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Living With Death: The Narrative Turn in *Being Mortal* From the Perspective of Medicine Humanities

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As the field of medical humanities continues to evolve, the concept of "narrative medicine" has gathered increasing public attention for its role in improving patient care through narrative-based approaches. Narrative medicine emphasizes the importance of understanding patients' stories to effectively implement humanistic care in clinical practice. *Being Mortal*, written by the renowned surgeon Atul Gawande, is a significant and representative work in the field of narrative medicine. Since its publication, it has attracted widespread attention, and sparked considerable reflection among domestic readers on the ethical and humanistic aspects of medical care. This paper draws on Rita Charon's *Narrative Medicine: Honoring the Stories of Illness* to analyze the theoretical framework and practical applications of narrative medicine in *Being Mortal*. Furthermore, the paper explores how narrative medicine provides a new vision for medical humanities by fostering more effective communication between doctors and patients. The findings suggest that integrating narrative medicine into clinical practice can help address critical issues, including doctor-patient conflicts and the lack of personalized care, ultimately leading to a more compassionate and patient-centered healthcare system. Moreover, narrative medicine holds great potential for advancing the field of medical humanities and improving the overall quality of healthcare.

Keywords: doctor-patient communication, medical humanities, narrative turn, *Being Mortal*

Introduction

In traditional medical treatment, doctors often treat diseases as narrowly biological phenomena requiring medical and behavioral interventions, while patients view diseases within the overall context of their individual lives. This fundamental difference in understanding causes a disconnect, leading patients to feel that their experiences are not fully resonated with or understood by medical professionals. Whether through the detached attitude and professionalism shown by medical staff or the relentless pursuit of medical technology, the holistic integrity of patients as human beings is often deconstructed, and their narratives during diagnosis and treatment are frequently not fully or properly comprehended.

As medical and health undertakings deepen and medical system reform progresses, increasing attention is being paid to the doctor-patient relationship and the construction of medical humanistic services. The frequent occurrence of doctor-patient disputes has adversely affected the working environment of medical staff and the medical experiences of patients, seriously damaging the reputation and image of the hospitals and imposing significant psychological pressure on patients. These disputes not only cause economic, psychological, and

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physiological harm to patients, hospitals, and medical staff, but also waste public resources, hindering the development of medical and health reforms. Therefore, it is imperative to identify the root causes of these problems, find effective entry point to prevent doctor-patient disputes, adopt comprehensive measures that address both symptoms and root causes, and build a harmonious, mutual trusting doctor-patient relationship. Traditional research on doctor-patient communication tends to mechanically oppose the two parties, focusing on information exchange issues while neglecting gaps in thought, opinion, emotion, and attitude. Narrative medicine, by telling the story of disease treatment from a narrative perspective, encourages medical workers to actively listen to patients' stories with respect, to interpret and respond to their narratives, to be moved by their suffering, and to take corresponding actions to alleviate it. Thus, narrative medicine is not only a medical practice model but also a concept and tool to promote effective doctor-patient communication (Zhao, Luo, Wei, & Zhu, 2024, pp. 291-296).

Being Mortal, written by American doctor Atul Gawande, is a seminal work in narrative medicine that explores aging and death. The book delves into what can be done when an independent, self-sufficient life is no longer sustainable, and discusses the crucial conversations patients should have with their doctor at the end of life. Drawing from his years of surgical experience and poignant, thought-provoking stories, Gawande offers a sober and profound exploration of what it means to grow old in the 21st century. The book addresses not only death and the limitations of medicine, but also how to live with autonomy, joy, and dignity until the end of life. It stands as an important medical narrative practice.

Based on *Being Mortal*, this study examines doctor-patient communication and humanistic care practice from the perspective of doctors. Specifically, utilizing the theory of narrative medicine, the research analyzes the practice of doctor's identity and their personal emotional engagement—both inward and outward—in the context of a biomedical model that often excludes emotional intervention.

Background of the Research

China's first healthcare reform, known as a basic failure from 1995 to 2005, aimed to establish a social health insurance system and improve the accessibility and affordability of healthcare services (Wang, 2006, pp. 21-23). However, specific policies such as the "drug pricing system" and "public hospital financing" were not effectively implemented, leading to increased patient costs and intensified conflicts between medical professionals and patients. For instance, the drug pricing policy, which allowed hospitals to mark up drug prices by up to 15%, resulted in higher out-of-pocket expenses for patients, fueling dissatisfaction, and anger towards medical staff. The second wave of reforms initiated in 2009 introduced measures like the "Essential Drugs List" and "zero markup drug sales policy" to address some of the previous shortcomings. Despite these efforts, issues such as the over-medicalization of daily life, inhumane treatment of medical students, and overworked hospital staff persisted. Attending physicians typically see 30 to 35 patients in a four-hour clinic, and patients are like objects to be processed on a medical assembly line. As a result, more and more people began to pay attention to the human aspect of medicine, and humanistic medicine was gradually recognized as an important and indispensable part of modern medicine.

The introduction of narrative medicine by Rita Charon offered a new approach to address the lack of humanistic care in traditional medical practice. Narrative medicine emphasizes the importance of storytelling in clinical practice, enabling doctors to better understand patients' experiences and emotions, which can lead to more empathetic and patient-centered care. This approach stands in contrast to traditional medical humanities, which often struggle to translate theoretical knowledge into practical clinical applications.

Being Mortal by Atul Gawande exemplifies the principles of narrative medicine. Through personal storytelling, Gawande illustrates the importance of "difficult conversations" between medical professionals and patients. These conversations, though initially sad or infuriating, lay the groundwork for developing treatment plans that align with the patient's values and preferences as their condition changes. This continuous dialogue is essential for uncovering the choices patients are willing and unwilling to make, allowing doctors to tailor treatment plans that are more favorable to the patient's needs and wishes.

In conclusion, while China's healthcare reforms have faced challenges, the introduction of narrative medicine offers a promising avenue for improving doctor-patient communication and enhancing the humanistic aspects of medical care. By integrating narrative medicine into clinical practice, there is potential to address the issues identified, such as doctor-patient conflicts and the lack of personalized care, providing a more compassionate and patient-centered healthcare system.

Purpose and Significance of the Research

This paper explores the narrative qualities, case portrayal, and life ethics in *Being Mortal*, situating the discussion within the broader framework of medical humanities. The objectives and significance of this analysis are manifold.

First, the study aims to enhance the perspective of medical humanities. Both globally and within China, the focus on medical humanities is evolving. As populations age globally, there is an urgent need to reflect on issues of aging and end-of-life care. Medical narrative texts are indispensable for stimulating public discourse on these topics. Introducing high-caliber foreign medical narratives provides valuable insights for developing Chinese medical narratives and fosters convergence between Chinese medical humanities and global practices (Guo, 2023, pp. 205-212).

Second, the paper addresses the critical aspect of doctor-patient communication. Narrative medicine seeks to enhance physicians' narrative competence, facilitating empathetic and effective dialogue with patients to achieve deeper mutual understanding. The foundation of a harmonious doctor-patient relationship is built upon such conversations. Although set within the American healthcare system, *Being Mortal* offers valuable insights. By examining care concepts across cultures and exploring effective care delivery within varied social structures, we can integrate medical humanities with Chinese cultural nuances, rather than simply replicating foreign models (Corbett, 2015, p. 32).

Clinically, *Being Mortal* articulates the author's observations and emotions related to medical practice, particularly concerning aging and mortality. This perspective is crucial for fostering more intimate and constructive relationships between medical professionals and their patients. The book serves as a catalyst for introspection and dialogue, encouraging a more compassionate approach to medical care that is sensitive to the cultural and ethical dimensions of end-of-life decisions (Shapiro, 2011, pp. 68-72).

In conclusion, despite challenges in China's healthcare reforms, introducing narrative medicine offers a promising avenue to improve doctor-patient relationships and enhance the humanistic aspects of medical care. Integrating narrative medicine into clinical practice can address issues like doctor-patient conflicts and lack of personalized care, leading to a more compassionate, patient-centered healthcare system (Palla, Turchetti, & Polvani, 2024, p. 1116).

Literature Review

Medical humanities have not been paid much attention until 1980s. Before, people are more care about how

medicine cures them. However, medical humanities are not a new idea, but have been around since the time of Hippocrates. After years of development, it is found difficult to make a difference in clinical practice until the appearance of narrative medicine.

Current Situation of Overseas Research

As early as the 1980s, people began to pay attention to the development of medical humanities. Over the past four decades, medical humanities have evolved into a multidisciplinary field that draws together methods and insight from the humanities, arts, and social sciences to address questions around human experiences of health and illness (Fernyhough, 2024, pp. 701-711). Under the guidance of this theory, many scholars have carried out research in this aspect. For example, centring on cultural representations of HIV/AIDS, Johnstone (2024, pp. 802-803) examines how an emphasis on the early harrowing years of the epidemic has perpetuated outdated ideas of HIV as a death sentence, largely overshadowed more recent advances in preventing HIV transmission, and skewed perceptions of a health-care crisis that is still ongoing. When it comes to narrative medicine, it is also part of medical humanities, which is created by Rita Charon to solve the problem on the lack of patient subjectivity and the continuous conflict between patients and doctors. In detail, she discovered that everything medical science could do—clinical work, research, teaching—was filled with narrative, and therefore, "medicine" and "narrative" were intrinsically linked. As a clinician, she knows what works for her and what does not for others: "Medical humanities is a concept you can talk about, but narrative medicine is something you can do" (Guo & Wang, 2019, pp. 147-152). Thus, narrative medicine has become an important tool to realize medical humanities in the United States and even in the world under Charon's leadership. In Charon's view, narrative medicine is "a rigorous intellectual and clinical discipline that fortifies health care through the skillful acceptance of people's accounts of themselves—identifying, absorbing, interpreting, and being moved by the stories of others" (Charon, 2006, p. 4). Once the theory has been put forward by Charon, there are mainly the following aspects. First is to discuss its theoretical framework, such as the re-exploration of the theoretical basis of narrative medicine. Brad Deford (2020, pp. 57-78) found that Paul Rico's "three mimes" in *Time and Narrative* not only transcend Rita Charon's three categories of "attention, representation and submissibility" (the three movements of narrative medicine), but also explain the intersubjective understanding of narrative medicine practice. Thus, medical practice generates empathy, which in turn expands Charon's narrative claims and ethical goals. Second is to discuss the practical feasibility of narrative medicine based on clarifying its definition and importance (Kalitzkus, Wilm, & Matthiessen, 2009, pp. 60-66). Third is the education and curriculum development of narrative medicine, such as teaching research of narrative medicine in medical English courses and British and American literature (Zhang, 2024, pp. 213-215; Ji & Liu, 2023, pp. 120-123). Fourth is the direct practice of this theory and thoughts mentioned in narrative medicine from the clinical level, so as to produce narrative medicine texts or parallel cases. *Being Mortal*, which is detailly analyzed in this paper, is one of the representative works.

According to the current research results, studies have shown that narrative medicine has positive effects on doctors' identity cognition, clinical practice, and improving the centrality of patients. For example, narrative medicine can help medical students develop professionalism in clinical practice by promoting reflective thinking and awareness of professional identity through group discussions and reflective writing (Li, Zhong, & Cai, 2024, pp. 1-12). In addition, through a narrative medicine approach, students are able to better understand the implications of the physician profession and gain a more holistic perspective on patients and disease in clinical practice. Empirical studies have found that medical students' communication skills, empathy, and patient-

centered care skills improve after training in narrative medicine (De Rivera Atienza et al., 2023, pp. 1-16). However, some studies have pointed out that these positive effects may be affected by the limitations of the study methods, such as small sample size and study design bias. A study conducted in Spain found that medical students maintained their call to humanistic value and patient-centered profession throughout their medical degree program (De Rivera Atienza et al., 2023, pp. 1-16). This suggests that narrative medicine has its unique value even in the context of evidence-based medical education.

Despite the emphasis placed on narrative medicine in medical education, there are studies that offer critical perspectives. Galen Strawson, for example, has questioned the narrative turn in his work, arguing that not all people understand themselves and others in a narrative way (Ahlzén, 2019, pp. 1-10). In addition, there are also great challenges in the development of narrative medicine, such as lack of educational resources, cultural and language barriers, difficulties in evaluation and quantification, privacy or ethical issues, etc., which increase the difficulty of practicing narrative medicine.

Narrative medicine remains a promising endeavor in the field of medical humanities that highlights the importance of valuing human subjectivity in clinical care in spite of the controversy. Future research may continue to explore how narrative medicine can be more effectively integrated into medical education and practice.

Status Quo of Domestic Research

China's medical development is greatly inspired by the West. China has experienced the same "dehumanization" of medical practice brought about by the great development of medical technology as the Western world. Since the development of medical humanities in China in the 1980s, medical humanists have continuously criticized this phenomenon, just like scholars in the Western world (Guo & Wang, 2019, pp. 147-152). Since the emergence of humanistic medicine in our country, domestic scholars have been making efforts to deepen medical practice through medical humanities. Although medical humanities explain human behavior and attitudes from the perspective of sociology and anthropology, contemplate the nature of medicine from philosophy and history, and regulate the legal norms and moral bottom line in medical practice from the perspective of law to provide a multi-range perspective for medicine, the main participants of medical practice are doctors and patients, and the research value of humanistic medicine needs to be realized through these two subjects. However, such a process still lacked an enabler—until the advent of narrative medicine.

The year 2011 is regarded as the first year of the development of narrative medicine in China. Since then, medical humanists have begun to discuss the basic connotations of narrative medicine, including its definition and categories, as well as the differentiation of related concepts, such as "medical narrative" and "parallel case" (Zhang, 2011, pp. 8-10). In addition, discussions also include scholars' personal understanding of narrative medicine and the significance and value of narrative medicine entering clinical practice (Liao & Yu, 2024, pp. 37-41). It can be concluded that during the early period of narrative medicine's introduction into China, it mainly focused on understanding and introductory articles, which is very common when a new concept is introduced.

In our country, narrative medicine can be divided into broad narrative medicine and narrow narrative medicine based on its content.

> Narrow narrative medicine is a kind of "top-down" medical practice which is carried out by medical staff with narrative ability. General narrative medicine refers to the research and description of other disciplines (especially linguistics and literature) and even the public in accordance with their own methods on the process of doctor-patient encounter and illness experience. (Guo & Wang, 2019, pp. 147-152)

With 13 years' development, Chinese narrative medicine has gradually explored the theoretical system and practical path suitable for China's national conditions (Yang, 2023, pp. 1177-1179). That is, we cannot tell a story only for putting out a story. Telling a story is a pathway, with the patient building a narrative connection with family members and making them feel warm, which is the essence of narrative medicine. At the same time, Yang Xiaolin (2022, pp. 5-8) also does relevant comparative studies, like comparing the life and health narrative with the wisdom of traditional Chinese medicine (TCM), and sorts out the similarities and differences between the two theories, so as to clarify the enlightenment of TCM life philosophy to build a life and health narrative system with Chinese characteristics.

In total, besides the similar research fields similar to the international development of narrative medicine, Chinese narrative medicine research actively explores the research that is line with national conditions and has its own national characteristics.

Theoretical Framework

Based on the narrative medicine theory in Rita Charon's *Narrative Medicine: Honoring the Stories of Illness*, this paper develops a theoretical framework for *Being Mortal*. The details include the following aspects.

First, the ideological aspects of narrative medicine dissemination. Narrative communication often carries a discourse system with ideological characteristics. Although narrative medicine advocates paying attention to patients, Rita Charon's application of narrative medicine presupposes an idealized and orderly state of nature, which is rooted in traditional Western liberalism and confessional culture, and brings with it a set of prescribed attitudes, thoughts, and emotions.

Second, the medical care for the individual. The core proposition of narrative medicine is to introduce narrative mechanisms in the medical field in order to address the neglect of human beings in medical practice. Its critical premise is that contemporary medicine overemphasizes the biological, natural, and technical aspects of medicine, and tends to rely on scientific data to describe the human body physiologically and pathologically, thus sacrificing humanistic care for individuals. Western modern medicine pays more attention to the disease than the patients themselves; that is, the high attention to rational exploration of the human body as a physical object causes medicine to increasingly depart from the humanities and dilute the fundamental purpose of medicine. However, the disease itself is not only a biological dysfunction, but more fundamentally a "disability"—being unable to contact the world normally. Therefore, it is difficult to provide comprehensive care for patients from a single perspective, and narrative intervention is needed to unify mind and body, bridge experience and action, and help patients rebuild the connection with society.

Last, the narrative vision of medical humanities. The subversive nature of narrative makes it unpredictable, disobedient, and ununified. As a result, narratives can always evolve, disrupting a linear process while exposing new connections in unrelated ways. The same is true for the efficacy of narrative in health care, closing the gap by powerful means of telling, listening, and gathering around some form of "campfire" to focus on one another. The integration of the three elements of narrative medicine is slowly being recognized as the ultimate goal to be reached through a spiral of attention and online behavior. Belonging can unite individual clinicians and individual patients, and can also establish equal groups for medical staff and patients based on shared experiences of illness. Therefore, the sense of belonging that is discussed in this paper has practical implications in achieving equal, accessible, and dignified care for all.

Text Analysis

When it comes to doctors and patients, we have to face the reality that they are not equal. It is even said that they are always in disagreement. Gaps in medical knowledge, views on death and health conditions all separate them. I once talked to a medical PhD student who was specializing in plastic surgery. He said many of the patients who come in do not have any disease or medical conditions, such as burns, and the cosmetic procedures they want are unnecessary. Many of them come in with a picture of the star and tell the doctor, "This is what I want", but such a change is not only unnecessary, but it can also bring risk and harm. At this point, the doctor is no longer a surgical or diagnostic machine, but must truly stand in the patient's shoes to refuse such a request.

The Ideological Topic of Narrative Medicine Dissemination

Narrative has multiple dimensions and power. Novelists emphasize the creativity of narrative, historians rely on the organizing instinct of narrative, autobiographers reestablish the link between narrative and identity, and anthropologists explore the identity of narrative. What is clear is that narrative works for us. It can do things that others cannot. Medicine is also a field full of narrative. The practice of medicine is replete with concerns about the temporal dimension of life, efforts to describe individual, impulses to solve mysteries, and awareness of the intersubjective and ethical nature of treatment.

Temporality. Doctors and patients are at different levels of time—the time of doctors and nurses is formed by the series of time states of ward rounds, surgeries, injections, and so on. The doctor and the nurse take the initiative to cause every state and are therefore in an active state, whereas the patient is eternally in a state of being called, of being rounded upon, of being operated on, of being injected, of being in eternal suffering with relation to time. As a result, although Charon did not give a clear definition in her book, we can conclude that temporality in narrative medicine refers to a complex interplay between individual experience of time and institutional experience of time, and patients' experience of time and doctors' experience of time under the context of disease and illness, which differ from chronological or linear time in daily life.

This temporality is evident in the introduction. Gawande was a junior surgical resident when he met Joseph Lazaroff. At the time, Gawande was an intern in the neurosurgery department of a hospital, and rather than being either a patient and a doctor; Gawande's role was more like a middle ground between the two roles, with the expertise of the doctor on the one hand and not completely "inhuman" on the other. Gawande describes, "how I stood outside his hospital room, his consent form in my sweaty hand, trying to figure out how to start a conversation with his dad". Lazaroff was reluctant to give up, but Gawande thought he had made a bad choice—not only would surgery carry a lot of risk, but it would give him nothing he really wanted (bowel control, physical strength, and old lifestyle). He took a long and terrible risk in pursuit of a fantasy. For Mr. Lazaroff, it was a choice about his future; and for doctors, they only give advice from the most rational point of view. This is just a point about time—the impact of a patient's choice on doctors is just a next step. Patients and doctors are never on the same level, and the active and passive relationship makes them deliberately avoid an honest discussion of patient choices. It is not difficult for doctors to explain the specific risks of various treatment options, but they never touch on the truth of the disease.

Scientific progress has transformed aging and dying in the course of life into subjects of medical intervention, incorporating "never say never" technical pursuit of medical professionals. The truth is that medicine is not prepared to prevent the death of the sick and the elderly—the near death is a complex situation, and it is hard to judge whether quality recovery can be obtained at this time, because the last stage of life is relatively uncharted.

From the patients to ourselves, we can imagine our own family members in their position. No one can escape the tragedy of life, but that's not the same thing as knowing how to deal with a powerless patient. The doctor knows what to do technically, but the condition is too serious to solve—this is troubling. How can we gracefully cross the end of life? This is an eternal question.

Singularity. Due to the different background of every one, singularity is of great significance in medical care. It is defined as a unique and irreducible individuality of patients in illness, which is a recognition that everyone's story of illness is different because of culture, experience social circumstances and emotion. The idea of singularity in narrative medicine is a response to patients' complaints that doctors or hospitals treat them like numbers or like items on an assembly line, that they lament that their singularity is not valued, and that they have been reduced to that level at which they repeat other human bodies (Charon, 2006, p. 63). At the same time, doctors gradually release their own uniqueness in the process of helping patients find themselves. Doctors' looking at their own processes is an important step to help improve services.

In practice, this unique discovery is based on the patients and the doctors or health care workers in the daily life of the deep enough to get along. This relationship is not limited to doctors, because in reality, especially in China, doctors are very scarce and do not have enough time to understand and accompany patients. Instead, social workers or other medical personnel can only get along with patients to explore the highly personalized core of patients.

Gawande is constantly exploring this process in *Being Mortal*. In the first chapter, Gawande mentions his grandfather, Sitaram Gawande. When Gawande's father became an American citizen, what he could never get used to was how we treat our old and frail—leaving them to a life alone or isolating them in a series of anonymous facilities, their last conscious moments spent with nurses and doctors who barely knew their names (Gawande, 2014, p. 14). Because in the United States, health professionals have a systematic standard for assessing a person's physical function, Sitaram can only meet some of the basic independent measures, and for those complex indicators, he cannot do. In the West, it would be considered absurd for such an elderly person to ask for retirement at home, or to live on their own will. Doctors will refuse to send him home and place him in a nursing home, where the consequences of not doing so will be severe. As a result, his grandfather did not die until he was 110. Then he was on his way to a courthouse in town, but when he got off the bus, it started, and despite having his families with him, he fell, most likely developing a subdural hematoma—bleeding inside the brain. Gawande's uncle took him home and he died a few days later. He made the rounds of his fields right up to the year he died (p. 16).

In the experience of Gawande's grandfather, we try to examine his choice. Whether you choose to live according to your own will, or follow the advice of American doctors to go to a nursing home life, it is right, or there are some problems. From Sitaram's point of view, he was more interested in living with his family than in a completely risk-free life in rehab. More importantly, he had his own insistence—every night before going to bed, he would ride his horse to inspect every acre of his land, which was very important to him; before he died, he had to go to the town courthouse, which was the same important to him. From a doctor's point of view, if he does not live in a nursing home, he is always in danger. The doctor's opinion represents the attitude of traditional medicine, which prioritizes the patient's length of life as the primary goal, to the exclusion of all other factors. But in Sitaram's case, if he takes the doctor's advice, he might get good care, but the spiritual satisfaction can never be satisfied—without the company of his family and his own persistence. Such a life for him, even it is long enough, but not complete enough. Sitaram has his own ideas about aging and refuses to leave his fate to

medicine, technology, and strangers, and the reality is that he has not only gained the joy of life and the peace of death, but also seems to have not lost in the length of his life.

From this, we can see that the doctor ignored the uniqueness of Sitaram in his diagnosis. And the doctor did not try to understand the reason for his choice—of course, this seems very difficult in modern medicine. From the situation in China, an outpatient doctor on a busy day has to see 30 patients, and in a busy day in a hospital in a second-tier city even see more than 100 patients. It costs a lot to allow a patient to talk to a doctor in depth. From the perspective of medical humanities, such a shift is necessary, but it should not be rushed. There are several reasons for this. First, people are paying more attention to the quality of life nowadays, especially in hospice care services. For patients, the meaning of "good death" should not be limited to one-way pain relief, but should include a higher level of satisfaction such as emotional experience. Second, the ideal situation is certainly that everyone can be treated as a unique individual, and we never deny the validity of achieving this ideal situation. But the reality is that there are many patients and a few doctors. With the continuous improvement of people's living standards and the development of the medical and health industry, there are also higher expectations and requirements for the professional ability, technical level and humanistic care of medical workers, and the relationship between medical and patient is increasingly tense (Ming et al., 2024, pp. 104-109). The increased demand for medical capacity has made it more expensive to train medical staff, making it difficult to apply such a highly emotional diagnostic approach to all diseases in daily life. Therefore, in practice, I am more inclined to gradually expand humanistic medicine from dying patients to all medical treatment. The key to the view is the transition from terminal to general patient. The value of life is only seriously considered when it is about to be lost.

Intersubjectivity. Whether it is doctors and patients, any subject in the dialogue and communication is no longer just an independent individual; like two magnets, there is always some tension between each other. I read a novel and can be imagined entering into a relationship with the author, even though we do not know each other. The way we read creates a powerful and transformative bond between us (Charon, 2006, p. 70). Intersubjectivity mainly refers to the ability of doctors and patients to understand each other and communicate empathy in medical practice. It emphasizes the interaction and participation between doctors and patients, as well as the common understanding and meaning constructed in this relationship.

According to the definition, the embodiment of intersubjectivity in narrative medicine mainly includes the following aspects:

First is its emphasis on individual uniqueness. Rather than focusing solely on the universality and replicability of disease, medicine has begun to focus on each patient's unique life story and experience. This focus on the individual helps to compensate for the lack of recognition of individual uniqueness and creativity in the traditional model of medicine. Intersubjectivity reflects the intertextuality between doctors and patients. The intimate doctor-patient relationship arises from dialogue and communication between the two parties and is based on the complex text shared between the doctor and the patient. Through narrative, doctors and patients can better understand each other's positions and feelings, and thus establish a deeper connection.

Subject intersubjectivity also involves an ethical dimension. Through narrative medicine, physicians and patients are able to learn how to manage and maintain a good doctor-patient relationship. This ethical emphasis makes narrative medicine not only a technique or method, but also a manifestation of values and responsibilities.

Gawande's father's case shows intersubjectivity more directly in the book. Gawande's father, also a doctor, was diagnosed with an incurable spinal cord tumor in his later years. In response, Gawande and his father had in-

depth conversations about treatment options and end-of-life issues. They discussed the purpose of treatment and what really matters at the end of life. In this process, the doctor communicates with the patient—in this case, his father—not only as a medical expert, but also as a listener and an understanding.

In this case, Dr. Gawande demonstrated the core principles of narrative medicine, namely dialogue and empathy between physician and patient. He did not see his father merely as a patient in need of treatment, but as a person with emotions, a story, and a personal will. They together discussed the value of life and the issue of death, an exchange that went beyond the traditional doctor-patient relationship to a deeper, human level of communication.

In clinical practice, the cognitive expansion of intersubjectivity is reflected in the emphasis on the subjectivity of patients and the in-depth understanding of the doctor-patient relationship. In the history of medicine, the cognition of the patient's subjectivity has undergone a metamorphosis, and modern medical historians strive to strengthen the status and value of the patient in the narrative of medical history. At the same time, the doctor-patient intersubjectivity in the clinical situation shows two basic characteristics: the dignity of the weak and the care of the other. This requires physicians to pay attention not only to the physiological needs of patients, but also to their psychological and social needs in practice, as well as respecting the subjectivity of patients.

Medical Care for the Individual

This part corresponds to "Bioethics of Narrative Medicine" in *Narrative Medicine: Honoring the Stories of Illness*. The core point is how to solve the thorny ethical situation between doctors and patients. Nurses and social workers have, to a large extent, been part of the solution and not part of the problem in bioethics (Charon, 2006, p. 203).

A high-tech driven medicine will inevitably suffer some technical ethics tests. Medical ethics had been in existence since Hippocrates, and ethics then had been little more than vague oaths to do no harm, rules for courtesy among professionals, and guidelines for decorum with the lay public (p. 204). However, with the occurrence of a series of events like Tuskegee syphilis experiment in 1972, ethics in the mid-20th century was put on the side of the patient in the opposite doctor-patient relationship to protect the interests of the patient. Hence, many of the early concerns of bioethics—informed consent, safeguarding patient's autonomy, and resource allocation—were powered by the suspicion that doctors, left to their own devices, will exploit patients or in some way harm them and that patients need defense against them (pp. 204-205).

However, both the early vague regulations and the "protection of patients' interests" since the 20th century were based on the opposition of the doctor-patient relationship. The doctor-patient relationship is not, and should not be, antagonistic. Certainly, there can be disagreement or disappointment or defeat within these dyads. There can be misunderstandings that lead to such polarized points of view that doctor and patient see different realities (p. 206). In any case, the doctor-patient relationship should not be hostile and mutually exploited. Both sides are individuals with independent value and dignity. They participate in decision-making, share information, and influence each other in the medical process.

The first principle of bioethics is benevolence, and patients need doctors to witness and understand their despair. In narrative medicine, physicians respect the individual wishes and decisions of patients by listening to their stories and understanding their feelings and choices. At the same time, the emergence of narrative medicine has brought the renewal of the definition of bioethics. Over the past decade, traditional bioethics has struggled

with its own principles, only to find itself too thin to counter the realistic conflicts of values in disease—the rise of principles ethics was to resolve the contradictions in the clinical relationship, rather than to enhance or strengthen the caring doctor-patient relationship (p. 208).

The appearance of *Being Mortal* is a best proof of the progress made in the practice of life ethics. First, it respects the patient's autonomy. Gawande emphasizes that respecting the patient's choices and wishes is crucial. In the final stage of life, patients should have the right to decide their own medical care methods, whether choosing active treatment or palliative care, and should be based on the patient's personal wishes. Giving patients the opportunity to make choices is a manifestation of the dignity of life. "The dignity of life is not just about extending life, but also about maintaining the quality of life". "The best thing in life is being able to go to the bathroom by yourself". This title was added by the translator herself, and I think it's particularly good. Bill Thomas wanted to rebuild nursing homes, and Keren Wilson wanted to completely abolish nursing homes and replace them with assisted living facilities. They pursued the same wish—to help people who are independent maintain their existence value. As 99-year-old Makover said, "I was so happy there. I was living, I was living the way people should live: I had friends, I played games. One of them would take the car, and we'd go. I was *living*" (Gawande, 2014, p. 131).

Second, the integrity of life is reflected. This integrity is reflected in two aspects. On one hand, in the final stage of life, help patients achieve their personal goals and wishes, including spending time with family and resolving unfinished affairs, to ensure that life can end without regrets; secondly, encourage people to formally acknowledge the limited nature of life and the inevitability of death. On the other hand, by planning and preparing in advance, including making a living will, people can be more courageous in facing the end of life. For example, Gawande mentioned in "Better Living" how Thomas implemented his practice in a nursing home. Although Thomas tried to solve the problem "in the way that he, as a doctor, understood best", he was stopped by the nursing home's care director—"I confused care and treatment," Thomas told Gawande. Thomas came to realize what was missing in the sanatorium—formal life itself. He had to fight what he called the three plagues of nursing house existence: boredom, loneliness, and helplessness (Gawande, 2014, p. 116). To cope with these three plagues, sanatoriums began to place plants, create gardens and vegetable gardens, and experiment with animals. Thanks to Thomas's tireless efforts, they got back a greyhound, a pug, four cats, and one hundred birds. The children of employees will play in the nursing home after school; friends and family can play in the nursing home's backyard garden, and there is a playground for children to play on. For Thomas, the shift from "order" to "chaos" in nursing homes was the source of the core's vitality. In such nursing homes, the patient is not an individual who can only stay in the ward to be dealt with, but there is "conflict"—conflict is the source of life.

Narrative Vision of Medical Humanities.

As medical professionals developed a deeper understanding of their own practices and improved their skills in paying attention and reproducing them, they found that they had become more honest, altruistic, empathic, and responsible, which are the hallmarks of the medical profession's ethos. When medical professionals used new narrative practices to examine and try to better understand clinical work, their connections became deeper, and their specific professional disciplines were no longer important—everyone was struggling on the edge of illness and health, work and life, others and self. What was important was that everyone, through a back door—more accurately, through an open door—achieved the goals of the profession's ethos, not through indifferent, desperate, or external efforts, but through authentic narratives that put the interests of patients first and brought joy and a

sense of belonging from work, which is the core point of narrative vision of medical humanities. Charon mentioned the monthly narrative ethics rounds held at the Allen Pavilion Community Medicine Inpatient Unit at Columbia University's affiliated hospital. Interns and residents wrote about patients who brought complex ethical and emotional problems, and then read them aloud. Meanwhile, occupational therapists, geriatric nurses, and cardiologists trained the interns in internal medicine on how to get life history narratives from patients, which was a required part of the geriatric rotation.

Similarly, *Being Mortal* explores Gawande's thoughts on aging, disease, and death, as well as the way modern medical systems handle these issues. The book presents the individual life stories and emotional experiences of aging, and Gawande presents concepts such as "end-of-life care", "assisted living", and "advance directives" and weaves them into the story. For example, Gawande's account of Felix's story. He was an expert in geriatric medicine and suffered a stroke at the age of 60, and his heart stopped beating at the age of 79. But he was fortunate to survive. His wife, Bella, became blind and suffered severe memory loss as a result of the disease. Felix was caring for his wife while also documenting his own physical changes and aging process. In addition, Peg, a private piano teacher, suffered from nausea sarcoma. After the painful treatment, she chose the "good death service". Back home, with the help of service staff, she continued her teaching work until the end of life. These events not only embody the reality of aging and death, but also reveal how to live through the final stages of life in a military exercise and autonomous manner. Gawande explores the limitations of medicine and the value of life, encouraging people to have more choice and control over the end of life.

Conclusion

Drawing on Rita Charon's *Narrative Medicine: Honoring the Stories of Illness*, this paper has analyzed the narrative turn in Atul Gawande's *Being Mortal* and its importance in doctor-patient communication and humanized medicine. The analysis focused on three key areas: the narrative characteristics of temporality, singularity, and subjectivity; individualized medical care; and the broader vision of medical humanities. While this study highlights the potential of narrative medicine in fostering more compassionate healthcare, its practical implementation remains a long-term challenge.

The research presented here is based on specific textual analysis but lacks a comparative and historical framework, which may introduce limitations in terms of scope and depth. Moreover, the exploration of medical narratives has primarily been conducted from a macro perspective, leaving room for a more detailed and focused analysis of *Being Mortal*. Despite these limitations, *Being Mortal* continues to serve as a valuable model for further study and discussion in the field of medical humanities.

This paper is intended to initiate reflection and dialogue rather than offer definitive conclusions. It is hoped that the analysis provided here will contribute to the ongoing development of narrative medicine and medical humanities, particularly in relation to the challenges posed by translation and linguistic issues in the creation and dissemination of medical narrative texts. Ultimately, this paper aspires to inspire further research, ensuring that the growth of medical humanities in China keeps pace with global advancements.

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