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The Hermeneutical Process and Clinical Ethics

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See page 39.

James Arthur McClung has constructed a sensitive analysis of the dynamics of time and language. The basic motion of his analysis begins by asking "the important question of whether a patient's wishes can be understood without examining the context in which they are expressed." His answer completes the analysis: " . . . the disagreement hinged entirely on statements to which the patient assented and on actions requested by the patient's family under different circumstances and at a different time."

I strongly agree with McClung that time and language interact to influence meaning. "Disagreement . . . under different circumstances and at a different time" could be the slogan of the hermeneutical approach to clinical ethics.

In this paper I basically affirm, but offer an alternative expression of, McClung's position. I will outline a scheme for understanding the hermeneutical process and review three alternative ways to interpret the intent of a treatment directive.

Hermeneutics is the science of interpreting texts.[1] Clinical medicine is a practice of hermeneutics.[2] Understanding the patient as text includes interpreting the meaning of the patient's declarative statements, such as advance directives and informed consent. Clinicians who use the hermeneutical process systematically are able to interpret the meaning of healthcare directives more authentically.

The text they must interpret can be as simple as the utterance of a single phrase or as complex as a full-length novel. Context and text, or event and utterance, must be considered as a unit for analysis. McClung has chosen to use the term "time" to hold the meaning of "context" or "event," and "language" to hold the meaning of "text" or "utterance." When he proposes that both time and language are essential to interpretation in clinical bioethics, he is applying the central claim of hermeneutics that context and text must be considered in their reciprocal unity.

The hermeneutical process includes two elements.[3] The first imaginatively reconstructs the context of the text to determine the original, intended meaning. The second discerns the application of the originally intended meaning to a current context. This double movement assumes the form of a complex question addressed to the author: "What did you mean then, and what do you mean now?"

There are three ways to pose this complex question: ask the author to clarify her intention, ask someone who has knowledge of the author to imaginatively reconstruct the author's intention, and ask someone who does not have knowledge of the author to imagine what a person similar to the author would likely intend in a similar situation. In clinical ethics, these three methods of clarifying the authentic intention are known as informed consent, substituted judgment, and the best-interest argument.

Informed consent involves a clarifying conversation for the purpose of understanding the author's intent. Without this checking procedure there is no sufficient interpretation of the patient's intention to guide clinical decision making. Without a clarifying conversation the interaction of context and text, time and language, can not be fully understood.

If the author has decisional capacity, the clarifying conversation proceeds as a reciprocal dialogue. The term "decisional capacity" describes a characteristic of a person who is capable of meaningful conversation. The conversation should lead to a decision that can reliably be interpreted by the listener as consistent with the personal meaning system revealed in the conversation. This clarifying conversation becomes a reciprocal checking process that is the most effective method of arriving at an authentic interpretation of the meaning intended in a directive statement. This interrogation follows the general formula: "What is it that you mean to say?" "What I mean is. . . . " becomes a powerful response that can not be denied by an interpreter without the risk of misunderstanding the author's intent.

Decisional capacity, or the capacity for clarifying conversation, is assumed to be present in the adult person. Because of the strong claim that persons know themselves and their value systems best, clinicians depend on each person's clarification of their own intentions.

The development, maintenance, and action of an authentic self that is capable of making a discernment of the most fitting response to the self's life situation is a complex assignment.[4] The processes that result in an authentic self-expression, such as an advance directive or informed consent, are exceedingly resilient, yet are vulnerable to fragmentation.

To have such clarifying capacity, one must have an intact personality. To be intact is to be sufficiently integrated to be able to deliberate out of the center of values that constitute personhood. This is the basis for an authentic decision. It is the core of autonomy. This is the subtle act of telling one's story. It must be carefully nurtured and enhanced.

It is not always true that a person is in the best position to express the authentic self.[5] The possibility of being decisionally incapable, or conversationally disabled, is a constant threat to authentic personhood. The determination that a person is or is not capable of making decisions or of entering into a clarifying conversation must be accomplished with careful sensitivity.[6] Such a determination is a complex process, to determine whether a person possesses clarifying capacity or must be considered decisionally incapacitated. In the clinical situation of life-threatening conditions, the care required for the determination is further intensified.[7]

Decisional capacity must be carefully determined because to accept as authentic the declaration of a nonintegrated person is to dishonor the intent of the person who made a declaration when the person was fully integrated. To ask a nonintegrated person to make a decision is to not respect what the integrated person had declared, and would declare again, if capable of doing so. This tendency to solicit and honor declarations that are unauthentic because of a fragmented personality is as much of an error as the tendency to ignore the authentic declarations of an intact personality because of a careless determination that misinterprets the person as incapacitated.

The nursing staff in this case were attempting, during the "lucid moment," to engage the patient as person in a clarifying conversation. This is the correct hermeneutical process. The nurses, reinforced by the neurologist, made a determination that the person had the capacity to engage in the conversation and to reach an authentic decision. The justification of this determination is a point of great importance. My reading of the account leads me to suspect that the nursing staff was unconsciously pressing a best-interest argument rather than relying on an objective, clarifying conversation.

Healthcare providers tend to allow the declarative statements of a person in crisis to trump their declarative statements made when not in crisis. In fact, this is precisely what the patient wants to avoid. The patient wants to avoid the distorting effects of crisis decision making and to avoid pleading for help when helpful intervention is not a real option. "Advance" in advance directive is intended to give the most authentic statement about the person's true intentions during a time when the person can most clearly discern from the depths of an integrated center of values. It is as though the patient is insisting: "Do not ask me about my

intentions when I am in the grip of pain or fear; do not trust my statements when they are coerced by powerful figures involved in my life crisis; listen to me when I can tell what I mean!"

There is a two-edged problem here. It may be that people can not conclude their most authentic discernment without being in the situation requiring the discernment. Yet, at the same time, the unanticipated forces of the critical moment can be the worst possible context in which to make a discernment. This is to say that decisions must be made in the context of the present-now, but the present-now is the worst time to make decisions. Despite these limitations, the person-in-the-moment remains the most authentic of decision makers.

Substituted judgment is the second way to pose the clarifying question. If the person is not capable of conversation as a reciprocal checking process, then the hermeneutical process guides us to a surrogate who now "acts the part" of the directing person. The surrogate is asked to reconstruct the horizon of the declarant and to answer the question: "What do you think she would want in this situation now?" The form of the question is not "what do *you* want in this situation?" To answer as the person would answer requires an act of moral imagination. It is an imaginative reconstruction of the value system of the person. This is precisely what is done by a responsible interpreter of any text. Using moral imagination, the surrogate must reconstruct the horizon of the author of the text. This substituted moral judgment requires exquisite sensitivity to time and language. It is not a substitution of the surrogate's moral judgment; it is, instead, a substitution of the surrogate's reconstruction of the subject's moral judgment in the form: "I imagine this to be what Mother would say in this situation."

This reconstruction can not occur without some distortion. Some misinterpretation will result from imposing subjective value onto the meaning of the original declaration. But this is the imperfect nature of substitute judgment. The imperfection must be accepted while being minimized by the proper exercise of the moral imagination of the surrogate.

The son as surrogate in the case example appeared to be acting out his sincere reconstruction of his mother's original directive. He seems to believe that he has faithfully performed substitute judgment as the second method of the clarifying conversation.

If there had not been an assigned proxy, or some other person knowledgeable about the patient's intentions, the third method of clarification would have been employed: the best-interest argument. This is the least satisfactory form of clarification because it is the most distant from any knowledge of the original intent of the declarant.

Clinical decision makers have a strong tendency to use this method despite its status of being the least satisfactory. Clinicians tend to answer the clarifying question in the form of "Any thinking person would mean this." Or, perhaps in the form of "I can't imagine anyone meaning anything other than. . . . " Or, even more prone to distortion is the form of "She must mean this because it is clearly in her best interest."

Ideally, best interest can interpret the good of the patient in such a way that harm can be minimized. Practically, best interest is interpreted from the meaning, the perspective of someone who may intend the patient's good as a goal but who has no contact with what the patient's interpretation of good might be. In fact, no imaginative reconstruction of the patient's personal value system is possible when using this method. Personal meaning is all reduced to one homogeneous, impersonal conception constructed by the interpreter. The original meaning of the author's advance directive is thereby negated. This third method of clarification is the least desirable to use as a hermeneutical guide in clinical decision making.

The action of the staff was to use the least satisfactory method of a best-interest argument in an unconscious way while consciously intending to obtain informed consent. This well-intentioned action should be carefully resisted when substituted judgment is properly exercised.

In this case under consideration, it is questionable whether the mother in her moment of relative lucidity, or the son seized by the stress of grief, was more capable of deciding out of the perspective of the mother's authentic value system. In my opinion, the person most capable of an authentic decision was the patient in her condition one year ago when she gave the direction "no life-preserving measures." The attempt to ask the patient for an interpretation during a period of questionable lucidity was a proper procedure, which should have been abandoned when it failed to meet the criteria as a clarifying conversation. The support the son received

from the bioethics consultation was proper because it focused on the substituted judgment of a proxy who could, to a limited but important degree, imaginatively reconstruct the intended meaning of the patient.

NOTES

1. P. Ricoeur, "The Task of Hermeneutics," *Philosophy Today* 17 (1973): 112-128.

2. K.M. Hunter, *Doctor's Stories: The Narrative Structure of Medical Knowledge* (Princeton, N.J.: Princeton University Press, 1991).

3. E.V. McKnight, *Meaning in Texts: The Historical Shaping of a Narrative Hermeneutics* (Philadelphia: Fortress Press, 1978).

4. R.J. Lifton, *The Protean Self: Human Resilience in an Age of Fragmentation* (New York: Basic Books, 1993).

5. M.W. Martin, *Self-Deception and Morality* (Lawrence, Kans.: University of Kansas Press, 1986).

6. B. Lo, "Assessing Decision-Making Capacity", *Journal of Law, Medicine & Health Care* 18, no. 3(1990): 193-201.

7. J.F. Drane, "Competency to Give and Informed Consent," *Journal of the American Medical Association* 252, no. 7(1984): 925-27.

In this paper we introduce narrative and hermeneutical perspectives to clinical ethics support services (CESS). We propose a threefold consideration of 'theory' and show how it is interwoven with 'practice' as we go along. First, we look at theory in its foundational role: in our case 'narrative ethics' and 'philosophical hermeneutics' provide a theoretical base for clinical ethics by focusing on human identities entangled in stories and on moral understanding as a dialogical process. Second, we consider the role of theoretical notions in helping practit The hermeneutical process and clinical ethics. Robert Lyman Potter. Journal of Clinical Ethics 6 (1):88 (1995). Abstract. This article has no associated abstract. (fix it).Â Theory and Practice of Clinical Ethics Support Services: Narrative and Hermeneutical Perspectives. Rouven Porz, Elleke Landeweer & Guy Widdershoven - 2011 - Bioethics 25 (7):354-360. Clinical Ethics as Medical Hermeneutics. David C. Thomasma - 1994 - Theoretical Medicine and Bioethics 15 (2). A Process and Format for Clinical Ethics Consultation. Robert D. Orr & Wayne Shelton - 2009 - Journal of Clinical Ethics 20 (1):79. Ethics Consultation and Empathy. Florian Bruns & Andreas Frewer - 2011 - HEC Forum 23 (4):247-255. A Systematic Approach to Clinical Moral Reasoning.