CHAPTER 9

Discussion
Health care practice gives rise to many morally challenging situations and involves complex ethical choices that bioethics attempts to answer. In a period in which we can no longer assume that we share higher principles or the same epistemic ground of moral experiences, recurring to foundational values or principles as a model for moral judgment however appears no longer reasonable. But even if it seems inappropriate - given moral pluralism - to rely on an ultimate foundation for ethical justification, we nevertheless need to be accountable to each other. We still have the basic ethical task of giving each other reasons to justify our moral claims and commitments, and of working out from there how best to proceed together in finding solutions to ethically complex issues (Walker 2007).

If we renounce from an ultimate foundational and deductive approach to ethics, what remains is nothing more (but also nothing less) than to start from the plurality of our moral understandings and to undertake validation within the thick descriptions of our moral practices. It then becomes important to make explicit our guiding normative understandings around a moral question and test them against others through inclusive dialogical processes, rather than relying on an abstract ethical justification, which assumes ‘objectivity’, reflecting a singular perspective.

This thesis is based on the idea that hermeneutic bioethics implies epistemological and anthropological premises that make ethics a dialogical practice rather than a set of theories that can be monologically applied. By stressing the primacy of practical over theoretical knowledge, hermeneutics assumes that our representations of things are grounded in our non-explicit, practical engagement with the world (Heidegger 1927). Through the things we do, we acquire experiential knowledge, moral knowledge included. This knowledge is not primarily general, cognitive or conscious, but particular, practical, and embodied. By engaging in social practices and sharing a particular life-world, we take up local skills of moral perception, we learn how to attribute moral meaning, engage in moral commitments, discern what others expect from us, and express what we expect from others. Rather than existing a priori, moral knowledge emerges primarily through shared living in social practices. Through our different moral experiences, local traditions and communities, we develop moral understandings that make us interpret moral situations, behavior and choices in particular ways and help us to find resolutions of solving moral issues.

In the introduction, I elaborated four consequences of these epistemological and anthropological grounds, for practicing hermeneutic bioethics: First, hermeneutic bioethics sustains that practical moral problems can only be significantly addressed if ethical evaluation remains dedicated to the participants’ local practical ethical knowledge and the subjective meanings a particular moral practice has for them. From a hermeneutic perspective, ethical investigation should therefore begin with a joint effort to explore the subjective meanings and moral understandings experienced by participants actually concerned with a moral problem. These subjective moral under-
standings play an ongoing role throughout the entire process of ethical evaluation. Second, the plurality of moral experience, epistemic background-conditions and moral interpretations implies the need for an ethical evaluation through a dialogical process in which participants explain and negotiate moral interpretations. As a consequence, hermeneutics envisions ethical evaluation as a shared process of mutually accounting to one another for one’s moral actions or positions by exploring each other’s moral points of view, particular reasoning and underlying values, by dialogically testing particular moral knowledge and ethical claims against those of others including wider ethical principles. Third, through this dialectical, reciprocal process of going back and forward between perspectives, by opening to another persons’ moral experiences and convictions, the dialogue partners are able to explain themselves, question their own points of view and those of others, integrate new insights and even revise their position. Consequently, this leads to moral learning and new moral understandings, which allow participants to then determine which is the ethically wisest way to proceed together. Fourth, the role of the bioethicist in a hermeneutic perspective is not that of a specialist who advises on ethically right solutions or justifications, rather it is that of a “scholar” who leads and sustains the critical-dialogical process of ethical evaluation (Verkerk and Lindemann 2009, p. 246).

In this chapter I will go deeper into these points, in order to address the central question of the thesis, which is how these theoretical ethical ideas of hermeneutic bioethics work in bioethical practice focusing on clinical ethics support and empirical ethics research. My aim is not to evaluate whether hermeneutic bioethics deals successfully with bioethical problems (for this see i.e.: Van der Dam et al. 2013), but to reflect on how hermeneutic notions and concepts are operative in the practice of hermeneutical bioethics, and what kind of practical and theoretical conclusions follow from this. To do so, I will summarize what we have learnt from the previous chapters for both fields, clinical ethics and empirical bioethics, referring to the four points mentioned above, namely: 1) The importance of the exploration of subjective meaning; 2) Ethical evaluation through a dialogical process; 3) Moral learning; and 4) Consequences for the role of the bioethicist and ethical theory. As my aim is to investigate how hermeneutic bioethics works in practice, taking my examples from the main corpus of this thesis, the ’results’ reported here relate to the process of doing bioethics (and in some points also to the content of what we discovered during this research). Finally, I will address some issues raised by critics of hermeneutics and formulate recommendations for hermeneutic practice in both fields of bioethics.

For the sake of argument, I sometimes overemphasize the difference between what I have called in chapter 2 a mainstream ‘monological’, foundational and/or deductive approach and a ‘dialogical’, interpretive approach to bioethics. I’m aware, that this distinction falls short, given the continuous development of ethical thought. Especially, in philosophical ethics today there are examples of approaches that do not fit neatly into the dichotomy between monological and dialogical. My objective, however, was not to analyze particular ethical positions, but to reflect on epistemological and anthropological presuppositions that are still present, certainly in bioethics, and that inspire critiques of hermeneutic bioethics.

Hermeneutical bioethics in practice: What have we learnt?

In this section, I present the main findings of this thesis related to the four points mentioned above and explain their significance for hermeneutic clinical and empirical bioethics.

The importance of the exploration of subjective meaning

In the introduction I stated that, as our moral understandings are strongly entrenched in our epistemic and social practices, hermeneutics holds that the process of describing of what is morally at stake, giving reasons or arguing for morally just resolutions cannot be conceived from an epistemically or historically neutral position. We always reason “from somewhere” (Nagel 1989). Hermeneutics sees a moral agent as being equipped with moral knowledge because she or he shares a social practice and a moral world with others. Within these shared moral practices each one of us arrives at their own particular moral understandings. If we differ therefore in the interpretation of our moral experiences (and we can no longer assume that we a priori share the same higher principles), then we need to make intelligible to others in ethical interaction how we interpret moral experiences and norms in the light of our local moral knowledge. For this reason, the exploration of subjective meaning has a central place in hermeneutic bioethics. In order to understand each other in situations of practical moral concern in health care, moral agents not only need to understand which practical moral understandings, claims or commitments are relevant for another person, but also why this person is committed to them. The first step of ethical evaluation therefore requires opening up to the other persons’ moral interpretation of the situation at stake and investigating the particular subjective meanings of the others’ moral commitments and emotions.

In hermeneutic clinical ethics, significant hermeneutic work usually needs to be done to make the implicit or explicit subjective or institutional moral meanings at stake in a given clinical issue intelligible. First and foremost, this hermeneutic work consists in exploring the moral claims of the participants in the case and the narrative accounts on which these are based, as the meaning of a particular moral claim can only be understood in the context of and in relation to other relevant ideas and identifications important to this person. In Chapter 4, we reflected on the case of Mr. Carnegie who refused all three therapeutic options available and was judged by his physician as being “inconsistent”. By listening attentively to Mr. Carnegie’s narrative, it became clear that his “no’s” were based on good reasons grounded in his long experience as COPD-patient: He refused surgery, because he had already undergone so much; he refused naso-gastric tube feeding because of previous negative experiences, and he re-
fused to include a DNR order in his claim for fair and equal treatment at the end-of-life; moreover, his fear that this was not always distributed to Afro-Americans and Caucasians fairly (a fear that is sadly confirmed by empirical research; see Crawley 2005; Sherwin and Winsby 2010). What seemed to be logically ‘inconsistent’ from the physicians’ perspective, could be explained in the light of Mr. Carnegie’s particular moral understandings. Besides the narrative exploration, this case also required critical awareness of how the physicians’ initial case description ‘constituted’ what was ‘at stake’, and came to influence the further discussion (Agich 2005), and attentiveness to prejudices, short-circuits in moral reasoning and distortions of communication born out of mistrust and recognition failures.

We have therefore learnt that the hermeneutic exploration of meaning during consultation consists of investigating the narrative texture of moral and epistemic experiences and “working towards achieving a sense of how things are ‘over there’” (Code 2002, 157), providing through this a basis for further deliberation. This effort in becoming acquainted with each other’s moral narratives helps participants not only to establish awareness of the particular moral understandings present in a clinical ethics intervention, it is also vital for the practicability of possible ethical resolutions: From the perspective of the single participant in an ethics consultation, an action will only be convincing for this person, if it is responsive to her or his ‘thick’ moral understandings of the situation, including moral identities, particular commitments and values (see also chapter 2 and 3). During the consultation, these might be altered or changed, but in a situation of moral concern a resolution will only be acceptable to parties if the evaluation is responsive and refers to moral meanings (Gadamer 1960). In the case of Mr. Carnegie, for example, this meant finding a solution that respected his spiritual beliefs and his particular way of coming to decisions (i.e. asking God for advice). The rather unconventional proposal made by the ethicist (to wait one more night and ask God for advice) was not totally risk-free (in Chapter 4 we reflect upon the risk of, the ethicist’s use of the patients’ own spiritual language being potentially misleading for the patient), but attempted to ensure that the patients’ reasoning was preserved and remained close to his own moral vocabulary and his particular way of making a decision.

It is important to remember that the meaning hermeneutics intends to make explicit during a bioethics intervention, in the clinic (as well as during the interview, see below), is not something that can be observed or retrieved as already existing in the mind of the other party. On the contrary, it emerges during the conversation, as the participants or the interviewees and interviewer make explicit what is important and specify what is at stake. New meanings are created in the encounter between people. So what is finally understood as ‘meaning’ is the result of a co-production in the shared process of dialogue.

On a process level, our studies on hermeneutic clinical ethics have demonstrated that the narrative exploration of subjective meanings in the clinical context is not only important for understanding diverse moral claims and exploring moral controversies, but also for relating moral claims to broader moral narrative and self-understandings, in order to illuminate and give voice to particular ways of moral reasoning based on epistemically diverse moral knowledge, for overcoming prejudices of participants towards each other through fostering insight into the differences in views on and descriptions of the situation, and for, through this, re-establishing a common basis for communication.

On a content level, we have learnt that hermeneutic clinical ethics shows that ethical conflicts arise when health professionals describe patient’s decision making at the end of life as ‘inconsistent’, ‘contradictory’, or ‘ambiguous’, based on their superficial understanding of the patient’s moral narrative account. Situations of complex decision-making at the end of life, in which patients seem to state contradictory claims, require an in-depth exploration of how patients describe their moral reality and attribute meaning to various choices they face according to their particular moral narratives and self-understandings, as well as of the fore-understandings and normative expectations (i.e. about the proper way of decision making) with which health professionals approach their patients.

Hermeneutic empirical bioethics considers the practical moral knowledge of real agents as the starting- and reference point for an elaborate process of empirical ethical research. Research that integrates multiple and enacted moral views will be – if performed critically – more responsible and “epistemically more reliable than exclusive reliance upon any one source” (Hardwig 1997, p. 63; Lindemann et al. 2009). Furthermore, first-person representations and dialogue between particular moral experiences and claims in research improve the quality of knowledge and the practical improvements derived from research (Abma 2005). For these reasons, hermeneutics investigates moral meanings of particular topics by studying the narrative structure of participants’ accounts. From a hermeneutic viewpoint, moral acts or commitments are only intelligible as part of larger personal narratives (MacIntyre 1981) (see Chapters 5, 7 and 8). Only through focusing on the contextual meaning of stories and narratives which a person tells about him- or herself, we can understand what is ‘at stake’ for somebody in a given situation (Mattingly 2010, p. 60).

In our study, we have assumed that wishes to die are narratively structured and relate to broader stories of self-interpretations in which patients recount their moral understandings to themselves and others – often in a quest for meaning in the face of death (Chapter 8). These statements account for the considerable subjective effort to find meaning facing death. In Chapters 5 and 8, we explained that in order to understand a phenomenon such as a wish to die of persons in a palliative stage, we had to investigate what it meant for them to have such a wish, and understand in which larger narratives of identity these wishes played a role for them and the people around them. Investigating the meaning and sense of wish to die statements gave considerable insight into what is important in the moral experiences of patients at the end of life; but also into how last wishes are structured, into how meaning (or absence of meaning)
regarding wishes to die emerges between people and in which way social interactions contribute to this. The model of the ‘anatomy of wishes to die statements’ that we propose in Chapter 6 depicts the complexity of meaning of wish to die statements: Such statements express not only an intention of what the person wishes for and particular types of motivations for the same, but they take on part of their meaning from the interaction in the social context.

In Chapter 7 we described how important it is to investigate patients’ wishes to die not only quantitatively, but also qualitatively. Quantitative research necessarily describes wishes based on a limited number of observable items. When asked for explanations, however, patients place their wishes in complex narrative accounts in which they associate moral values, experiences and understandings of themselves in relationships with reasons for action. While quantitative knowledge about wish to die statements is important to understand how often these wishes appear or which clinical factors are involved, an in-depth understanding of how patients experience their wish to die, what they wish for and why, undoubtedly requires an approach that makes the narrative experience central.

Through our hermeneutic approach, we found that, in order to gain a detailed understanding of the motivations underlying a wish to die, one needs to explore not only the reasons a person reports as causing his or her wish, but also the subjective meanings, accessible through larger personal narratives that reflect what is important in a patient’s life. When we asked participants for their subjective explanations of their wish to die, they responded not only by mentioning single events (i.e. pain, suffocation, anxiety, being dependent), but also explained their wish in the context of wider moral narratives, which we have called the ‘meanings of the wish to die’. In a wish to die, different intentions and motivations are based on different moral understandings and storylines that persons narrate about themselves; these can co-exist contemporaneously and are not always integrated into a coherent whole. As mentioned above, in Chapter 5 we demonstrate how people can even seemingly wish for contrasting things based on different moral narratives and sets of values, which are equally important to them and connected with their identity. Without detailed knowledge of these subjective meanings and the narrative structure of a wish to die, it is likely that one misses out what the patient actually is wishing for and why.

On a process level, our studies showed that hermeneutic empirical ethics research enables the exploration of the complex moral reasoning behind moral phenomena such as wishes to die statements and therefore gives a deeper insight into the moral world of decision-making at the end of life, than quantitative or less narrative-oriented qualitative research approaches. The focus on subjective moral meanings as they emerge in narratives of real moral agents gives insight into how people do their moral work in linking moral self-understandings, values, social commitments and reasons for action.

On a content level, our hermeneutic empirical ethics research has revealed that the ethical commitments inherent in wishes to die are essentially narratively structured and should be understood as such. As narratives about wishes to die contain and constitute self-conceptions, they also contain reasons for actions (Chapter 7). Patients not only report single reasons they hold as causal for their wish to die (as suggested largely by quantitative research), but they also explain their wish to die in a broader context of moral narratives that we call ‘meanings’. Providing good care for patients with a wish to die requires an in-depth exploration of meanings and associated narratives in which a particular patient has placed his or her a wish to die.

In conclusion, our studies on hermeneutic clinical ethics and hermeneutic empirical ethics showed that the exploration of subjective moral meaning is indispensable for understanding what is morally at stake for those concerned. The investigation of moral narratives helps to link particular moral claims to values, self-understandings and moral commitments relevant for a person confronted with a moral problem and makes particular ways of moral reasoning explicit. Additionally, the understanding of subjective meaning also illuminates diverse epistemic knowledge, and helps to surmount prejudice through a deepened understanding of the other person’s perspective. Detailed knowledge of moral meanings is therefore an imperative precondition for an ethical evaluation in a dialogical sense, as well as for finding solutions to ethical problems that relate to the self-understandings of real moral agents.

**Ethical evaluation through a dialogical process**

In the introduction, we showed that given its epistemic assumptions, hermeneutic bioethics opts for a dialogical and practical, rather than a monological and theory-driven model of bioethics. Dialogue is at the heart of hermeneutic ethical reasoning. Due to of the interpretive character of moral reasoning, including the need to acknowledge the epistemic differences between moral perceptions, one cannot rely on the monological judgment of a single bioethicist for the ethical evaluation of a moral conflict. By acknowledging the plurality of our moral understandings and knowing that we cannot rely on an ultimate foundation for ethical justification, hermeneutics sees normative assessment possible only by testing moral claims and assumptions by means of a shared and participative deliberative process. The concept of dialogical ethics implies a model of ethical evaluation which is based on the negotiation about moral dissent through deliberative practice. The resolution of a moral problem has to be elaborated and negotiated, rather than deduced from an ethical theory. If moral knowledge is essentially practical, embodied and, as such, not always immediately conscious (as was argued in the introduction and also in Chapter 2), the search for normative solutions in situations of moral dissent requires a shared process of investigation and interpretation of moral understandings, so to make various perspectives explicit and develop common points of view.

In the introduction, we explained that hermeneutics envisages ethical deliberation as a process in which understanding and moral learning is possible alongside normative evaluation of the ethical issues at stake. Gadamer emphasizes that the process of understanding contains three different moments of understanding, inter-
pretation and application (‘application’ means for ethics the application of moral norms to the concrete situation) (Gadamer 1960, p.392). Although these aspects are distinct in the dialogical process of understanding – so Gadamer – in each dialogue these moments are inherently present and directly linked. In the process of understanding of what is morally at stake for oneself and the other, one interprets the assertions of others in the light of one’s own moral commitments and the ethical issues at stake. In doing so, one continuously applies new understandings to practical moral questions. In this evaluative process – according to Gadamer – all three elements are necessarily enacted and combined.

For hermeneutic clinical ethics, this implies that critical normative evaluation during a clinical ethics support intervention is not a second step in a case-discussion (once the descriptive analysis is finished), but an inherent part of the process of understanding different moral positions present in the situation. In the process of understanding the moral claims of the other, one immediately applies the other’s moral propositions to the situation and tests them against the norms inherent to one’s own views on the issue at stake. This implies that normative evaluation is directly linked up with the process of understanding, as one cannot understand the other party without taking into account the relevance of what the other is saying for oneself and in relation to the issue at hand (Gadamer 1960). In Chapter 2, we explained that a dialogical approach strives to establish a participatory and dialogical process of evaluation and moral learning among the persons involved in a case by taking its starting point from the enacted moral norms inherent in the participants’ argumentation. We explained this by referring to a hypothetical case example, but the reflections presented in Chapters 2 and 3 are based on our practical experience in hermeneutic clinical ethics. What we present here as the ‘lessons learnt’ is based on our practical experience in cases similar to this hypothetical case.

In Chapter 2 we described how a dialogical process of ethical evaluation works in the clinical context. In hermeneutic clinical ethics, dialogue is initiated by inviting the participants to open up to differing moral interpretations of the ethical problem. As hermeneutics holds moral understandings to be situated and structured by interpersonal interaction, it assumes that an ethical problem cannot be treated separately from its performative context. In clinical ethics, this implies creating inclusive deliberative processes that bring together all the parties concerned in a dialogical process on the moral issue and reflecting on the often subtle interactions between subjective moral understandings and the relational and institutional context. The participants are invited to frame the moral problem and describe their moral perspective on it. Through an exploration of personal experiences, moral claims and values are made explicit. The clinical ethicist ensures that everyone is equally heard and is able to articulate him- or herself, which might not be equally easy for everyone. In a further step, the participants are encouraged to become aware of their own personal and professional values and moral understandings underlying the moral claims advanced, as well as explain and give reasons for them to the other participants. Participants are invited to ask for clarifications and give reasons for their moral ideas. Addressing moral emotions is important at this stage, as it helps reveal unexpressed moral expectations or values and could also contribute to overcoming misunderstandings or conflicts, for example, when patients or families feel, they have not been respected by health professionals. This was the case of Mr. Carnegie in Chapter 4. A similar situation could arise where there are tensions between health care team due to differently perceived moral responsibilities (Molewijk et al. 2011). By considering opposing points of view and by gaining insight into other party’s interpretation of the situation, the participants become sensitized to other persons’ perspectives: This is essential if the group is going to work together towards a joint solution. By becoming aware of the diverse moral perspectives of the others, participants can become aware of the partiality or one-sidedness of their own interpretation and incorporate new views based on what they learnt from the others’ propositions. This in turn leads them to revise and refine their own moral ideas and sustain their own point of view with a richer and more reflective understanding. Hermeneutic clinical ethics support can therefore achieve important results by leading participants to review, alter and thus strengthen their own moral argumentation. The aim of hermeneutic clinical ethics is not to say which individual judgment is best, but to enable the participants to discuss together which values, responsibilities and norms are relevant or guiding in this case, and jointly find a consensus about a common course of action on which the involved can agree or – where a consensus is finally not possible – better understand each other’s position and why they disagree (Verkerk and Lindemann 2009, p. 243).

In this evaluative process, broader normative ideals and principles play an important role since they provide the socio-cultural ethical frame in which the issue at stake and the participants as moral actors are situated. In fact, within their moral argumentation, participants (implicitly or explicitly) refer to broader moral norms or principles inherent in their personal, social or professional practices (see Chapter 2). As described in Chapter 2, the participants are sustained by the ethicist to reflect and apply these moral norms to the situation, and discuss whether these are the morally best norms to be applied in this situation together with the other participants. Through the dialogue, it may become apparent that it is necessary to complement the norms inherent in the participants’ argumentation with other, also wider social or institutional norms or principles they have not yet taken into consideration, but which are relevant in the given situation. In this regard, the role of the ethicist is also a critical one as she or he has to stimulate the group to take into account ignored social principles that are relevant and illuminative for the participants or the institutional or practical setting in this particular context. Respecting the social situatedness of the ethical problem at stake, it may become evident that social or institutional norms have a prescriptive force in this particular moral situation, even overriding local moral understandings. By helping the group to make these norms explicit, the ethicist fosters awareness of social or institutional perspectives. However, in the dialogue, these wider social norms should effectively be connected to personal moral understandings and situations. Participants
need to understand them as personally meaningful in order to be convinced as moral actors to effectively apply them.

We have learned from the studies in hermeneutic clinical ethics that a dialogical approach is epistemically more justifiable than a monological approach, as it establishes truly inclusive, participative, more democratic processes of ethical evaluation in establishing what is right through the dialogical testing of different moral claims. The aim of a hermeneutical approach to clinical ethics support is to strengthen the participants so that they are able to work out a shared response to an ethical problem and to be aware of the consequences of resulting moral choices (Metselaar et al. 2014). This process definitely goes beyond a simple cognitive understanding of the other person's moral experience; it is a critical, deliberative and reflective process in which the participants’ moral claims are ethically evaluated through dialogue. Through this dialectical process of back and forward between gaining insight into the moral words of others and testing various knowledge claims, exploring moral perceptions and giving reasons, participants are enabled to reflect critically on their moral views and come through this to an ethical evaluation.

In hermeneutic empirical bioethics, dialogue plays an equally important role, although different research approaches and aims lead to different forms of dialogue and deliberative evaluation in hermeneutic research projects. A dialogical approach in empirical research is guided by the idea to avoid scientific overly narrow or even biased analysis, which could be too remote from real moral experience or may fail to catch the experience of what is actually at stake for real moral agents. It is assumed that through a dialogical investigation of the experience of real moral agents the quality of knowledge will be improved, and that those concerned with a moral problem might be served better through such research results (Abma 2005). Dialogical here means a research approach that elaborates research results through deliberative and inclusive practices. Consequently, some hermeneutic approaches emphasize participative-participation in the research process. Hermeneutic empirical bioethics rejects the positivist idea that research is able to objectively describe the ‘true reality out there’ or ‘mirror reality’ as it is (Charmaz 2006, p. 13; Alvesson and Sköldberg 2008, p. 5). It rather assumes that research is guided by the idea to avoid scientific overly narrow or even biased analysis, which could be too remote from real moral experience or may fail to catch the experience of what is actually at stake for real moral agents. It is assumed that through a dialogical investigation of the experience of real moral agents the quality of knowledge will be improved, and that those concerned with a moral problem might be served better through such research results (Abma 2005). Dialogical here means a research approach that elaborates research results through deliberative and inclusive practices. Consequently, some hermeneutic approaches emphasize participative-participation in the research process. Hermeneutic empirical bioethics rejects the positivist idea that research is able to objectively describe the ‘true reality out there’ or ‘mirror reality’ as it is (Charmaz 2006, p. 13; Alvesson and Sköldberg 2008, p. 5). It rather assumes that scientific observations are always outcomes of acts of interpretation. This fact alone does not make research results less true or precise, given that everything we understand is mediated by language and interpretation, but it highlights the need to be attentive and transparent about how the interpretation, and hence the research results are arrived at through scientific processes.

Hermeneutic empirical ethics offers different methodological possibilities of dialogically elaborating ethical evaluations in interaction with research participants. Some authors adopt a classical understanding of hermeneutics in empirical research, interpreting qualitative interview transcripts as texts (Bolmsjö and Hermerén 2003; Mak and Elwyn 2005; Tranvag et al. 2014; Vatne and Nåden 2014). Accordingly, the dialogical part is more concerned with interaction during the qualitative interview and a classical hermeneutic dialogue in a Gadamerian sense of text interpretation of transcripts. Other hermeneutic bioethical research projects have the aim to directly foster moral reflection and change in the practice of the participants (action research) or elaborate new ethically-normative procedures together with the participants (Widdershoven and van der Scheer 2008; Molewijk et al. 2008; Widdershoven et al. 2009). Our investigation on wishes to die served a more descriptive ethical aim in that we investigated the understanding of what palliative patients mean when expressing a wish to die, and assumed that this knowledge and its ethical consequences could help to improve the care provided to these patients. However, regardless of whether research aims for more ethically descriptive or more normative-interventional results, hermeneutic approaches sustain that this is best done through a dialogical process in which the research participants are perceived as active partners from whom one can learn. They make a substantial contribution to the research process, rather than being considered subjects under observation to be analyzed according to pre-established scientific parameters.

Dialogue in our research project was restricted by the research setting and the particularly sensitive topic we investigated. On average, we interviewed participants 23.5 days before death. Many patients we interviewed were lying in bed and talking to us was often tiring for them and possible only for a short period of time (see case study Chapter 8). Participant participation in research as used in other projects (i.e. respondent validation, participation in analysis process, focus groups etc.) was therefore not possible, but neither was it ethically desirable in this setting. We did follow-up interviews and interviews with family members and responsible health care givers to obtain through this data triangulation a richer interpretation of patient’s statements and to reduce the interpretive margin of these complex patients’ reports.

However, the semi-structured qualitative interviews focusing on subjective experiences were already dialogical. During these interviews, the interviewee and the interviewer collaborated to make the moral understandings and experiences of the interviewee explicit. From a hermeneutic perspective, this requires more interaction and collaboration than can be found in a more traditional research intervention that seeks to establish objectively identifiable assertions of the research subject and gives the interviewer a more detached and passive role (Holloway and Jefferson 2000, p. 29). In our research project, we assumed in a hermeneutical sense, that what persons told us during the interviews – in other words what we collected as ‘data’ – was the result of a practical engagement between the interviewer and the interviewee and that the meaning of what was said, was not simply revealed by the interviewee to us, but was a result of the interaction and constellation of the two interview-partners (Charmaz 2006). To this extent, we went beyond what Smith and colleagues refer to as the “double hermeneutic situation” of the interview, in that the “researcher is trying to make sense of the participants trying to make sense of what is happening to them” (2009, p. 3). Instead, we assumed that meaning making was not happening only in the first person (in the interpretation of the research subject) and/or in the third person (in the researchers’
observation and analysis), but in the second person (through collaboration in the joint search for understanding the meaning of the interviewee’s experience and thoughts in the research pair, but also through reciprocal expectations in understanding; Bohnmann 2000). We therefore assumed that our ‘data’ was co-constructed by how the interview partners related to each other, by how they interacted through questions and answers, by the issues they raised or did not raise, how the questions were understood, through the attention, expectations or fore-understandings both brought to the interview, but also through non-verbal communication or the way it was dealt with moments of silence.

In our study, this assumption had several methodological consequences, which we could not describe at length in our publications. First, it influenced how we conducted the interviews: for example, we were aware of the way questions were asked, what the interviewee assumed was expected of him or her, how well both (the interviewer and the interviewee) managed to construct a relationship in short time, whether empathy or enough distance was displayed/maintained at the right moments, or how carefully the story of the patients was followed by the interviewer. All this influences how and what was narratively revealed. During the interview process no question is considered neutral, as it is always “contextual and negotiated” (Charmaz 2014, p. 71). We also often adopted a more affirmative or personal interview style (different from a more distanced style often usually used in interviewing) to accommodate interviewees and give reassurance through emotionally difficult narratives. While we tried to interrupt the interviewee’s accounts as little as possible, we interacted more with personal questions and comments, affirming our empathy or understanding of what the interviewee told us, when the content was especially emotionally upsetting to the interviewee (i.e. “I can see that this is difficult to you”). In these moments, the dialogue often took on a more personal character in which the interviewer as a person became ‘visible’ to the interviewee.

The degree to which one is able to create a personal, protected atmosphere, in which interviewees trust that they can share their intimate thoughts, depends on how well both parties collaborate in the research setting and influence what is said during the interview. Charmaz (2006, p. 72) points out that especially patients with a prolonged history of severe illness often receive negative reactions by others when trying to talk about their painful, frightening or morally tabooed thoughts. These interviewees are often highly sensitized to the reactions of others and continually observe how the other reacts to what they say and whether they are capable to bear painful stories. If dialogue partners verbally confirm that they are able to bear the story of the patient, but show slight negative emotional reactions through body language (i.e. a rigid facial expression or twitch), patients conclude that their story might be too burdensome for the other and stop talking or trivialize their experience. In the interview, non-verbal communication is therefore decisive. We were aware that our attitude and body language significantly influenced what was said and that the affirmation of openness, but also of familiarity with these reflections could either facilitate or hinder participants in sharing their experiences. As matters of illness, dying and mourning are deeply human universal themes, (negative) emotional reactions on the part of the interviewers are not totally avoidable. This is especially true in cases where the interviewee’s account resonates or contrasts with the fore-understandings the interviewer brings to the setting. Interviewers (as each of us) have some ideas of a ‘good death’ in mind or have perhaps had negative experiences or fears connected with dying. These fore-understandings consciously or unconsciously influence how and what is asked or, more frequently, not asked during interviews. Hollway and Jefferson record that in emotionally difficult interviews both parties are often “defended” (not only the research subject, but also the researcher), meaning that “both will be subject to projections and introjections of ideas and feelings coming from the other person” (2000, p. 42), and both might attempt to avoid addressing painful memories or thoughts. Hollway and Jefferson highlight the importance of a responsible research approach to take the “defended subject” and the “defended researchers” as part of the setting influencing data generation and analysis. Due to of the limits of one’s own subconscious introspection, it would be naive to assume that these reactions could all be prospectively managed during an interview. Yet they become visible in the analysis of the transcripts, for instance in passages where the interviewer does not follow the interviewees’ story or when the interviewer introduces new questions, whereas what the interviewee said required further exploration. In our analysis, we always included a reflection of the emotions of the interviewers on the basis of oral reports and their field-notes. Being aware that research results are also co-constructed in this sense, enables to develop a more responsible approach to knowledge generation (Walker 2009).

To avoid monological interpretation of transcripts, we intentionally organized the process of analysis in a dialogical way between multi-professional researchers in our research group using a three-tier analysis: After independent coding and interpretation by three researchers with different professional backgrounds (Kathrin Ohnsorge, philosophy/bioethics; Christoph Rehm-Sutter, philosophy/bioethics/biology; Heike Gudat, palliative care physician), for each interview we compared and discussed our different readings and interpretations. In a third phase, we then presented these interpretations at research group meetings and discussed them again critically with the entire team of interviewers who also came from different professional backgrounds (pastoral care, palliative care nurse, palliative care art therapist) (Chapter 5). We saw the differences in interpretation, we frequently encountered due to our different professional backgrounds and subjective fore-understandings, not only as hindering but also as productive points from which to deepen our discussion. In these cases, we discussed going back and forward between the data and our interpretations – with a constant comparative method (Charmaz 2006) - until we achieved a deeper, often totally new understanding and reached through this (in most cases) an interpretation, we could share, at least with regard to the main features of a case (for an example of how we resolved these, see paragraph on moral learning). The process of data analysis is in a hermeneutical sense not seen as a purely theoretical process in which data is analyzed.
in front of existing theoretical literature, but as a practical interpretive and dialogical engagement of the researchers with the data, which involves not only the theoretical knowledge, but also the experiential moral knowledge of the researchers. The personal and theoretical pre-understandings a researcher brings to the interview should – from a hermeneutic perspective – be revealed as best as possible during the analysis, but are not necessarily seen as a hindering aspect, but rather can be – if critically reflected upon – a constitutive resource that contributes to and enhances the richness and quality of research results. Reflection on the researchers’ emotional responses (i.e. fear, sadness, confusion, surprise or sympathy) might for example be used to “enhance their understanding of what is initially beyond words” (Hollway and Jefferson 2000, p. 166). However, all interpretations must always be empirically grounded and based on evidence substantiated by data.

Hermeneutic bioethical research is based on the epistemological assumption that all research outcomes, even those with a low level of abstraction, are the result of acts of interpretation. For reasons of transparency, this should be underscored in publications. In our research project, we have tried to emphasize that our results do not describe wishes to die ‘as they are’, but reflect an interpretive process that started together with the participants during the interview and ended during the multiple case discussions and analysis sessions in the research-team. In Chapter 6, for example, it was important for us to clarify that the list of intentions and the model of the ‘anatomy of a wish to die’ do not represent the patients’ exact wish to die, but classifications or “ideal types”. And that what patients, families and health professionals told us about their experiences was much richer and more nuanced than could have been represented by these idealized schemes. This is important when using these results, as often too easily practitioners take models as taken-for-granted analytic tools in which to fit moral experiences, rather than using such tools to enrich personal skills to listen to and understand the complexity of human experience.

A reflection on our empirical study revealed that interviews are truly dialogical and that data generation is the result of a co-production through the interaction between interviewer and interviewee. A dialogical approach to data analysis helps to have multi-perspectival, more reflexive process of interpretation. Awareness of these conditions and adopting an open dialogical approach contributes to responsible knowledge generation and makes data generation more transparent during interviews, as well as for the process of data analysis.

In conclusion, our studies have illustrated how a dialogical approach to ethical evaluation in clinical ethics and to data generation and analysis in empirical ethics can be carried out in practice. In both bioethical settings, a dialogical approach furthers collaborative evaluation, richness and reflexivity of arguments and more responsible ethical justification procedures and knowledge. In clinical ethics, a hermeneutic dialogue establishes a democratic process of mutual ethical evaluation through a joint exploration of local moral perceptions, through giving reason and explaining moral understandings and testing of each others’ arguments and moral claims. In herme-
entiated approach and that ‘respecting patients’ autonomy’ does not mean ‘leaving it up to the patient to decide’, but implies assisting patients, where appropriate, to reflect on their wishes. Hence, they could come to a new understanding of the patient’s needs in this situation and articulate a new basis for communication.

Our studies have illustrated that in hermeneutic clinical ethics moral learning through dialogue enables the participants to gain insight into alternative moral experiences and types of reasoning, respect the differences, understand these differences, and revise and refine their moral arguments. As such, moral learning in hermeneutic clinical ethics enables a fresh and better understanding of each other, as well as a more fruitful communication and collaboration process in the clinical setting.

In hermeneutic empirical bioethics, learning from the case material is an inherent part of the research process. Hermeneutic empirical bioethics takes empirical data not simply as illustrative material for ethical reflection, but sees it as a meaningful text, which one can learn from and engage with in a reflective process. From a hermeneutic perspective, learning during the research process entails a cyclical process of knowledge-generation, a hermeneutic circle, which has its starting point in the (scientific) fore-understandings of the researcher (Rehmann-Sutter et al. 2012, p. 443). The theoretical knowledge and practical problems underlying the research question serve as background knowledge for data interpretation; the analysis of the empirical material leads to new unexpected, reflective insights and a revision of the original background knowledge or hypothesis. These new insights can thus inform theory construction. A revised theoretical reading of the data can in turn lead to a refreshed interpretation of the material stimulating new insights or new conclusions for practice or policies (Alvesson and Skoldberg 2008, Smith et al. 2009). In this cyclical process, both theoretical thinking and modes of practice will ideally be altered (McMillan and Hope 2008; Widdershoven and van der Scheer 2008). Since this process leads to a transformed interpretation of the issue of research and its theoretical framework, the research process is also transformative for the researcher him- or herself. In ethical empirical research this process is enlarged as this leads not only to knowledge generation through the interpretation of data in light of theoretical knowledge, but also to normative conclusions as results of an interpretation of norms and practice values in confrontation with the complexity of empirical insights.

An example from the process of our data analysis may illustrate how theoretical pre-understandings, empirical data and a dialogical approach cyclically bring about a learning process, as well as new theoretical insights that are normatively relevant. The example of our interpretive process on the theme of “ambivalence” is reported in Chapter 5. In this chapter, we presented the stories of two women who generated confusion in the health care team by both making wish to die statements and also confirming, directly or indirectly, their wish to live. While reading through the transcripts, some members in the research team interpreted them according to the perception of the health care team, as demonstrating that the two women were (consciously or unconsciously) ‘double bookkeeping’, by not being totally clear or honest with themselves or others about their wish to die. Others were uncomfortable with this conceptualization of what the patients were experiencing. Discussing our interpretations then led to a closer look on how patients actually do their moral work around their wish to die. Turning back to the transcripts, we discovered that in their narratives opposing or dichotomous values and wishes regarding living and dying appeared. Based on these insights, we then looked to the philosophical and psychological literature on ‘ambivalence’. Using conceptual frameworks in literature (especially in Merleau-Ponty), we were able to find new meaning in the narratives. Looking more closely to how people deal with seemingly opposing moral values in their lifes, the notion of ‘ambivalence’ made us realize that ambivalent pondering is a normal part of daily decision-making and that seemingly opposing wishes might be well sustained by different values in a persons life which both are equally important for this persons’ sense of identity. In following the narratives about their values and normative ideas, we were able to understand that both women were not necessarily presenting two opposing or contradictory wishes. This led us to the theoretical insight, that they rather presented different story lines, not necessarily dialectically related to each other, each with its own moral meaning and its own normative implications and claims. In the logic of the patient these storylines co-existed even when being seemingly contradictory. Interpreting already existing moral norms in health care (i.e. respect for persons, respect for diversity in moral understandings) with regard to this data, led then to the normative conclusion that in caring for patients with a wish to die, it is ethically important not to negatively label or pathologize apparent inconsistencies of patients’ statements, but rather to reflect on the complexity of narratives patients express while trying to find words for their “multiple moral understandings in an authentic way” (Chapter 5).

From our study, we have learnt that hermeneutic empirical ethics comes about in cyclical exchange between data analysis, theoretical or ethical interpretation, and theoretical and practical background knowledge. Moral learning is an inherent part of the research process. A learning process in empirical research alters both, theoretical knowledge and moral practice, and is transformative for the researchers themselves. Normative conclusions of empirical research, as the ones on ambivalence mentioned above, are brought about by using empirical data to critically examine theoretical claims (i.e. psychological theories on ambivalence), and by reflecting on the norms and moral values found in the empirical material with the aim to come to better practices. From a hermeneutic point, both empirical data as well as ethical norms, are interpretive, that is they are the outcome of interpretive processes and need to be interpreted. In empirical research as in practical ethical questions in concrete cases, they have to be linked through practical ethical judgement.

What is the role of empirical data for the normative conclusions? Empirical data shows the complexity of ethical challenges in real life, the norms and values that are operative in people’s moral understandings. It points out moral lacunas in practices
In a hermeneutic sense, ethical theory can thus help to make bioethical argumentation richer, more detailed and more stringent, but it is not a canon that can be applied to moral practice to deduce what is ethically right in an objective sense. Clinical ethics also has the subtler task of uncovering and dealing with power or knowledge differentials between participants who could distort descriptions and interpretations and impede an atmosphere of trust and a true ethical evaluation (Chapters 3 and 4). Other contextual factors, such as institutional aspects, the place or the number of people involved, might influence the process and also need to be taken into account.

Contrary to the approach of the ‘ethics expert’, who is entitled to make the right moral judgment on the basis of his specialized expertise – an idea often presented in clinical ethics debate – we argued in Chapter 3 that the capacity for moral judgment belongs to human persons qua participants in moral communities: we expect everybody who desires to belong to a moral community to be able to account for his or her actions. If ethics is understood “not as an abstract body of knowledge but as a practice of justifying moral action, then in the matter of ethics nobody is ‘naturally more competent than someone else, but may at most be gradually more enlightened and as such in a better position to find a standpoint and determine it critically’” (Pieper 1994, p.15, see chapter 3).
Our investigations in hermeneutic clinical ethics clearly demonstrate that the hermeneutical ethicist is not merely a mediator, nor an ethics ‘expert’ who provides clients with prescriptive normative solutions; a hermeneutical ethicist’s purpose is to foster and sustain the dialogical process. To be able to sustain the participants in a maieutic way, the bioethicist needs particular hermeneutical-deliberative skills, as well as practical and theoretical ethical knowledge. During the ethics support intervention, the bioethicist refers to ethical theory as a tool for systematizing the ethical analysis, as well as for making ethical argumentation more coherent.

The role of the ethicist in hermeneutical empirical bioethics requires hermeneutical-dialogical as well as more theoretical ethical skills. Hermeneutics acknowledges that the researcher plays an influential role in the research process, both in data, and during the process of data analysis. As described in the section on dialogue (above), the preconceptions and fore-understandings of the researcher influence the data generation and analysis. Hermeneutics therefore emphasizes that empirical research requires methodological steps to strengthen transparency and self-reflexivity during the research process. As described in the section on dialogue above, the hermeneutical-dialogical tasks of the interviewee are manifold. Interviewees need to create an atmosphere in which the interview partner can open up, initially raise a few questions so that the interviewee can develop his own thoughts and story, and also ask more probing questions to deepen his understanding and induce the interviewee to elaborate further, especially on their moral understanding and experiences. In interviews on such emotionally difficult topics as ours, the interviewer also has responsibility of ensuring the interview situation does not become too challenging or burdensome to the interview partner. In these situations, it is ethically important to “give the participant’s comfort level higher priority than obtaining juicy data” (Charmaz 2006, p. 66).

In the process of data analysis, hermeneutic skills regard the interpretation of the material in a constant comparative method (Charmaz 2006), elaborating emerging themes in participants’ accounts, but also reflecting critically about the research process, the co-construction of data and analysis, the participation and affectedness of the researcher and deliberative skills in the dialogical evaluation conducted by the research team. What a particular researcher contributes to the research setting in the form of preconceptions, moral understandings, experiences, but also his theoretical knowledge and philosophical convictions, influences the interpretation and the results themselves. Again, hermeneutics does not consider this to be a limitation, as there is in fact no “view from nowhere” from which one could start doing research. There is simply no alternative than to start reflection with and through one’s particular local way of thinking. But researchers need to be as honest and reflexive as possible about their local knowledge and fore-understandings and do their utmost to avoid their preconceptions leading to a distorted or too parochial interpretation of data. A hermeneutical approach therefore requires a continuous critical reflection of ones’ own assumptions for strengthening transparency and self-reflexivity during the research process (for examples on how we did this in the research project, see above under dialogue and moral learning).

Although the methods commonly used in qualitative research (for us Interpretive Phenomenological Analysis and Grounded Theory) are inductive, in hermeneutical empirical ethics theoretical knowledge plays a role in all stages of research. First, theory helps in framing the ethical research question by referring to the scientific discussion and currently existing knowledge gaps. Second, it offers the epistemological and theoretical background knowledge needed for setting up the research methodologically. Third, data generation and data analysis are influenced and enriched by the particular (practical and theoretical) fore-knowledge of the researchers. During interviewing, the researcher will react to the interviewee and ask further questions, based on his practical and theoretical background knowledge. As the elaboration of the research results happens through an interpretive process, the fore-knowledge, as well as the theoretical knowledge, of the researcher influences what is recognized in the data and how data is interpreted in a decisive way. Fourth, the analysis usually leads to new reflective insights, which can then inform theory construction; at a later phase, a revised theoretical knowledge can allow for new insights in data analysis or lead to practical conclusions in relation to a second interpretive process. As mentioned above, the relation between (ethical) theory and empirical data is thus a cyclical movement in which both parties are altered (McMillan and Hope 2008; Widdershoven and van der Scheer 2008).

On the basis of our empirical study we have learned that the ethics researcher needs specific hermeneutical-dialogical and more theoretical ethical skills. Hermeneutics acknowledges that the researcher has an influential role during the entire research process. As the researchers’ preconceptions, fore-understandings and performance are co-constructive during the interview, and analysis, hermeneutical empirical research requires methodological steps for strengthening transparency and self-reflexivity during the research process.

In conclusion, our studies have demonstrated that hermeneutical bioethics in practice requires ethicist to take an active and participatory role in the process of joint deliberation by sustaining dialogical evaluation and moral learning, while reflecting critically on their fore-understandings and preconceptions they refer to in their performance.

Three points of critique and a preliminary response

Hermeneutical bioethics has been subject to various questions and criticisms. In this chapter, I will touch upon three arguments frequently raised against hermeneutical bioethics: 1) the alleged tendency towards relativism; 2) the suggestion that hermeneutical bioethics remains on a descriptive level of interpretation; and 3) the limits to the level of understanding and agreement that can be achieved through dialogue.
The problem of relativism

The criticism that hermeneutics opens the door to moral relativism entails several different arguments. These regard not only hermeneutic bioethics, but also other types of ethical approaches that – as explained in the introduction – can be called ‘interpretive’ in a broader sense (as coherentism or some forms of feminist ethics, narrative or phenomenological ethics etc.) (see Bernstein 1983). Dunn and colleagues argue against hermeneutic bioethics (2012, p. 478): ‘If prescriptive conclusions are drawn from dialectical-interpretive exchanges or other facts about individuals’ moral experiences, then such conclusions will be relative to the dialectical, narrative or interpretative form of the research account’. Here, I will address some concerns about relativism that seem most relevant for the practice of hermeneutic bioethics.

From the chapters in this book, it should have become sufficiently clear that hermeneutic bioethics is not prone to a relativism in a sense of ‘anything goes’. From a hermeneutic perspective, it does neither follow that all ethical judgments are equally valid in a given situation of moral concern, nor that normative claims are only justifiable within their individual context of moral meaning or that of cultural peers. Throughout the chapters of this thesis, we have demonstrated that hermeneutics is dedicated to a strict process of critical validation of normative claims in the context of experienced social practices in clinical ethics and bioethical research alike. Hermeneutic evaluation therefore relies on anything but arbitrary judgments, as it elaborates a thorough critical process of ethical evaluation.

Hermeneutic ethics assumes that the way in which the dialogue occurs, which norms are considered to be relevant or not in a given situation and effectively discussed, depend partly on the persons participating in the dialogue. In this sense, hermeneutics assumes that the dialogue and its outcomes are in fact to a certain extent ‘relative’, as the participants in the dialogue bring in their situated understandings. Yet, hermeneutics also assumes that situations are not closed, but part of larger traditions, moral understandings or social practices. Hermeneutics focuses on learning processes which result from the critical confrontation between different, even initially opposing moral understandings and knowledge claims, each of which referring to wider social moral understandings and norms. It is precisely this critical confrontation between different interpretations and moral understandings, which brings about an ethically-reasoned revision and reevaluation of moral claims, norms, convictions, values and attributions of responsibility. In this context, argumentation is by no means self-referential (as Dunn and colleagues assume), but in its reflective process draws on widely inclusive social norms and normative practices relevant to the situation at stake.

In this dialogical move of testing and balancing perspectives against each other, some arguments are recognized by the dialogue partners as ethically more sound, convincing or relevant than others regarding the situation of moral concern. In the dialogical process, one does not simply accept or take over the convictions of others, but a serious ethical evaluation entails from a hermeneutic point of view always a revision of ones’ moral ideas through learning from the others’ views while being persuaded by ‘good reasons’. Reasons are ‘good’, if they are not only coherent, but also meaningful to the participants, enabling them to learn and eventually revise their moral views. Albrecht Wellmer (2004) explains that agreement in dialogue comes about, when something is accepted as true, because I recognize what the other says is true for me and together we can come to an agreement about truth. Because I recognize as ‘true’ what I hold as justified myself, I will only recognize an other persons’ assertions as ‘true’ and therefore be persuaded by them, if they make sense to me: “that what makes sense as a persuasive reason to me is precisely for that reason a persuasive reason for me. I cannot place myself outside of my convictions, reasons, and evidences; if I doubt, that only means that I do not feel myself persuaded by the reasons available to me, that they are for me (still) not persuasive reasons.” (Wellmer 2004, p. 102).

The moral truth that emerges in such an inquiry and on which ethical justification relies, is neither the objective representation of the third person observer, nor the subjective truth of a first person speaker, but is truth “in the second person”, as generated through the (also moral) commitment for a communal understanding through mutual perspective taking within inter-subjective justificatory practices (Bohmann 2002, Bernstein 2010, p. 109). As Wellmer affirms, truth in this sense is “transsubjective”, in that it is based on an agreement in which “precisely all those taking part are similarly persuaded by good reasons”, while what ‘good reasons’ are is not based on abstract a priori criteria, but “is attached, in an irreducible way to the perspective of the one ‘persuaded’ by good reasons” (Wellmer 2004, pp. 102). ‘Truth’, then, does not refer to an external fact that can be perceived through correct representations of ‘how things are out there’ (correspondence theory of truth), but can only be elaborated through a joint effort by dialogically testing each others’ assertions:

“For the concept of a ‘good reason’ is attached, in an irreducible way, to the perspective of the one persuaded by good reasons. One cannot describe from a metaperspective which ‘qualities’ reasons must have in order to be really good reasons. To call reasons ‘good’ is not the ascription of an ‘objective’ quality, rather it is the adoption of an attitude with normative consequences. These reasons compel me to accept that p is true” (Wellmer 2004, p. 102-3, italics by the original author).

For the work of clinical ethics support, to understand agreement as an “attitude with normative consequences” requires participants to accept that they cannot simply agree to the moral proposition of the other or simply take over the other person’s point of view. Only if they are truly convinced (see Chapter 2) can they agree. In empirical ethics, this means that the dialogue during the interview, as well as the interpretation in data analysis, should continue until new insights are clear enough to bring about a coherent interpretation and a genuinely new insight to the issue at stake.

From the perspective of dialogical ethical evaluation, in dialogical agreement truth is “transsubjective” and radicated within intersubjective justificatory practices (Wellmer 2004, p. 102; also Walker 2007). The classical ethical fear of relativism, which entails that without a stable and secure fixed point super-partes, ethical judgment must necessarily lead to arbitrariness of judgment – an assumption which Richard Bernstein...
(1983) has called the “cartesian anxiety” of ethics – turns out to be itself delusive, in that it suggests the need for an absolute foundation. From a hermeneutic epistemology, monologic-foundational approaches are not only as situation-bound or ‘relative’ as interpretive ethical approaches, but they are also unaware of the eventual ethnocentric bias of their ethical thought and base their judgment on non-transparent evaluation procedures. Wellmer therefore calls the old antagonistic fear, that “the only alternative to ‘truth-absolutism (…) is a relativistic-historistic dissolution of the concept of truth”, an “optical illusion” (2004, p. 108), because it is grounded in the epistemological assumption of the necessity of having an ultimate justificatory ground in the absence of other more dialogical and transsubjective concepts of truth.

Descriptive versus normative ethics

Closely related to the critique of relativism is the question of whether hermeneutic bioethics achieves a normative or prescriptive level at all, given that it focuses on making explicit and interpreting moral understandings. This question is raised not only by critics outside hermeneutic ethics (Dunn et al. 2012), but also from within its ranks (Lesch 2002). Accordingly, hermeneutics is labeled – unjustified as will be shown – as a “weak normative approach” (Lesch 2002, p.231).

With regard to clinical ethics, this criticism essentially is related to whether hermeneutic ethics truly arrives at prescriptive conclusions that can guide moral action in clinical practice. Behind this question lies a view of ethical justification as a two-step process, which entails first descriptively analyzing the moral problem at stake, and second, well distinct, making a normative-ethical analysis leading to an ethical justification of what should be done. The studies carried out within the framework of this thesis demonstrate that hermeneutics envisages ethical evaluation as a more complex process in which the understanding of each others’ moral claims, their ethical interpretation and application, are intermingled. Throughout this thesis, we have argued that the process of understanding is inherently normative, while at the same time critical, and that ethical evaluation occurs along the way of this critical normative effort of striving to better understand and test each other’s arguments (Gadamer 1960; Fairfield 2002; Widdershoven and Molewijk 2010). Hermeneutic dialogue is a critical, deliberative and reflective process that aims to bring about insight into the moral appropriateness of moral claims, values and responsibilities at stake. Through this dialectical process of going back and forwards between gaining insight into the moral words of others and testing various knowledge claims, exploring moral perceptions and giving reasons, participants reflect critically on their moral views and develop a new and richer understanding of the situation. Hermeneutic clinical ethics does not merely prepare the ground for ‘strong normative ethics’. Although it does not aim to prescribe ‘definitely right’ ethical solutions, it certainly does foster a reflective process in which participants critically examine moral arguments and indeed develop shared normative judgments. Hermeneutic dialogue is not a descriptive-ethical, but a normative-ethical activity.

With regard to hermeneutic bioethical research, it is generally assumed that the interaction between data analysis and normative reflection should be reciprocally illuminative and that analysis needs to arrive at normative conclusions (and not only ethically descriptive ones) in order to count as an empirical ethics study. MacMillan and Hope (2008), for example, emphasize that empirical ethics research should arrive at normative conclusions to be counted as empirical ‘ethics’ and not sociological research. Our research clearly had a descriptive aim, but also led to normative conclusions: One normative conclusion was that, given the complexity and variety of meanings that a wish to die can have for the person who holds it and the often shifting and ambivalent ideas present in such a wish, it is an ethical imperative for professionals who care for a person with a wish to die not to take the wish at ‘face-value’, but to investigate its meaning for the person who holds it, the intention behind and how it comes about within the social context (see chapter 5 and 6).

As our study showed that the wish to die is highly influenced through social interactions, another normative conclusion from our study was that professionals who care for persons with a wish to die should critically reflect on their own ideas and be careful not to impose them inappropriately. This holds equally for those who are in favor of assisted dying and for those who are against it (chapter 8).

However, the main normative outcome of our study, consists of the practical-ethical implications of the insights in the complexity of the structure of a wish to die. As mentioned above, the aim of the project was not to determine under which conditions a wish to die is ethically justifiable or not, but to create insights and instruments (as the model of the anatomy of the wish do die described in chapter 8) that help those confronted with a wish to die to be able to decipher better what the patient is actually wishing for and why and to be able to care for someone with a wish to die in a more responsible way. The normative outcome of our research is therefore practical and applied, in the sense that more understanding of what these wishes might mean, enables health care workers to offer better care and better assistance to people with this wish at the end of life. For example, is it important for health care workers to recognize that wish to die statements frequently consist of seemingly contradictory wishes that are also fluctuating over time. If this is not recognized, patients may be labelled as ‘ambivalent’ or ‘inconsistent’ in decision-making, which is an obstacle to compassionate and good palliative care. Hence, if wishes to die are not recognized as potentially fluctuating, health care professionals might take the patients’ expressions of end-of-life wishes for granted or regard them as final decisions. Furthermore, knowledge about the richness and complexity of meanings encourages health professionals not only to investigate the causal reasons for a wish to die, but also to investigate the patients’ moral values and personal narratives.

Our research was not designed to directly bring about prescriptive results, but the study results entail significant practical-ethical consequences concerning good end-of-life care. Our conclusions thus have a specific kind of normative relevance or normative impact, which differs from the normative-prescriptive results, which are often,
regarded as the proper outcomes of empirical ethics studies (MacMillan and Hope 2008, Dunn et al. 2012). The outcomes of our study have normative strength, because they refer to the context of health care practice in which values of ‘good practice’ (i.e. respect for diversity in moral understandings, responsibility in care giving, best care according to best knowledge etc.) are already in place. They urge professionals to critically reconsider their practice, taking into account the complexities, which were elucidated. Against the backdrop of what is considered as good care practice, these results have a normative (and possibly even a prescriptive) impact as they require health professionals to enrich and structure their reflection, the way they deal with patients and the way they reconsider critically their own position and input into the communication and ethical evaluation of wish to die statements. This implies that our study is in fact a bioethical and not a sociological empirical study. It also implies that criteria for the definition of ‘empirical ethics’ need to be refined.

Our conclusions are different from prescriptive results of empirical ethics studies, which are formulated as general rules which explain like a ‘table of commandments in a catechism’ (Dewey 1985, p. 166; see chapter 2), what should be done and what not. Instead they offer a more openly ethical orientation for action enhancing and enriching interpretation and reflection. As claims, they are not absolute truths, but contributions to an ongoing debate on good care.

From a hermeneutic perspective, the distinction between descriptive and normative ethics can itself be questioned. For hermeneutics, understanding as implied in empirical research is never purely descriptive, as it is part of a moral relationship with the other; with the commitment in wanting to understand, one will feel invited to show respect, recognition and care; understanding is in that sense always practical, which includes moral commitments and normative claims of the dialogue partners. Moreover, descriptive research results concerning moral views and practices do not provide morally ‘neutral’ information. They have direct practical ethical implications for how one should behave in health care practices. Recognizing descriptive results, i.e. about different intentions behind wish to die statements, as important and practice-relevant, implies already the interpretation of these results within a particular moral reference system with its associated values and norms, for example the moral premise that responsible health care practitioners should investigate in detail what the palliative person wants when expressing a wish to die.

The limits of dialogue

A third objection against hermeneutic ethics regards the limits to the dialogical process and the agreement that can be found in it. The clinical conditions in which hermeneutic dialogue is practiced are rarely ideal. Agreement has to be found in the context of empirical uncertainty, administrative constraints and limited budgets. Hermeneutic dialogue in health care settings is exposed to strict time constraints of health care workers and has to deal with hierarchies, which at times can compromise the ideal of “unconstrained communication” (Habermas). In other words, if dialogue is to be organized in healthcare practice, certain conditions must be met. We need to be realistic about these limits and open for failure of hermeneutic dialogue. It might not be possible to accommodate all moral claims and there will be moments in which we will not be able to reach a consensus, or even a practical agreement. Nevertheless, hermeneutics assumes that dialogue is indispensable even in these situations in attempting to create space that establishes a common ground where we can at least address each other, find out more about our differences and avoid a breakdown in communication. Sometimes all that can be achieved in a hermeneutical process is to find a new basis for deliberation, by breaking down oppositions and creating space for renewed openness to listening to opposing arguments.

Next to practical limitations, theoretical concerns can be raised about the nature of dialogue and agreement. Postmodern thinkers rightly stress that through our social situatedness and embodiment, we are all epistemically differently located and reason morally from different viewpoints. From the perspective of difference, we may doubt whether or not it is possible to understand the other during dialogue and be concerned about whether hermeneutics overestresses the importance of understanding, might illicitly fade out differences in order to arrive at a common understanding. Related to this, it may be objected that after dialogical evaluation and testing, different positions may remain that might be equally ethically justifiable.

In answer to these objections, it may be stated that they are actually in line with hermeneutic thinking. In fact, a hermeneutic approach to ethics acknowledges that there is a limit to what we can understand from the other, but argues that this should not dampen our efforts to engage in work towards a better understanding, even if such attempts are always ‘work in progress’ or partial. Hermeneutics holds that understanding is possible, as we share in many cases enough practical knowledge and epistemic background conditions to actually be able to understand what the other person wants us to know, or even to elaborate together a shared agreement of how to proceed.

However, hermeneutics does not assume this ‘understanding’ to be total or final (Gadamer 1060). Heidegger emphasized that, as our reasoning is always mediated by the practical fore-structure of our understanding, we are never able to understand others, as they do from their own perspective. As was explained in the introduction, this condition of human reasoning is, according to hermeneutics, part of the finitude of human existence. ‘Responsible knowing’ in ethics (Lindemann et al. 2009) acknowledges the fact that human understanding is confined within these epistemic limits and that dialogue about our different moral understandings, while hopefully leading to better and refined moral judgments, will never result in an absolute and objective knowledge of the situation.

Hermeneutics, however, goes one step further in that it not only acknowledges difference as part of the human epistemic condition, but it also sees the epistemic difference that comes to light in ethical controversy, first and foremost as the precondition for dialogue and ethical evaluation: The interplay of giving and asking for reasons becomes possible in a precise manner, because of the differences between the interlocu-
tors and the questions that result from this towards the other; for hermeneutics the epistemic difference is the precondition and motor that makes us enter into dialogue, explore and question the other’s viewpoint, and reason for and explain one’s own perspective with the goal to find an agreement. What occurs when we truly make a hermeneutic attempt to understand and find an agreement then, is neither the assimilation of the others’ viewpoint as my own, nor the subsumption of my own perspective, but a new understanding and agreement on what remains from both ours viewpoints as convincing for us.

The strength of agreements found through a critically-reflexive and deliberative process of dialogue lies exactly in the fact that they contain not only reflections from a monological point of view, but are perceived as strong by the participants because everyone contributed to. They represent the outcome of a shared moral learning process in which viewpoint are refined and altered. Their strength lies in the fact that they represent, as described above, a reflection in the second person: a new elaboration of shared co-reflexions and co-operations through which the participants come to agree upon what should be done in this situation.

We should, however, acknowledge that when we reason from a concept of intersubjective truth as the result of multiple perspective taking, the ensuing agreement is valid ‘for the time being’. Wellmer asserts quite concisely: “But if it is correct that a transsubjective space of truth can only be constituted by way of an irreducible difference between the perspectives of different speakers, this also means that consensus and dissent are equiprimordial: just as every controversy about truth claims has its telos in an uncoerced consensus, so does every consensus carry in itself the seed of new disagreements. And this now means that truth, as encompassing various perspectives is essentially controversial. That truth is transsubjective means that truth is, at the same time, contested” (Wellmer 2004, p. 103).

New insights or arguments may appear that may pull the agreement newly into question and let the dialogue continue. This is not a weakness of dialogue, but a characteristic of transsubjective truth found through dialogue.

Recommendations for future research

The lessons learned give rise to recommendations for future investigations in hermeneutic bioethics, both in hermeneutic clinical ethics and in hermeneutic empirical ethics research. Below, I will formulate these in the form of open questions for the further development of hermeneutic bioethics.

Recommendations for hermeneutic clinical ethics

What is an agreement?

As was already said on a theoretical level, the questions how to determine the validity of ethical norms deserves further attention and philosophical reflection in future hermeneutic bioethics. The notion of ‘agreement’ should be investigated in greater detail. In clinical ethics, we need to ask the following questions: What happens when we agree with each other? When do facilitators and dialogue partners know that they actually understand ‘enough’ from each other to draw normative conclusions? Even though we usually assume that those who are required to act also need to be able to justify their moral choices and actions to themselves, in health care settings we are often confronted with situations that require shared ethical agreement on moral actions (e.g. when a team of health care professionals has to act coherently towards a patient or when there is doubt about the constancy of the patients’ decision-making capacity). If serious disagreement arises during the dialogue phase, but decisions have nonetheless to be taken, whose norms ought to be binding and who should or could have the responsibility for making such decisions?

The normative authority of the ethicist

Another question arising from the discussion in Chapter 4 is how normative a clinical ethicist should be during clinical ethic support. To what degree should an ethicist be ethically directive in deliberative processes? While hermeneutic clinical ethic support generally emphasizes an interactive, equal and more ‘decentralized’ model of deliberation among participants, experience of practising hermeneutic clinical ethic support (van der Dam et al. 2013) indicates that besides facilitating dialogical interactions there might also be a need for “top-down” supportive facilitation regarding the implementation and continuity of CES, even if this is not directive in content. Hermeneutic bioethics should reflect on the relationship between a possibly more authoritative attitude and the general task of facilitating a multiple-perspective-evaluation of the situation.

Integrating the perspective of those who have difficulties in expressing themselves

While the clinical cases we have presented include patients who were all able to speak for themselves, it is important not to overlook situations (indeed frequent in clinical settings) in which persons are not capable of explaining their moral point of view or contributing in a meaningful way representation of their position. This is especially important as the central hermeneutic notion of understanding seems to be essentially dependent on the ability to speak up for oneself and participate actively in dialogue. It is evident that this is often not possible in a clinical setting due to physiological, psychological, social and other aspects associated with the patient’s condition.

Hermeneutics affirms that those who, due to their physiological, psychological, social or other conditions, cannot actively take part in the dialogue, need to be either appropriately supported in expressing themselves or should be assured adequate representation of their moral understandings (i.e. through persons who are very familiar with their experience and values). Yet, it is difficult to say how this should be organized for people who are apparently able to participate, but for whom it is too difficult or too painful to talk about their experiences. The facilitator’s presence is useful in encouraging and sustaining the process of verbalization, since talking about moral perceptions
and understandings is often new to participants. But is articulation of one’s own experience always possible, especially in the clinical setting, for persons who go through all kinds of debilitating experiences, always possible? What if life is too “damaged” (Code 2002) to be talked about, if experience is too fractured or too chaotic to be packed into ‘meaningful’ or ‘understandable’ narratives (Frank 1995)? Future hermeneutic clinical ethics (as well as research) should focus on the implications of this for dialogical ethical evaluation and elaborate practical solutions, where possible, to integrate or at least attempt to respect experiences that cannot easily be integrated into a dialogical setting.

**Recommendations for hermeneutic empirical ethical research**

*Improving participant participation in empirical bioethics research*

Especially in palliative care settings, for practical reasons (because of the interviewee’s health status), it is often not possible to include patient-participants in a direct participatory way either into the development of the study (i.e. development of the research question and interview guide) or the data analysis phase. However, a more participatory approach can be achieved by establishing different ways of participants’ participation in palliative bioethical research, perhaps not with patients directly, but through focus groups with their relatives. Even though the epistemic problem remains that even for patients with advanced diseases but who consider themselves not in closeness to dying, wishes to die might be perceived and thought about differently, there might be ways to include palliative patients in advanced stages of illness or families of patients with a wish to die in different research settings.

*Methodologies for critical self-reflection among researchers*

As was described above, self-reflection of one’s own moral pre-understandings is essential for hermeneutic researchers. As our study shows, reflection is important both during the interview as and data interpretation. On a practical level, it is important for hermeneutics to develop theoretical implications of the researcher-involvement in the interview process, but equally in data analysis. Hollway and Jefferson state that research subjects might be “defended”, that is trying unconsciously to avoid talking about morally difficult issues; the same might hold for “defended researchers” (2000). While on a practical level, these reflections need to find methodological or reflective tools to rise awareness, more research is needed to investigate what happens in interviews when one or both, the interviewee and the interviewer are, ‘defended’ and what this means for the process of data interpretation and the results.

**General conclusion**

Hermeneutic bioethics is based on the central idea that a sound ethical evaluation of a situation entails a process of learning from alternative moral perspectives, normative ideas and sensibilities and critically examining those of ourselves and others in dialogue. Because we often start from different interpretive grounds, we need a dialogue with others to challenge and enrich our perspective and to come to see limitations of our own position of which we have not been aware. We can project our moral lives and widen and evaluate our moral arguments by investigating each other’s moral and epistemical positions and, in a collaborative process, negotiate and construct together what for the time being can count as the ethically best course of action. In times in which the acknowledgement of moral pluralism requires us to look for interpretative, dialogical and inter-subjective conceptualization of ethics, hermeneutical bioethics proposes a rich approach to clinical ethics and empirical ethics which is both practically relevant and philosophically grounded.
References


Discussion


