issues by means of physicians (47.4%) and those who not agreed with this position (52.6%) (Q.A). When asked if the conflict could arise from a difficulty of philosophers to fully understand practical medical issues, a great majority of participants agreed with this statement (77.5%) (Q.B). Nevertheless, when asked if the two disciplines would be too different and a dialogue could not be hypothesized, the great majority of participants did not agree with this idea (80.8%) (Q.C). Finally, when asked if the "boundary" issues between

Table 1. Statistical comparisons (X^2) between positive (in agreement) and negative (in disagreement) answers to the questionnaire questions

Questions	In agreement	In disagreement	X^2	P
The State-of-the Art: The Conflict between Medical Doctors and Bioethicists				
Q.A: Does the conflict arise because physicians do not understand the importance of philosophical issues in their job?	47.4%	52.6%	0.49	n.s.
Q.B: Does the conflict arise because philosophers do not fully understand practical medical issues?	77.5%	22.5%	52.17	5,096E-13
Q.C: Are the two disciplines (medicine and philosophy) too different so that a dialogue could not be hypothesized?	19.2%	80.8%	64.95	7,668E-16
Q.D: Are the "boundary" issues between physicians and philosophers usually managed in an ideological way?	76.8%	21.4%	56.65	5,199E-14
Q.E: Is there an urgency for a debate on medical issues between physicians and experts in philosophy?	83.2%	16.8%	76.45	2,264E-18
The Resolution of the Conflict: Some Proposals				
Q.F: In order to solve the conflict, do the philosophers need to go more in depth to "technical" aspects of medical issues?	80.9%	19.1%	66.18	4,117E-16
Q.G: In order to develop a discussion on clinical ethics, is there a need of a shared ground for physicians and moral experts on daily clinical experiences?	86.17%	13.3%	93.23	4,653E-22
Q.H: Do you think that physicians need a more intense education in Humanities?	72.3%	27.7%	34.27	4,793E-09

physicians and philosophers are usually managed in an ideological way, a statistically relevant percentage of respondents (78.6%) did agree (see Fig1 – Q.D). With respect to the urgency for a debate on medical issues between physicians and expert bioethicists, participants generally agreed with this statement (83.2%), as depicted in Fig1 – Q.E. Regarding the ways to solve such a conflict, participants strongly felt that philosophers need to go

Figura 1. Percentages of agreement (Agr) and disagreement (Dis) answers to question D-H



more in depth to "technical" aspects of medical issue, in order to better understand and thus provide their suggestions (80.92%; Fig1 – Q.F). They also agreed that is a need for shared daily clinical experiences in order to develop a debate on clinical ethics (86.71%), as shown in Fig1 – Q.G. Finally, when asked if physicians need a more intense education to humanities, the majority of respondents did agree (72.25%): this effect is depicted in Fig1 – Q.H.

2. The root causes of the conflict

As we tried to show with this brief survey, the world of bioethics is an abode of conflicts, arising from various misunderstandings: physicians and bioethicists often seem to be at odds since they have not fully understood each other's experience, and therefore tend to undermine the existence of a fruitful dialogue. Indeed, there is the possibility of "dialogue" in the strict sense only if two persons encounter and share a common space of experience on which to reflect and can at least use a similar language. Here, then, is the source of the problem: physicians and bioethicists (and, more generally, physicians and patients) speak different languages because they live profoundly different experiences. In order to recreate this dialogue – which currently appears to be impossible, almost in Europe, under the conditions outlined above – we need to replenish a common fabric of experiences to share, to divulge. And a possible way to solve such a conflict could be found in the so-called inter-subjectivity.

The current almost complete absence of dialogue, at least in Europe, and thus the birth of several artificial structures which fill the "communication gap", arise, in our opinion, in a change of perspective that is fundamentally modern: the abandonment of a positive vision of the human being and the relationships that it can establish in the three main directions (with himself, with his fellows, with those unlike him). Once the classical conception of human "natural sociability" and the consideration of his "friendship" (*philia*) as part of the common life and the apex of the good life are abandoned, all that remains is the opportunity to artificially rebuild a communicative fabric and dialogue. The modern reflection on intersubjectivity, in fact, has set reality in the center of the conflict, with the merit of highlighting the ever possible tragedy of relations, but at the cost of the loss of the ideal of the original agreement within human persons.

The two great lines of modern thought that denied the possibility of a relationship, the individualistic one of Hobbes, Nicole, Bayle and Mandeville and the dialectic of Hegel, are added, albeit in the opposite way, to the similar conclusion to consider the historical relationship overtaken by the conflict. In an individualistic line, the relationship is considered essentially impossible, although empirically inevitable, as effectively expressed by some contemporary individualist philosophies[1]. In a dialectic line, however, the "recognition" has as its destiny the conflict of lordship and servitude which finds a historical configuration in his resolution of the state public ethics. Within these currents of thought every meeting is constantly under the sign of a "mutual theft", as Jean-Paul Sartre writes: "Thus, by limiting me, each constitutes the limit of the Other, and deprives him, as he deprives me, of an objective aspect of the world"[2], and therefore "the essence of the relations between consciousnesses is not the *Mitsein*; it is conflict"[3] and this "conflict is the original meaning of being-for-others"[4]. The conflict as fate is the consequent outcome of the idea that the relationship is actually impossible.

The idea is that the relationship can be accomplished only if it can be resolved on the level of the state or the contractual artifice. The theory of conflict arises from the ambiguous conviction that the individual needs otherness just to satisfy his/her own desire for self-assertion, which is inherently non-relational. In brief, there is no proper subject-in-relation, but there is only "trade" of relations between persons who are extraneous, and so there is "trade war" of the signs of recognition.

1 See: Rand, A., Branden, N. *The Virtue of Selfishness. A New Concept of Egoism*, Signet, New York, 1964.

2 Sartre, J-P. *Critique of Dialectical Reason. Vol. I*, Verso, London, 2004, p. 103

3 Sartre, J. P., *Being and Nothingness: A Phenomenological Essay on Ontology*, Pocket Books, New York, 1978, p. 429.

4 *Ibid.*, p. 364

3. Discussion

The results obtained by the survey are really impressive, as they clearly represent the current state-of-the-art. We will, thus, present few samples that can strengthen the results of our survey.

First of all, the contemporary debate on euthanasia[5]: although it is of great interest to philosophers, mass media and supporters of eminently ideological positions (Fig1), tends not to arouse any interest in the medical environment, because, quite simply, it is not is a medical act. On the other hand, however, a real physician – and not the medical doctor that lends himself to awareness campaigns that are often suitably guided by politically and ideologically one-sided associations – recognizes the need for a guide and an ethical direction that only "moral experts" (Fig1) can provide, as they have already thought long and hard about the philosophical underpinnings of the action.

The constant reference that bioethicists make to extraordinary clinical cases makes it therefore liable to lose sight of the routine matters with which it has to deal with as part of the medical profession. Once again, we realize the victory of the "frontier bioethics" over "everyday bioethics". The distortion of bioethics (from every day to the frontier) is perhaps dictated by a tendency towards media exposure of the clinical problems: sensationalist communication, with which the mass media have accustomed us to, is based on the need to strike and arouse (positively or not) the public, to create an audience even with people's lives. In that way, the exceptional cases become the best way to captivate and attract the general public, who often prefer the gossip and voyeurism to the truth of every day[6]. "Everyday bioethics", however, regarding situations that can more easily arrive to the people (such as the treatment of the sick, the medical doctor/patient relationship, clinical trials and pharmacological issues related to disability, drugs, elderly, psychiatry), tends to be overshadowed quite simply because it is not news.

If, then, on the one hand, the mass tends to feed more and more on the strong emotions of the "frontier bioethics", on the other, medical doctors have begun to develop a healthy disregard for the current bioethical reflection because it is bioethics itself that is disinterested in what the medical doctors really deal with on a daily basis (Q.B).

Yet bioethics was born with other intentions and concerns: the bioethics conceived by Potter was characterized as a bridge between the world of values and that of the biological facts, in order to ensure survival, in an era profoundly transformed by technology. But the situation today seems to have changed dramatically: if medical doctors continue to deal with facts and everyday experiences, philosophers persist in supporting the presence of some values, and bioethicists fail to represent that point of connection that Potter desired. Maybe, philosophers do not know very well the facts that physicians are dealing with now (Fig1), perhaps because they cannot find a point of "incarnation" of the values... Yet: frontier bioethics continues to be widely present in the media while everyday bioethics often succumbs, and, with it, also the possible dialogue between physicians and bioethicists (Q.B).

4. A shared ground for a new bioethics

If the current state of things, on the one hand, seems to confirm a difficulty of dialogue between realities that are characterized as profoundly different (in our case of medicine and philosophy), on the other, we must recognize that the Potter's idea was not qualified as a merely contrived juxtaposition: medicine and philosophy share a ground of investigation. It is not to justify in some way the presence or the necessity of philosophy in medicine – a justification that would appear, using the criteria outlined before, as artificial – because this has been acquired since the beginning of the medical art and which is configured as a science thanks to philosophy. It is, however, to rediscover a natural commonality of purpose and closeness of the two disciplines, and thus to define what should be this presence, that is, what place should have the philosophy

5 See: Collier, R. "Euthanasia debate reignited". *Canadian Medical Association Journal* 181, (2009), doi: 10.1503/cmaj.109-3034.

6 See: Brannigan, M.C. *Cultural Fault Lines in Healthcare: Reflections on Cultural Competency*, Lexington Books, Lanham, 2012, p. 64

in medicine. As Josef Seifert notices, "medicine has to grasp much more than natural science affords to know and has to teach more than practical technique. It has to proceed from an understanding of the nature and value of human health, of human life, and of human personhood. […] Human medicine has to be based on an understanding of the human person"[7]. In this regard, in order to rediscover a common background of dialogue, it seems necessary to retrieve the role of philosophy as a critical reflection on the exercise of everyday medicine and not as an instrumental application for the resolution of extreme cases.

However, without going into attempts to historically reconstruct the medical profession, we can take a "phenomenological" cue from common experience: the traditional question, "how can I help you?" with which the physician gives, as a result of the patient's demand for treatment, cannot be formulated properly if he does not possess, in addition to an adequate knowledge of the medical art, a profound knowledge of human beings[8]. Only if he has previously reflected on the meaning of health and illness, on the telos of the treatment, on the nature of the good of the patient, on the implications of the interpersonal therapeutic gestures, can he offer the most necessary and appropriate aid in all circumstances, aid which is defined not merely as a purely technical act.

The importance of not reducing the medical act to a purely technical one is determined by the nature of the object that the physician is faced with: to use a play on words, the object-non-object of the physician is a subject, that is, a human being. And here lies not so much the paradox of medicine itself, as "the paradox of human subjectivity: being a subject for the world and at the same time an object in the world"[9]. Moreover, the medical act is directed to the human subject in se and per se, but is directed to human persons as subjects to relationships, and therefore we are parts of a "system" of relationships that lives and feeds on us. The subject to whom the medical act relates is, thus, not only a subject, but a subject (primarily) and many subjects (secondarily). If the human being, by his nature, is a social being, there will never be the intervention on the individual person, since the human being is like a thread in a web of relationships.

In this perspective, the mutual relationship between "natural sciences" and "sciences of the spirit" could instill in the first a supplement of soul needed not to close into a self-referential technicality, and, at the same time, could restitute concreteness to the latter, so that they may become capable of providing an adequate response to the new needs and doubts. A balanced and comprehensive training of the physician that is based not only on technical knowledge can thus be seen as a first response to the assistance that is not only *Evidence Based*, but, above all, *Patient Based*, which is centered on the patient and on his needs.

Today the therapeutic action is conceived more as an "integrated act" because it is the point of convergence and the scope of knowledge that is not only strictly medical, but also philosophical, psychological and ethical. For this reason, the need is felt to set up the medical formation in a direction that would take account of these new requirements.

It is in this context of understanding the human in all his aspects that Humanities are situated: a reflection that is not concerned simply with human beings as objects, but the human, that is the understanding that the human being has of itself and that leaves behind of it in tradition. This is the reason why they constitute the horizon of reference for any discussion on the human being that does not wish to be limited to a partial and reductionist point of view.

5. The Humanities: understanding the human being in his complexity

By the term "Humanities" we refer to those sciences whose object of study is the human being in his complexity. Humanities are commonly seen as having

7 Seifert, J. *The Philosophical Diseases of Medicine and Their Cure. Philosophy and Ethics of Medicine, Vol. 1: Foundations*, Springer, Dordrecht, 2004, p. 35.

8 See: Pellegrino, E.D., Thomasma, D.C. *A Philosophical Basis of Medical Practice: Toward a Philosophy of the Healing Professions*, Oxford University Press, New York, 1981, pp. 22-24.

9 Husserl, E. *The Crisis of European Sciences and Transcendental Phenomenology. An introduction to phenomenology*, Northwestern University Press, Evanston, 1970, p. 1978.

their end in understanding or comprehending reality as opposed to the sciences of nature which are limited to explaining phenomena: this contraposition between the world of facts and the world of meanings could represent a disadvantage for the techno-scientific culture, which is increasingly patterned after a procedural rationality incapable of grasping the *Lebenswelt*. The same contraposition has brought a severe disqualification for the humanistic culture, which has ended up radically critical with respect to the techno-scientific progress, refusing to interact fruitfully with it. In this regard, it is widely acknowledged that we actually need a renewed effort in the integration of the techno-scientific and the humanistic fields, in order to recover a global vision of problems through a reciprocal relation between explaining and comprehending, a procedure that presupposes an intimate link between facts and meanings.

The deeper explanation of human conduct is, indeed, teleological rather than etiological: it aims to look the "what for" instead of the "why", because the human being is more complex than the other living beings: we can understand the human action only in the light of the purpose that has motivated and that gives meaning, rather than with the immediate cause that produced it. Literature, art and philosophy can introduce us to the human experience in its depth, offering us the opportunity to access to a meditative thinking that can give us back a more complex conception of human experience. Literature furnishes a global vision of human life, because regards as own the point of view of the biographic time: Ricoeur observes that, thanks to literary narration, the human time emerges as a biography, that means as a dynamic existential continuity where past, present and future penetrate and receive meaning inside a project-of-life that only the narrative memory is able to gather in its totality[10].

The bridge of bioethics dreamed by Potter ceases, therefore, to become artificial when once again it is possible to dialogue between the two fields of knowledge who share the same object of investigation: the human being. To build this dialogue, which does not appear to be spontaneous, we need to rediscover that common ground to start from which is the experience of the physician as a human being and at the same time, the experience of the patient (Fig1). An adequate reflection on the meaning of the concept of "experience" can perhaps help us gain additional elements to reconstruct the foundations of the bridge of bioethics.

6. A common yardstick – the need of the experience

The hypothesis we would like to explore here, as a result of our previous reflections, is this: the difficulty of communication is probably given by a misunderstanding of the world of experience, as Agamben correctly highlights: "The question of experience can be approached nowadays only with an acknowledgement that it is no longer accessible to us. For just as modern man has been deprived of his biography, his experience has likewise been expropriated. Indeed, his incapacity to have and communicate experiences is perhaps one of the few self-certainties to which he can lay claim"[11]. The world of experience, constituting a continuous and indispensable source for any reflection, needs to be constantly attended by a yardstick, as an object of stable comparison. Indeed, if all scientific knowledge and all science are based on experience, even ethics must be based on experience.

The thoroughly modern drama (following the scientific revolution) consists in having supported the crucial role of the experiment to the bitter end as a term of objectivity of speculation, relegating the experience in the world of subjectivity, and thus arbitrariness[12]. The reduction of the "the tangled web of human experience"[13] to the experiment, undertaken by the

10 See: Ricoeur, P. *From Text to Action: Essays in Hermeneutics*. Northwestern University Press, Evanston, 1991.

11 Agamben, G. *Infancy and History. The Destruction of Experience*, Verso, London, 1993, p. 13.

12 See: *Ibid.*, p. 17

13 Cassirer, E. *An Essay on Man. An Introduction to a Philosophy of Human Culture*, Yale University Press, New Haven, 1944, p. 25.

modern science, has thus brought to a misunderstanding of the former, and, then, to a complete incomprehension of human world of life[14].

If the experience covers the whole range of human action (from knowledge to love, relationships, and even science), the experiment is cut out into a very small part of human life. The question that arises therefore is: how is it possible that much of human life is dominated by the arbitrariness, and the only points of truth are traceable at very limited times (and which, moreover, concern only some subjects)? Here lays the theoretic and practical drama of the contemporary age, inherited from modern thought: the field of objectivity, relegated to a few moments of human life, is in a way recovered in the form of intersubjectivity, in the form of an attempt to call into dialogue individuals who otherwise would be in an eternal conflict.

The sharp break between the world of objectivity (i.e. the world of exteriority) and the world of subjectivity (i.e. the world of experience, the inner experience), as well as creating an internal conflict in the experience of the individual human being, tends to discredit the world of experience, denying the very existence of the dialogue in a profound sense. The condition of possibility of dialogue, indeed, is the presence of the experience, guaranteed by the persistence of the subject in his individuality. The current drama is not that today there are no more experiences, but they are enacted outside the individual, with the result that the individual merely observes them, with relief.

Decisive is the ability of judgment and communication: a real experience is always judged by the conscience and told to other consciences, so as to constitute a first common background, even if the experience in se is not totally reducible to the "mere language" (it is constituted by the un-said, by the emotions, etc.). In this regard, the experience, rather than being "artificially recreated" or ruled, comes across the subject, which is, ultimately, "owned" by the experience itself: "When we talk of "undergoing" an experience, we mean specifically that the experience is not of our own making; to undergo here means that we endure it, suffer it, receive it as it strikes us and submit to it. It is this something itself that comes about, comes to pass, and happens"[15]. The worlds of thought and practice can simply be re-unified within an experience, thus constituting a powerful yardstick and comparison, that is the first element necessary (even no sufficient) for a positive dialogue.

7. Communicating the experience: the narration

The question that might motivate us to take a further step is this: what is the appropriate way to communicate the experience? Once acknowledged that a more complex concept of experience is essential to the knowledge of the world of values and that the reflection on the lived experience constitutes a way to know a certain kind of truth, it is necessary to find a way of appropriate communication to the experientially known truth.

In this regard, narrative plays "a vital role [...] in understanding the human time and therefore, the human action that itself is required"[16]; the famous expression of Mink, "stories are not lived but told," is thus only partially true. The stories are told for the fact that we live them and, at the same time, they are lived for the fact that we tell them. The sense of narration here is much broader than simply handing down of facts, as Carr writes: "Narration in our sense is constitutive not only of action and experience but also of the self which acts and experiences. [...] I am the subject of a life story which is constantly being told and retold in the process of the being lived"[17]. A narration exists since it is experienced, and at the same time, a lived experience is possible as there is a narration. As suggested above, since there cannot be an experience without an "experiencing subject", there cannot be a narration without a "narrative subject". MacIntyre expresses this fact with the concept of

14 See: Agamben, *op. cit.*, pp. 17-18.

15 Heidegger, M. *On the Way to Language*, Harper & Row, New York, 1982, p. 57.

16 Kemp, P. "Per un'etica narrativa. Un ponte per l'etica e la riflessione narrativa in Ricoeur". *Aquinas. Rivista internazionale di filosofia* 31, (1988), p. 440.

17 Carr, D. "Narrative and the Real World: An Argument for Continuity". *History and Theory* 25, (1986), p. 126.

"unity": "That background is provided by the concept of a story and of that kind of unity of character which a story requires. Just as a history is not a sequence of actions […], so the characters in a history are not a collection of persons, but the concept of a person is that of a character abstracted from a history. What the narrative concept of selfhood requires is thus twofold. On the one hand, I am what I may justifiably be taken by others to be in the course of living out a story that runs from my birth to my death; I am the subject of a history that is my own and no one else's, that has its own peculiar meaning"[18].

The same narration, then, is never isolated but it is always embedded in a context of narrations that make the experience possible and complete it: in this sense we can say that the ability to gain experience of the human subject is both original and activated by other narrations. Our experience is always in relation to other experiences, and thus originates in a context of shared narrations that enhances the experience, making it mature[19].

Once understood narration as a shared experience we can think of a return to the experience, and narration as a possible field of dialogue. The narration has the advantage of immediately intercepting the field of personal experiences, since it makes them present because it is not limited to reproduce the visible; rather, it makes visible: "Today we reveal the reality that is behind the visible things, thus expressing the belief that the visible world is merely an isolated case in relation to the universe and that there are many more other, latent realities"[20]. We are not arguing here the futility of philosophical reflection in favor of a rising without supervision of the figurative arts, but rather we are pointing out that "classification is a condition of knowledge, not knowledge itself, and knowledge in turn dissolves classification"[21].

Therefore, we are not dealing with an *aut-aut* between philosophy and narration, but rather an *et-et*: we must return to integrate the world of speculation with that of narration, so as to keep playing with rigorousness a life that is effectively lived. The better way to represent an experience seems to be, thus, the narration, for experience has its essential correlation not in knowledge but in authority, i.e. the power of words and narration; and no one now seems to wield sufficient authority to guarantee the truth of an experience, and if they do, it does not in the least occur to them that their own authority has its roots in an experience[22].

Why, thus, narration is so important? Because, following Greenlagh et al.: "1). Stories are a natural and universal form of communication; 2) Stories create engagement through metaphor, rich imagery, suspense and other literary devices; 3) Stories are sense-making devices – i.e. they allow people to make sense of events and actions and link them to past experience; 4) Stories embrace complexity. They can capture all the elements of a problem; 5) Stories offer insights into what might (or could or should) have been, and hence consider different options and their likely endings; 6) Stories have an ethical dimension, and hence motivate the learner; 7)Stories occur in both formal and informal space. Hence, story-based learning can occur from a very wide range of sources; 8) Stories are performative. They focus attention on actions (and inactions) and provide lessons for how actions could change in future situations"[23].

Moreover, with particular concern to the clinical field, "narrative accounts bridge part of the gap between textbook descriptions and actual clinical manifestations"[24], since "case narrative serves as a repository of events"[25]; in this regards, "physicians use

18 MacIntyre, A. *After Virtue. A Study in Moral Theory*, University of Notre Dame Press, Notre Dame, 2007, p. 217.

19 See: *Ibid.*, p. 218.

20 Klee, P. "Creative Credo", en H.B. Chipp, P.H. Selz, J.C. Taylor (eds.), *Theories of Modern Art. A Source Book by Artists and Critics*, University of California Press, Berkeley, 1968, pp. 182-185.

21 Horkheimer, M., Adorno, T.L.W. *Dialectic of Enlightenment. Philosophical Fragments*, Stanford University Press, Stanford, 2002, p. 182.

22 See: Agamben, *op. cit.*, p. 14

23 Greenlagh, T., Collard, A., Begum, N. "Narrative based medicine. An action research project to develop group education and support for bilingual health advocates and elderly South Asian patients with diabetes". *Practical Diabetes International* 22, (2005), p. 126.

24 Benner, P.E., Hooper Kyriakidis, P.L., Stannard, D. *Clinical Wisdom and Interventions in Acute and Critical Care. A Thinking-in-Action Approach*, Springer, New York, 2011, p. 23.

25 Montgomery, K. *How Doctors Think. Clinical Judgment and the Practice of Medicine*, Oxford University Press, New York, 2006, p. 80.

both the scientific or hypothetic-deductive and the practical or interpretative and narrative, but it is the latter that makes them clinicians"[26]. This means, for the physicians, to deepen his/her abilities to adopt or identify others' perspectives, to inhabit and be with the other through the movements of attention, representation and affiliation, which may be reached through fortifying narrative skills and soft skills in general. In order to indicate how these skills can be acquired, we will show the model developed in University Campus Bio-Medico for the degree course in Medicine and Surgery.

8. Conclusion

The path taken so far desired to emphasize that the emergence of the conflict in the bioethics field is a modern reductionist and anti-social reflection on human being, forced to take refuge in contractual solutions (inter-subjectivity, for example) to find peaceful remedies to its natural selfish belligerence. On the other hand, it seems that, in order to overcome the conflict in the field of bioethics, we should first of all start from a common ground on which to work, i.e. human experience. This is precisely the vocabulary that doctors and bioethicists need: not a disembodied vocabulary, perhaps logically coherent but far from everyday life, but a vocabulary measured on real facts and experiences. The point for further reflection seems to be the concept of human experience in its deepest sense, as the scope of relationships and rediscovery of the values, to be discussed further on the possibilities of communication of this experience, in particular on the narrative as an effective way to engage the experience of the other persons.

An appropriate conclusion would be a brief proposal of a curriculum developed by the UCBM in order to create a dialogue between physicians and bioethicists. In the degree course of Medicine and Surgery of the University Campus Bio-Medico there is constant training in the field of Humanities both as institutional courses and as extra-curricular activities (in the University there are several clubs, including the "Philosophy Club", as well as seminars on philosophy and ethical evaluation of clinical cases). Regarding the institutional courses, it is worth mentioning within the Humanities: Fundamental of Anthropology and Ethics (1st year); History of Medicine and Social Medicine (1st and 2nd years); Fundamental of Bioethics (3rd year); Social Psychology (3rd year); Clinical Methodology and Bioethics (4th year); Clinical Bioethics (5th year); Legal Medicine and Philosophy of Medicine (6th year).

This curriculum helps medical students in rethinking and narrating their experience, while understanding other's experiences. To experience, thus, is at the same time to activate the other's experiences of humanity that is within human person – and not a humanity shouted and trumpeted onto the front pages of the newspapers, as do the egregious cases of bioethics; it is characterized, thus, as a daily practice, very day to day, which allows, however, to rediscover a common field of dialogue and possible resolutions for conflicts.

26 *Ibid.*, p. 45.

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