Chapter 12
The Moral Experience of the Person with Chronic Pain

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Abstract There is an ethical landscape associated with the understanding and management of the person with chronic pain, which spans a range of structural, policy, educational and clinical issues. This ethical landscape has normative (what one ought to do…) and non-normative (what one actually does…) terrains. Healthcare providers and patients alike encounter a moral tension between these normative and non-normative ethical terrains. This moral tension, if unrecognized and unresolved, can have damaging effects on a person's sense of 'self', sense of agency and therefore their ability to effectively participate in actions and activities required towards better health. The Ethical Reasoning Bridge is an ethical reasoning model that conceptualizes how healthcare providers can negotiate this normative and non-normative ethical landscape in terms of their decision-making in clinical practice. The use of narrative reasoning can assist healthcare providers to support patients to develop narrative capabilities (speaking, acting, telling and imputing personal responsibility for actions). If healthcare providers can learn to negotiate the normative and non-normative ethical terrains which form the landscape of chronic pain ethics, we can assist persons with chronic pain to develop narrative capabilities, and also identify 'a wider moral space' (Kleinman in What really matters: living a moral life amidst uncertainty and danger. Oxford University Press, Oxford, 2006) in which they can begin to resolve the moral dilemma they face in having to comply with the normative expectations of others at the cost of denying their own lived experience.

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1 Introduction

What does it mean to talk about the moral experience of the person with chronic pain? And would the answer, assuming that there is such an experience, have any relevance in either clinical or ethical decision making in the diverse range of issues (physical, psychological, pharmacological, ethical and practical) which arise in the clinical management offered by various health care providers?

McGee et al. (2011) conducted a study in which focus groups were convened in five major cities in the United States. These focus groups consisted of key stakeholders thinking about the issues involved in the management of persons with chronic pain. These stakeholders included persons with chronic pain, healthcare providers, insurance and pharmaceutical representatives, law enforcement officers and advocacy groups. Arising from these in-depth conversations was the recognition and description of a landscape of 'chronic pain ethics'. This ethical landscape included recognition of a range of structural, policy, educational and clinical issues resulting in the following call:

> … chronic pain ethics needs to be focussed upon and framed by the experiences of people living with chronic pain. A moral foundation is required, based in an understanding of the suffering experienced by people whose (pain) experiences have been invalidated, who continue to encounter a culture of stigma and distrust, and find their dignity undermined by a system and a society that appears disinterested in taking a stand for the care and consideration to which they are entitled (McGee et al. 2011, p. 1383).

In this chapter I will argue that the moral experience of the person with chronic pain forms part of a larger landscape of a chronic pain ethics which has normative ("what one ought to do") and non-normative ("what one actually does") terrains and, furthermore, that it is in understanding the relationship between these two moral 'poles' that ethics, commonly understood as the regulation of professional duties, obligations and behaviours, can also be seen as having a valuable role in the therapeutic and agentive process for—and with—the person with chronic pain (Edwards et al. 2014).

As suggested above, the normative parts of this ethical landscape are often its most familiar and recognized parts, having to do with the duties and obligations of healthcare providers, as laid out in the respective professional guidelines, standards and codes of conduct in each discipline. Even so, meeting these ethical obligations is not necessarily straightforward and can sometimes take healthcare providers to uncomfortable places. Regardless of health discipline or practice setting, we can be exposed, as healthcare providers, in our attempts to deal with the suffering and tragedy of others; experiencing stress ourselves and, at times, feeling incompetent to deal with what is being asked of us. A leading physician, writing in his capacity as both a doctor and, at the time, as President of the American Academy of Pain Medicine, told of his ethical distress—indeed, his torment—at the suicide of his patient (Webster 2014). He had been caught between his patient's cries for help, and not coping with ongoing, intractable pain and his perceived professional obligation to reduce, over time, his patient's opioid medication. The physician stated unequivocally that his patient never overused his medication, neither showing signs of abuse nor addiction. Yet he felt compelled to reduce his average daily dose, telling his patient in the face of his concern, "It will get better." Ironically, his response to his patients suffering, he lamented, was diminished by his own fear of receiving regulatory sanctions, together with the stamp of unethical practice, if he did not comply with current policies of opioid management (Webster 2014). Even good practitioners can let their patients down. None of us is quarantined from this possibility; caught in a tension of competing, even conflicting normative ethical obligations, and doing less than we might otherwise like to do if circumstances were somehow different. The notion of persons with chronic pain having normative ethical obligations is less clear or obvious compared with health practitioners but is, nonetheless, real and discussed below.

The non-normative parts of this ethical landscape surrounding chronic pain provide a context for understanding how the experiences of both healthcare practitioners and patients are enmeshed in and shaped by larger social and political factors at work in both healthcare systems and wider society. The conclusions of McGee et al. (2011, p. 1383) regarding the experience of people with chronic pain: "whose experiences have been invalidated," "who continue to encounter a culture of stigma and distrust" and "who find their dignity undermined by a system and a society" bear testimony to this point. Yet it is important to recognize that the "normative" and the "non-normative" forms of chronic pain ethics are part of the same larger landscape. The moral experience of the person with chronic pain, although involving the exploration of a person's lived experience, and therefore unique and individual is, nevertheless, also an expression of wider healthcare, and social, cultural and political systems that impact the sense of agency of both patients and health care providers, who each desire better care for persons with chronic pain. The challenge for both healthcare providers and persons with chronic pain alike is to learn how to negotiate their way in this diverse ethical landscape by understanding the different kinds of inquiry, decision-making and action necessitated by it.

2 The Moral Injury to the Self in War

A century ago, during World War 1, the medical practitioner and psychiatrist WH Rivers treated men from the trenches in France who were suffering what was then termed "shell shock." This term conveyed the "erroneous but culturally legitimizing idea that physical trauma, such as concussion, from bombardment with high-explosive munitions was responsible for the symptoms" these men experienced (Kleinman 2006, p. 204). These symptoms were varied in severity and scope but included paralysis, mutism, psychological deafness, nervous tics, stuttering, panic attacks, nightmares, sleep disturbances and amnesia (Barker 1992).

It became apparent to these sufferers, their doctors and other interested parties such as politicians and higher-ranking officers in the armed forces, that these symptoms:

> served the highly practical purpose of removing the soldier from the extreme danger of the war zone. The diagnoses were (*therefore*) stigmatized and sufferers were popularly regarded as malingerers, cowards or madmen (Kleinman 2006, p. 205).

Rivers argued that these disorders were not due to physical head trauma but arose from psychological trauma and that this did not make them “any less legitimate forms of pathology deserving humane care and technically competent treatment interventions” (Kleinman 2006, p. 205). Rivers treated men, mostly officers, who, he believed, were:

> experiencing neurotic symptoms because of conflicts between inner feelings, largely unconscious, of self preservation and societal and military values that required them to be brave and steadfast in the trenches, where they could neither flee nor fight but had to passively persevere under shelling (*described by one writer as being like “hurricanes of steel”*) that appeared to kill soldiers randomly and over which they could exert no control at all (Kleinman 2006, p. 208).

Rivers helped his patients (mainly British army officers) face what was really at stake which was, in his opinion, the resolution of a moral dilemma: they were conflicted between their deep and instinctual need to survive and their fears of disgracing themselves in the ultimate test of manhood as normatively defined by their British society at the time. The challenge for these men lay in their attempts to maintain or retrieve a good and moral self in the untenable position that their society had placed them. It may not be surprising for readers to learn that many U.S. veterans of wars in Afghanistan and Iraq, who are sufferers of Post Traumatic Stress Disorders (PTSD’s), also “feel morally tainted by their experiences, unable to recover confidence in their own goodness” (Brooks 2015).

Rivers approach to treatment then could be described as “ethnographically informed” (Kleinman 2006, p. 210) in that it involved helping patients gain insight and self-knowledge (the latter he termed “autognosis”) not only about their own psychological state but also about the social, cultural and political context which had shaped the conditions for their moral dilemma. Interestingly, it is now increasingly recognized that the suffering experienced by Afghanistan and Iraq veterans due to PTSD’s, is to be overcome, at least in part, by framing this suffering in terms of the moral dimensions of their experience and not just the psychological ones (Brooks 2015; Sherman 2015). In some rehabilitation programs, for example, veterans are assisted to reflect on their experiences and recognize just how much choices are limited when one is faced with a random, tragic situation; and to then reconsider how responsibility and blame for terrible things should be apportioned (Brooks 2015; Sherman 2015). Treating the pathological effects of memory as in PTSD, involves therefore an understanding of the politics of violence and trauma and the vital question of how to live a moral life under such dangerous conditions (Kleinman 2006, p. 213). Therefore, these approaches mirror, to some extent, Rivers’ approach to the WWI soldiers he treated.

In her novel, “Regeneration,” Pat Barker recounts a series of therapy encounters between Rivers and his pacifist patient, the poet Siegfried Sassoon, which would, in part, lead to Rivers’ conclusion that:

> …it was prolonged strain, immobility and helplessness (*in the confinement of the trenches*) that did the damage, and not the sudden shocks or bizarre horrors that the patients themselves were inclined to point to as the explanation for their condition. That would help to account for the greater prevalence of anxiety neuroses and hysterical disorders in women in peacetime, since their relatively more confined lives gave them fewer opportunities of reacting to stress in active and constructive ways. Any explanation of war neurosis must account for the fact that this apparently intensely masculine life of war and danger and hardship produced in men the same disorders that women suffered from in peace (Barker 1992, p. 222).

Rivers’ early observation that underlying the ongoing problems of these men from the trenches was an unresolved moral dilemma regarding the integrity of the self was also accompanied by the insight above, expressed in the context and language of a century ago, that the conditions of “prolonged strain, immobility and helplessness” formed the genesis of these problems these men experienced. This then enabled him to generalize this finding to others and their experiences. In addition, in turn, this points us to the experience of the person with chronic pain and the possibility of it, too, having moral dimensions and for not entirely dissimilar reasons.

3 The Moral Struggle for the “Self” in Chronic Pain

Rivers understood that norms in the social world could be expressed in and become “part” of the body such that:

> Cultural values could guide our gestures, our posture, and even our emotions and our sense of who we are in the direction of what the group regarded as good and desirable. Thereby, we become normal and moral human beings—normal and moral in the eyes of a particular group or society, that is (Kleinman 2006, p. 226).

In his phenomenology of perception, Merleau-Ponty (1962, p. 7) would later offer a concept of the body where bodily comportment “not only identifies the body as “mine” but also reflects the body as a social and cultural entity.”

A number of studies using an applied phenomenological method known as Interpretive Phenomenological Analysis (see Larkin et al. 2011), and which explored the lived experience of persons living with chronic pain, were critically appraised by Smith (2011) and by Edwards et al. (2014). The collated findings of these critically appraised studies provided a picture of the person with chronic pain as caught in a tension. On the one hand, they experience the need to describe their condition in objective, pathological and/or biomedical terms (Snelgrove and Liossi 2009; Smith 2011; Snelgrove et al. 2013) firstly, as a way of legitimizing their being-in-pain, then as a means of distancing themselves from their condition, and finally, as it was acquired (and perpetuated) through no fault of their own. On the other hand, there is the need to acknowledge the reality of their pain and their own lived experience, which they describe as an “elusive,” “deceptive” and unseen (Snelgrove and Liossi 2009; Lavie-Ajayi et al. 2012), which erodes their sense of “self” and its relationships with others, including family members, friends and health professionals (McParland et al. 2011; Relieving Pain in America Report 2011; Lavie-Ajayi et al. 2012).

Lavie-Ajayi et al. (2012) termed this tension “narratological distress,” defining it as an internal battle between two unwanted narratives. Participants in Lavie-Ajayi et al.’s study related times when they would bow before the pressure of social norms; normative in the sense of “who they ought—or were expected—to be.” They would:

> …surrender to the narrative of the absence of illness. Facing scepticism from family, friends and health professionals, they ask themselves to submit to the external narrative, which positions their pain as imaginary or as an exaggeration, paying the price of alienation from their own experiences and pain (Lavie-Ajayi et al. 2012, p. 199).

The price of resolving this narratological distress, in this particular way, was a debilitating alienation from one’s “self,” an outcome which has also been termed as “living with a body separate from the self” (Osborn and Smith 2006). It is a moral struggle to retain, or indeed retrieve, a “good self” (Osborn and Smith 1998; Smith and Osborn 2007; Relieving Pain in America Report 2011):

> I’m some waster, they should have someone who’s impressive, to look up to but how can they look up to me with what I do all bad tempered and crippled, dossing about lying down every 10 min. All they see is a bit of a man…terrible” and “…You stop caring. …If someone else gets a pain you’re not sad for them, you’re glad that someone else knows how you feel […] that’s awful” (participant ‘Tony’: Smith and Osborn 2007, p. 525, 526).

and,

> …my personality’s gone, I used to be right bubbly and lively you know but it’s, that’s gone, and even my mum says that I have changed, she never really says in what way, she says I have gotten more snappy and more nasty. You want the old Alice back but you can’t” (participant “Alice”: Osborn and Smith 1998, p. 72).

It is also salient to return to the experience of Iraq and Afghan war veterans (Sherman 2010):

> Yet, what moved me as I listened to soldiers, especially those recently returned, is how desperately they wanted to feel their old civilian selves. Or, at least, they wanted to feel more porous boundaries between being a soldier and a civilian—whether as a parent, a child, or a colleague in the work force; keeping their different selves fully separate was just too numbing.

It is apparent that it is not only healthcare providers who find themselves in the normative landscape of chronic pain ethics: others too are “obligated” to comply with normative expectations, including their own learned expectations, of what it is to be a “good” or “worthwhile” person in their life situations. But, as we have seen, the demands of doing this can come at the cost of denying what is happening in their own lived experience and bodies, as in the loss or separation of their previous "good selves." Kleinman suggests that "norms" and their demands upon persons can be deleterious—it certainly was for the officers treated by Rivers in WW1—and that norms may need to be refashioned, so that there is "a wider space for others to build their own moral careers, where they have alternatives to established norms and ways of being normal" (2006, p. 215). This suggests a need to understand and value the non-normative parts of the chronic pain ethics landscape, where norms can be questioned rather than merely complied with.

4 Narrative Identity and Capability in the Work of Paul Ricoeur

While it is beyond the scope of this chapter to comprehensively describe the current approaches to the management of persons with chronic (non-carcinogenic) pain, it is worth noting that so-called "pain education" provides a way, at face value, of resolving the moral tensions for the chronic pain sufferer described above. In "pain education," the aim of explaining pain is to shift a person's conceptualization of pain from "that of a marker of tissue damage or disease to that of a marker of the perceived need to protect body tissue" (Moseley and Butler 2015, p. 807). By assisting a person to realize that their pain is real and not imagined and that they are not neurotic, crazy or a malingerer can be very helpful indeed, modifying a person's pain experience and functional abilities for the better (Moseley and Butler 2015). However, the evidence and efficacy of this approach is still maturing (Moseley and Butler 2015). Gallagher et al. (2013) in a study, which acknowledged that pain education did not always achieve positive outcomes, demonstrated that this education process was more effective when delivered in the context of metaphor and story. Arguably, this suggests some utility in stories where persons can consider information in the context of others' experiences and how those experiences may "speak" to their own experiences and the development or trajectory of their particular "self."

The hermeneutic phenomenologist Paul Ricoeur reminds us that the "self" is constituted in relation to "others" (Ricoeur 1992). And so it can be appreciated that a moment of cognitive learning, as can occur in pain education, takes place in the larger history of a person's story and the development of a "self" which is constituted "culturally and socially." Ricoeur argues that it is in this set of social and cultural interactions that the potential for a person to discover new capabilities (such as learning and agency) is facilitated or extinguished (Ricoeur 2006).

Situating this discussion once more in the context of a landscape of chronic pain ethics, I propose that there is a role for healthcare providers to recognize and facilitate, where possible, the project of persons with chronic pain in retrieving or discovering new and more flourishing versions of their moral "selves." This is an ethical enterprise, and it requires that the healthcare provider leave the territory of normative ethics (and its focus on professional obligations and the regulations of these) and move into the area of non-normative ethics. With Kleinman, I suggest that narrative reasoning provides a means of creating a “wider moral space”; what he also calls “local moral experience” (Kleinman 2006), so that persons can recover a moral sense of themselves, in the ethical or moral landscape created by the tensions of normative moral obligations, and the inability to meet these without significant personal (and health) costs.

For Ricoeur, it is narratives which allow human actions to be truly apprehended and rendered intelligible to others (Dauenhauer and Pellauer 2012). This is based on the analogy that we make sense of our own personal identities in much the same way as we do of the identity of characters in stories (Dauenhauer and Pellauer 2012). In narratives, there is a unifying process where we come to understand the characters by way of the plot that ties together what happens to them, the aims and projects they adopt, and what they actually do (Dauenhauer and Pellauer 2012).

Ricoeur argues that every action (in terms of a change in the world) involves initiative that in turn requires a bodily agent possessing capabilities and vulnerabilities who inhabits some concrete context and situation (Ricoeur 1992). He describes four fundamental human capabilities: (1) speaking, (2) acting (doing or making), (3) narrating (or telling), and (4) imputing action to some person or persons as worthwhile or not worthwhile (Ricoeur 2006).

This notion of capabilities has particular significance in the context of non-normative ethics and the person with chronic pain. The capabilities described below constitute active processes in the formation of a “self” which importantly also become a means for establishing a recognition of persons; and in the first instance that of “self-recognition” (Ricoeur 2006, p. 17).

The first basic capability is the capacity to speak: “I can speak.” Speaking is itself a kind of action since the speaking subject is able to designate himself/herself by the use of specific linguistic processes, thus expressing intentionality in the phenomenological sense of expressing one’s relations with the world (Ricoeur 2006, p. 18).

The second capability is the capacity to act. The subject may recognize himself or herself as the “cause” or “initiator” of an action, leading to the assertion: “I did it; I am the one who did it” (Ricoeur 2006, p. 19). Thus, the subject also becomes an *agent* capable of answering the 1st person oriented question relating to the “who” of an action, as distinct from the 3rd person question regarding the “what” of an action, and the reporting of an event as its merely occurring (Ricoeur 2006). To the agent can be ascribed the capacity to designate themselves as the true authors of their deeds. In other words, the action belongs to the agent who appropriates it and calls it his or her own.

Thirdly, there is the capacity to tell: to tell stories about events and characters, including oneself. This connection between plot and character leads to the notion of a narrative identity (Ricoeur 1992, 2006). Narrative identity provides a temporal dimension to the notion of identity (and formation of “self”) (Ricoeur 1992). Until the story is finished, the identity of each character or person remains open to revision(s) and therefore, in order for a subject of action to assign an ethical value or qualification to his or her personal life, this subject (or agent) needs to be able to "gather this life in the terms of a narrative identity"(Ricoeur 2006, p. 20). MacIntyre refers to this as "the narrative unity of a life" (MacIntyre 2007).

Ricoeur differentiates between two aspects of identity. There is the self's *idem*-identity (Latin) which gives the self, among other things, its spatio-temporal sameness (Ricoeur 1992; Dauenhauer and Pellauer 2012). That is, its sense of continuity. There is also the *ipse*-identity which is what accounts for the self's unique ability to initiate something new and ascribe this to a "self," be it oneself or another, as the agent (Ricoeur 1992; Dauenhauer and Pellauer 2012). A narrative identity relies on a dialectical relationship between "sameness" and "selfhood"; that is, a constant movement between the maintenance of the continuity of a life and its capacity (self-initiated) for change (Ricoeur 1992, 2006).

Fourthly, there is the capability to hold oneself accountable; to impute moral responsibility for an action(s). What does this add to the notion of agency and "authorship" described above in the capability for action? Imputation is a Kantian notion and refers to a judgment by which a person is declared to be the author (freely taken) of an action which is then regarded as his/her moral fact or deed (Bok 2001). This speaks, therefore, of the capability to accept or bear the consequences of one's own acts. All narratives have ethical dimensions and narratives call for us to evaluate their characters as such. The "promises" or "assertions" of a narrative present characters in such a way that evaluations of what they do or suffer become part of the (self) interpreted meaning of an experience or event(s) (Ricoeur 1992; Dauenhauer and Pellauer 2012).

Ricoeur's analysis of a personal narrative identity is central to his hermeneutic phenomenology of the self, expressed here in the first-person: Since my personal identity is a narrative identity, I can make sense of myself only in and through my involvement with others and through the exercise of my capabilities. I do not simply enact a role, function or practice that has been assigned to me (in contrast to post structuralist ideas) but can initiate new actions and choices. Although I can be evaluated in any number of ways, ultimately, it is the ethical evaluation, which is, over time (and generally speaking), the most important evaluation; one made in the light of my responsiveness to others (adapted from Dauenhauer and Pellauer 2012). The narrative unity of my life (its virtue in Aristotelian terms) is made up of the moments of its responsiveness or failure to respond to others, with the intention (telos) that my responsiveness will bring about a better life with and for others (Ricoeur 1992; Gillett 2009; Dauenhauer and Pellauer 2012).

Understanding and working with patients' narratives have been taught by several authors in the health field: Medical and nursing education (Charon 2006; Greenhalgh 2006; Carel 2012); medical ethics (Brody 2002; Frank 2004); psychiatry and ethics (Kleinman 2006); psychology (White and Epston 1990). It is not my purpose here to reiterate the "how to" of various approaches to using narrative. However, these approaches have in common the notion that narrative reasoning (or practice) can help persons see themselves and their situations in ways not constrained or shaped by the dominant and normative narratives that they are seemingly enmeshed in. Healthcare providers have as part of their training and practice, skills in asking questions and interpreting responses and, therefore, are in a position to use narrative reasoning should they choose to do so. Whilst the biopsychosocial approach in healthcare, with its aim of being more holistic and patient centred than its antecedent, the biomedical model, has become widely accepted, both the inclination and the skills needed to implement this approach remain much less evident (e.g. Epstein and Borrell-Carrio 2005; Morris and Wilson 2008; Karp 2012; Singla et al. 2015; Overmeer and Boersma 2016). For example, even when the value of narrative reasoning is appreciated, as a means of understanding the lived experience of a patient in the biopsychosocial approach, its translation to and use in clinical practice is not:

> While likely not practical in routine clinical practice, the use of patient narrative in clinical therapy and research (i.e. "narrative medicine") can provide valuable insight into the human pain experience (Vetter 2012, p. 154).

The use of narrative reasoning in clinical practice, from either a clinical or ethical decision making perspective, becomes an issue of what questions—of the patient or themselves—practitioners consider important and what interpretive lenses they use to receive the answers to those questions (Edwards et al. 2014). How healthcare practitioners understand the necessary movement, even from moment to moment within a session, in reasoning and decision making between diagnostic and procedural forms of reasoning and those forms of reasoning needed to understand another person's belief(s) and lived experience, is also relevant in the importance practitioners place on using narrative reasoning.

5 The Ethical Reasoning Bridge

One conceptualization of what it means to navigate between these different forms of reasoning in healthcare practice and which assists the practitioner to traverse the normative and non-normative terrains of the chronic pain ethics landscape can be found in our reasoning model "The Ethical Reasoning Bridge." The Ethical Reasoning (ER) Bridge is an ethical (and clinical) reasoning framework derived from research of the decision making of expert physical therapists (Edwards et al. 2004; Edwards and Delany 2008) and describes a movement between normative and non-normative ethics. It further develops an idea, originally expressed by KM Hunter, who described the inquiry task of the medical practitioner as crossing a bridge where, on the one side, information is sought about a case which is universal (or normative) and shared by all or most patients and, on the other, information is sought which is unique to this particular patient case (Jones 1997).

On either side of this metaphorical bridge, are pylons, which are constituted, in an epistemological manner, by different conceptions of knowledge and the particular logic associated with them. On the normative ethics side of the bridge are assumptions about knowledge and truth which also underpin the empirico-analytical (or positivist) paradigm of quantitative research (Higgs et al. 2007). That is, knowledge or truth is rationally or objectively known, universal (or generalizable), measurable and predictive. This understanding (or epistemology) of knowledge is illustrated by the diagnostic act of taking blood pressure which involves the interpretation of an objective, measurable, predictable and generalizable finding. In turn, it involves a normative logic concerning what blood pressure values one "ought to find" and what one "ought to do" in response to this outcome. Physiotherapists, similarly, use this logic in assessment of such things as joint range of movement and muscle function. In ethical terms, use of these normative assumptions represents a "deductive" logic or reasoning in so much as we apply a universal or generalized ethical approach (e.g. utilitarianism), or ethical principle (e.g. respect for autonomy, beneficence, non-malfeasance, or justice) to a particular ethical dilemma in order to make a judgment or "test" as to its "fit" for answering the diagnostic ethical question, "what is at stake ethically in this situation?" (Edwards et al. 2011, p. 1657). To this end, Fox has described normative ethical problem solving, exemplified by, but not confined to, the four principles, as "a rigorously rational, formal, largely deductive mode of argumentation" (1994, p. 48). The question of "what is ethically at stake?" on this side of the ER Bridge, is therefore answered in terms of the collectively (normatively) agreed professional and ethical duties and obligations of a community of practice.

On the non-normative side of the ER bridge, the process of understanding lived experience of illness and disability (including pain) uses a narrative (or inductive) form of reasoning which "generates" rather than "tests" hypotheses. A different set of underlying assumptions regarding knowledge or truth is also used. On this side of the bridge, truth and reality are context dependent, leading to multiple realities and the idea of knowledge as a social construction (Edwards et al. 2011, p. 1657). Narrative reasoning involves understanding the manner, therefore, in which a person "edits" and "re-tells" their story (and thus their narrative identity) as an interpretation of personal experience over time (White and Epston 1990). Narrative reasoning also recognises that the meaning(s) people attribute over time to their personal situations may also be constitutive of their perceived self-identity, sense of agency and actions (or inactions) (Brody 2002; Kleinman 2006; Mattingly 2010). In other words, a person's (or indeed community's) interpretation of their experiences not only shape their decision making and actions but may lead to what Nussbaum (2006, p. 73) refers to as "adaptive preferences," where the expectations for change, in ethical terms such as equity and justice, may adapt or "atrophy" due to the prevailing and inhibiting influences in their particular context.

Narrative reasoning can therefore assist in also understanding the social determinants or "unjust background conditions," as termed by Nussbaum (2006, p. 73), which might either shape or constrain a person's (or group's) sense of moral agency. The assumptions underpinning this account of reality and experience therefore acknowledge how a person's sense of moral identity and agency is, in part, shaped by various discourses (e.g. historical and power relations) and social determinants (see Edwards et al. 2014, for further discussion).

The reasoning movement "to and fro," across the ER Bridge, not only requires skill on the part of the healthcare provider in being able to both move between and use these fundamentally different reasoning logics, but also an ability to make a shift in their perceptual "posture" (Edwards et al. 2004, 2014). A practitioner's normatively oriented intentionality,[1] when listening to and examining a patient, is to look for what they recognize (e.g. a doctor looks for the signs and symptoms of a particular disease entity). This leads to a categorization and ordering of the features of a presentation (clinical or ethical) with an emphasis on recognizing what is known and what—in a normative sense—is expected or ought to be found (Edwards et al. 2011; Kahneman 2011). Phenomenological (narrative) thinking requires putting this logic to one side (bracketing as it were) in order to understand, paradoxically enough, the person/patient as someone (a self) who is not "diagnosable" or "reducible" to a clinical (or ethical) pattern (Frank 2004; Komesaroff 2008). Instead, in phenomenological and narrative terms of the "self," what occurs is a project of mutual recognition between practitioner and patient. Ricoeur characterizes the challenges in achieving mutual recognition as "a struggle against the misrecognition of others at the same time that it is a struggle for recognition of oneself by others" (Ricouer 2005, p. 258). This can typify the clinical encounter and, in many respects, the stigma (suggested by McGee et al. 2011) which is commonly faced by the patient with chronic pain:

> I have a Masters degree in clinical social work. I have a well-documented illness that explains the cause of my pain, but when my pain flares and I go to ER, I'll put on the hospital gown and lose my social status and identity. I'll become a blank slate for the doctors to project their own biases and prejudices onto. That is the worst part of being a pain patient. It strips you of your dignity and self-worth (Participant in Relieving Pain in America Report 2011, p. 19).

There are inevitably differentials of power and rank in a clinical encounter, and so it is the healthcare provider who has the mandate to "cross and recross the ER Bridge" between the normative and non-normative sides in order to also "see" and "hear" the patient with a non-normative intentionality and situate this in the knowledge and obligations of their role as healthcare providers. This crossing and recrossing the ER Bridge can lead to a mutual recognition and "brings self-recognition to fruition" (Ricoeur 2006, p. 22). Self-recognition (and agency) becomes possible with the exercise of one's capabilities (to speak, to act, to tell, and to impute responsibility) (Ricoeur 2006).

The story near the beginning of this chapter about the pain physician and his patient's suicide was a very honest and personal expression of this healthcare provider becoming caught in a tension between his complying with his perceived obligations (in relation to opioid management) and listening to the cry of desperation from his patient. It is a normative (obligation-based) and non-normative (lived-experience-based) moral tension that he experienced. However, he is able to exercise capabilities of speaking, acting, telling and imputing responsibility as a

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[1] Intentionality here is a phenomenological term which does not refer to a practical intention to 'do something', but instead to the proposition that we have a conscious relationship with an object—externally or in mind or memory—which we interpret and develop meaning about (Larkin et al. 2011).

way of using this story to question the then current policies of opioid management and its ethical implications for physicians and patients; importantly with a purpose of calling for change.

We should, as healthcare providers, endeavour to assist persons with chronic pain (our patients) to develop these same narrative capabilities as a means of resolving the moral dilemma that they face; between the normative expectations placed upon them and the less visible but real imperative of acknowledging their own lived experience and the effects this has upon the integrity and health of their "selves." Narrative approaches in healthcare and ethics in healthcare have been previously described by a range of authors as mentioned earlier. This chapter describes, more particularly, how healthcare practitioners can understand both the influence and relationship of particular forms of reasoning and problem solving—diagnostic/procedural together with narrative/phenomenological— in professional practice. It is in developing awareness of and skill in using these different forms of reasoning that allows practitioners to traverse both the normative and non-normative ethical terrains of the landscape that is chronic pain ethics. Normative ethics has a focus on compliance with established duties, obligations and values. Non-normative ethics considers what Kleinman (2006) calls "local moral experience" and allows for the possibility of questioning existing norms and values in the light of a person's lived experience. Learning to traverse these normative and non-normative terrains assists practitioners to not only recognize better the influences which shape their own practice but also support persons with chronic pain, who feel caught in this tension and experience this as a moral dilemma, to change or widen the interpretive lens with which they view their moral "selves."

Current research continues to provide evidence in ways to better teach and encourage healthcare practitioners to use biopsychosocial approaches in the management of persons with chronic pain (Overmeer and Boersma 2016). The addition of a moral component: learning how to work with the moral experience of the person with chronic pain, and how this may influence outcomes, requires further research and evaluation.

6 Conclusion

The moral experience of the person with chronic pain is constituted in a dilemma which occurs as an inability to resolve the tension between normative expectations of others (and themselves) regarding expected attitudes and behaviours in the face of ongoing pain and the non-normative realities of the actual lived experience of that pain and its effects on the "self" and its relationships with others. This moral experience is an important part of the landscape of chronic pain ethics and its understanding has a utility and value for both practitioners and patients. In portraying chronic pain ethics as a landscape, which is wider than the commonly understood conception of professional ethics as a regulation of behaviour, non-normative ethics, then, becomes a means by which the moral agency of the person with chronic pain becomes a new and important focus. Narrative approaches in health have been widely described and advocated. In this chapter I outline a model of reasoning and decision-making, the Ethical Reasoning Bridge, which describes how practitioners can traverse the normative and non-normative ethical terrains, and in doing so, can begin to assist their patients to do so for their contexts. However, the role of narrative reasoning in the conduct of daily healthcare practice and, in particular, the development of narrative capabilities with patients, in order to enhance their sense of agency, remains under researched.This chapter is a revised and modified version of the following paper: Edwards et al. (2014).

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