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bioetica@unisabana.edu.co
Universidad de La Sabana
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Dell'oro, Roberto
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Why Clinical Ethics? Experience, Discernment and the Anamnesis of Meaning at the Bedside

¿Por qué la ética clínica? La experiencia, el discernimiento y la anamnesis del significado al lado del paciente

Por que a ética clínica? A experiência, o discernimento e a anamnese do significado ao lado do paciente

Roberto Dell'Oro[1]

Abstract

The article asks about the function of clinical ethics. It does so by confronting the assumption that ethics is supposed to help in the solution of concrete problems, relying upon a defined set of principles and rules. The scientific character of such an approach to clinical ethics complements the very understanding of modern medicine as being increasingly scientific and technical; that is, as oriented toward the production of effects. The paper claims that, rather than sharing in the "suspension of meaning" pursued by medicine for the sake of scientific objectivity, the main task of clinical ethics consists of a retrieval, or "anamnesis," of the very questions medicine seems to suspend: the significance of illness and disease, of birth, suffering and death, and of the service to the ethos of generosity that sustains the healing professions. Also, the paper offers a cultural "etiology" of "the suspension of meaning" in ethics, and pleads for a moral reflection that begins with a free and open confrontation with clinical experience. Attending to the moral meaning of concrete situations, the paper argues that formal modes of logical argumentation are only derivative functions of the moral language and, thus, cannot exhaust the broad spectrum of ethical discourse in medicine.

Keywords: Clinical ethics; ethical principles; moral experience; post-modernity (Source: DeCS, Bireme).

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1 Director of the Bioethics Institute. Loyola Marymount University. United Stated. rdelloro@lmu.edu

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Resumen

El artículo pregunta acerca de la función de la ética clínica; lo hace mediante la confrontación del supuesto de que la ética debe ayudar a la solución de problemas concretos, a partir de una serie de principios y normas. El carácter científico de este tipo de enfoque de la ética clínica complementa la comprensión misma de la medicina moderna como un campo cada vez más científico y técnico; como orientado hacia la producción de efectos. En el artículo se afirma que, en lugar de compartir en la "suspensión de sentido", perseguido por la medicina en aras de la objetividad científica, la principal tarea de la ética clínica consiste en un sistema de recuperación, o "anamnesis", de las mismas preguntas que la medicina parece suspender: la importancia de la enfermedad y la patología, de nacimiento, el sufrimiento y la muerte, y del servicio al espíritu de generosidad que sustenta las profesiones de la salud. Además, el articulo ofrece una "etiología" cultural de "la suspensión de sentido" en la ética, y aboga por una reflexión moral que comienza con una confrontación libre y abierta con la experiencia clínica. Atendiendo el sentido moral de situaciones concretas, el artículo sostiene que los modos formales de argumentación lógica solo son funciones derivadas del lenguaje moral, y, por lo tanto, no pueden agotar el amplio espectro de discurso ético en la medicina.

Palabras clave: ética clínica; principios éticos; la experiencia moral; posmodernidad (Fuente: DeCS, Bireme).

Resumo

Este artigo questiona acerca da função da ética clínica. Para isso, realiza uma confrontação do suposto de que a ética deve ajudar na solução de problemas concretos, baseada numa série definida de princípios e normas. O caráter científico desse tipo de enfoque da ética clínica complementa a compreensão em si da medicina moderna como um campo cada vez mais científico e técnico, isto é, orientado à produção de efeitos. Neste artigo, afirma-se que, em lugar de compartilhar na "suspensão de sentido" perseguido pela medicina em prol da objetividade científica, a principal tarefa da ética clínica consiste num sistema de recuperação ou anameses das mesmas perguntas que a medicina parece suspender: a importância da doença e da patologia, do nascimento, do sofrimento e da morte, e do serviço ao espírito de generosidade que sustenta as profissões da saúde. Além disso, o artigo oferece uma etiologia cultural da "suspensão de sentido" na ética e argumenta sobre uma reflexão moral que começa com uma confrontação livre e aberta com a experiência clínica. Atendendo ao sentido moral de situações concretas, o artigo sustenta que os modos formais de argumentação lógica somente são funções derivadas da linguagem moral e, portanto, não podem esgotar o amplo espectro de discurso ético na medicina.

Palavras-chave: ética clínica; princípios éticos; experiência moral; pós-modernidade (Fonte: DeCS, Bireme).

In this paper, I reflect on the function of clinical ethics in medicine as oriented to the retrieval of meaning. In a somewhat Platonic vein, I will term such a task, always poised between forgetfulness and remembrance, the *anamnesis* of meaning.

The task calls for preliminary clarifications. On account of its closeness to the professionals and their practice, clinical ethics can be seen as a form of mindfulness that impels the practice of medicine towards its own *telos*, i.e., the ends proper to medicine. At the same time, because it articulates the ends of medicine in the context of a communal ethos, with its needs, values, and priorities, clinical ethics may be better understood as a function of critical analysis that borrows from the anthropological *milieux* in which it operates. The *telos* of medical action cannot be found independently of the context it is supposed to serve.[2]

With the philosopher of medicine Edmund Pellegrino, I do share in the belief that such *telos* can be pursuit only in an attitude of faithfulness to the *internal morality* of medicine. And yet, unlike him, I would refrain from postulating a notion of internal morality that reduces it to an univocal concept, one that borrowing from the resources of *naïve* realism, leads to a sort of abstract definition. In this view, the internal morality of medicine becomes something like an *eidos*, or an idea, grasped once and for all in an intuitive insight, untouched by time and accidental circumstances.[3]

Against the assumptions of such an uncritical epistemology, one might see the internal morality of medicine more as a dynamic process, unfolding through the concrete intermediation with particular ideologies of human fulfillment. This latter movement, unlike the fixed essentialism portrayed above, commands an appreciation for the disclosure of meaning in history, and for the truth of the *humanum* that inhabits the social context in which medicine operates.

I see the function of clinical ethics in medicine as articulating a twofold commitment to the search for meaning, a search that has been hindered, in the medical context, by the limited vision of positivist natural sciences, and in ethics, by an excessive preoccupation with normative dimensions. The former is a recurring temptation of medicine, most visible, of late, in the discussions on matters of genetics and research. As for the latter, search for meaning entails much more than simply rearranging the "internal coherence" of a "content-thin" ethical strategy, each time awaiting for the next edition of the *Principles of Biomedical Ethics* by Beauchamp and Childress (3).[4] It is not enough to keep the system open to the latest normative integration, in an endless exercise of "reflective equilibrium," if such a system fails to address "deepest matters of our humanity," to quote Leon Kass. Brilliant moral theories might come too late, when ethics has already lost its soul.[5]

2 For the debate on the goals of medicine, see Mark J. Hanson and Daniel Callahan (1).

3 For a clarification on the presuppositions of Pellegrino's philosophy of medicine, one can see the collection of essays edited by Roger Bulger and John McGovern (2).

4 The book, first published in 1979, is now in its 7th edition. The changes in the evolution of the book testify to the authors' attention to the unfolding of the methodological debate in bioethics. On the other hand, their commitment to a principle-based approach remains unshakable, in spite of mounting external criticism.

5 On the condition of contemporary bioethics, relative to a lack of questioning about moral meaning, see Leon Kass (4); also Gilbert C. Meilaender (5).

Perhaps the central claim of this paper is to encourage a dramatic shift in paradigms that turns, first and foremost, to the interpretation of experience – in this case, the experience of clinical practice with all its complexity and nuances – as the central task of clinical ethics. In this perspective, the ethical methodology specific to clinical ethics cannot be defined *a priori* to the challenges of clinical practice itself; rather, as the articulation of an ethical gesture that already pervades such practice in a quest for intelligibility.

Mindful of the latter suggestion, I intend to convey the following thesis: the contribution of clinical ethics to the practice of medicine at the bedside – I take this restriction of the *material* object of ethical analysis to define the specific task of clinical ethics vs. bioethics more in general – consists in a twofold retrieval of meaning: relative to medicine, first; and, secondly, relative to ethics. In more synthetic terms, I would identify the function of clinical ethics in what I call the "anamnesis of meaning".

THE SEPARATION OF PRINCIPLES AND MEANING IN MEDICINE

Some time ago, Warren Reich suggested that the problem of the search for meaning in medical ethics might be illustrated by the metaphor of the stethoscope. Richard Baron, in a famous article for the *Annals of Internal Medicine*, tells the story: "It happened the other morning on rounds, as it often does, that while I was carefully auscultating a patient's chest, he began to ask me a question. 'Quiet' I said. I can't hear you while I'm listening" (6)[6].

The stethoscope metaphor is emblematic of the inattention to meaning ("not hearing") brought about by the reductionist focus (the mode of restricted "listening") in the methodologies of both modern scientific medicine and contemporary ethical theory.

To start with, the mind-set created by modern scientific medicine has required for medicine *to be inattentive*, i.e., not to hear the sick person's experience of illness. Influenced by a positivist framework, 19th century medical scientists popularized the notion that *practical* clinical medicine should be viewed as a form of applied *theoretical* medicine. In the United States, the reformation of medical studies introduced by the medical educator Abraham Flexner, in the first part of the 20th century, completed the picture. Moreover, this happened as a result of modernity's understanding of scientific knowledge, which Hans Georg Gadamer poignantly describes as a capacity to produce effects. In the *modern* version of scientific knowledge, the mathematical-quantitative isolation of laws of the natural order provides human action with the identification of specific contexts of cause and effects, together with new possibilities for intervention (8). In relation to clinical medicine, such an idealization entails a tendency to reduce the *praxis* of medicine, with its matrix of subjective components and contextual features, to the detached "objectivity" of theoretical knowledge, and to interpret the healing process itself as a production of effects (9).[7]

Of course, one cannot in principle question the application of scientific reasoning to medicine. In trying to identify and explain the cause of symptoms, medicine

6 Baron, quoted by Warren Thomas Reich and Roberto Dell'Oro (6). In an analogous phenomenological vein, see Richard Zaner (7).

7 As for Weber's avalutativity principle, see his "Science as a Vocation"(10).

employs probabilistic laws and rules, theories and principles, of the biomedical sciences. Concepts of normal and abnormal, for an example, are statistically derived concepts, based on scientifically validated norms of human biological functioning. In the attempt to classify symptoms as the manifestation of particular disease entities, medicine relies upon hypothetic-deductive and inductive reasoning. Moreover, in order to determine what can be done to remove or alleviate the cause of particular diseases, medicine appeals to prognostic knowledge about the course of the diagnosed disease, as well as the efficacy and toxicity of relevant therapeutic possibilities. And yet, in spite of its undisputable scientific basis, medicine cannot be entirely equated with science. The goal of medicine is not to reduce different segments of scientific explanations into a unified theory; rather, the specific goal of medicine consists in bringing together, in a synthetic action, which is theoretical *and* practical at the same time, an understanding of illness with a specific medical decision on behalf of the patient.[8] Unlike the patho-physiology of disease, the phenomenon of illness cannot be observed, analyzed and explained *noumenically;* i.e., "in itself." As Gadamer suggests, it can be fully understood only *hermeneutically;* i.e., through an act of interpretation that takes place within the sociological, cultural, and ideological matrix of a defined life-world. For this reason, medicine represents a peculiar unity of theoretical *and* practical knowledge within the domain of the modern sciences, "a peculiar kind of practical science for which modern thought no longer possesses an adequate concept" (8).

8 Such a perspective has been forcefully maintained by Edmund Pellegrino (11, 12).

My point here should not be misconstrued. Careful scientific attention to the patho-physiology of disease, together with ever more extensive bio-technological applications, has certainly yielded marvelous advances in modern medicine (13). Yet, its positivist reduction has also created a mind-set that brackets questions of meaning, themselves highly significant to human well-being and to the ethical aspects of medicine.

Consider the case recently publicized in the news concerning the FDA discussion for approval of an *in vitro* fertilization technique which, in an attempt to prevent certain illnesses, like muscular dystrophy and respiratory problems, uses DNA from three people (14). Most commentators, especially scientists and doctors, welcome the advent of yet another technological fix to a congenital predisposition with an attitude of unquestionable awe. On the other hand, the more critically minded,, among them ethicists, are willing to grant that some moral problems for this "three parent baby" solution do exist after all: doubts about safety are raised, together with the fear of unforeseen eugenic slippery slopes. Strangely passed over in silence, though, remains the most obvious question, "whose child will this baby be?" Of course, experts are quick to rebut this preoccupation as scientifically naïve, if not totally unfounded: they reassure the concerned public that because the female donor of healthy mitochondrial DNA to the defective biological mother provides, in the end, a very negligible genetic contribution, she cannot be described appropriately as "a parent." However, when considered from another angle; namely, that of the *personal* identity of a child thus produced, the question "whose child will this baby be?" comes to the fore as actually very serious. This is so because personal identity is now imperiled by what I would call "an ambiguity of belonging," in which the embodied

matrix of traceable biological debts represents for the child in question more an opportunity for doubt, than a condition for self-identification. The lack of evidence about one's *distinct* genetic lineage turns the trust in the source that gives to be, under normal circumstances the syngamy of two genomes, into puzzlement about one's *own* origin and identity.[9]

The ethical judgment on the technology in question is not the point here. I am not concerned with the ethics of artificial reproductive technologies *per se*, but with the discussion on the more recessive premises about the body, embodiment, and the "embodied self," premises that drive these technologies in the first place and, more in general, our understanding of reproductive medicine's goals. I ask: how important is it to unpack what remains tacit in the public discussion about a case such as this, and why? What are the philosophical models of embodiment presupposed by medicine, and, consequently, by medical ethics today? How to articulate, in the concrete clinical context, an anthropology that speaks to the nature of the body as a gift, the person as a "unified totality," and the inter-subjective quality of the body as a medium of relationality. How is one to make *philosophical* sense of those categories, unequivocally rich, yet also culturally opaque?

Perhaps, the judgment of Edmund Husserl in his *Crisis of the European Sciences*, while summarizing the development of modern sciences, offers at the same time a prophetic anticipation of the predicament of contemporary medicine:

> The exclusiveness with which the total world-view of modern man lets itself be determined by the positive sciences and be blinded by the "prosperity" they produced, meant an indifferent turning away from the questions which are decisive for genuine humanity. Fact-minded science excludes in principle precisely the questions which man finds the most burning: questions of the meaning or meaninglessness of the whole of human existence (16).

With the latter quotation, I come to my first conclusion. The first task of clinical ethics is to foster a search for the meaning of the very questions medicine seems to suspend: the significance of illness and disease, of our human condition as embodied, of birth, suffering and death, and of the service to the ethos of generosity that sustains the healing professions.

ETHICS AND THE PRIMACY OF EXPERIENCE

The stethoscope metaphor symbolizes also the mind-set of the moral philosophy that has dominated and shaped much of our ethical inquiry in medical ethics. In the critical judgment of many, the field has concentrated on a very restricted version of moral language, the language of biomedical quandaries, as well as principles and rules that sustain the rational argumentation for the "solution" (the language here is telling!) of concrete cases.[10]

9 For a stimulating analysis of the way in which biotechnology redefines embodiment, see Marie-Jo Thiel (15).

10 The literature on the methodological debate in bioethics is very extensive. For a thorough examination of the potentials and problems of a principle-based approach see Raanan Gillon (17); for a critical assessment, Edwin R. DuBose (18) Henk Ten Have (19); most recently on the methodological debate, George Khushf (20).

Such a normative preoccupation with problem solving, however, strongly fosters an attitude of *inattentiveness*—the word recurs again, here—to the moral components and voices that do not communicate in the language of quandary, do not create a challenge for ethical argument, or do not speak with the precision and articulation required in our intellectual culture to attract the attention of "serious" ethical argumentation.

I will delve a bit into the "etiology" of what I would call "the suspension of meaning" in medical ethics. In addition to a critical integration of positivistic attitudes in medicine and the reduction of moral discourse to the normative, one must mention the basic presumption of a cultural situation, which, in the name of post-modernity, raises serious doubts against the possibility of engaging in questions of meaning across moral boundaries.

The "Suspension" of Meaning in Medical Ethics

A look at the relatively brief history of epistemological developments in medical ethics shows a methodological shift in the fundamental preoccupation of ethicists. The scholars who originally shaped the field of bioethics (21)[11] did indeed seek a horizon of meaning capable of sustaining ethical discourse that aimed to address the value implications of technological developments in medicine and the life-sciences. Such a horizon of meaning had a pluralistic character: it inspired moral anthropological interpretations in a theological fashion, as well as generally humanistic, when not explicitly non-religious, hermeneutics.

At the end of 1970s and the beginning of the 80s, however, a major shift occurred. Under the increasing influence of contemporary Anglo-American moral philosophy, medical ethics developed a preoccupation with the elaboration of normative criteria (so called *principles* of respect of person, beneficence, non-maleficence and justice) that drew their justification from the perspective of a restrictive cluster of concepts in political philosophy.[12] This moral philosophical approach sought to create a consensus based on shared arguments that were divorced from the horizon of meaning and the meaningful narratives that initially inspired them. Under the strong influence of the need to provide a consistent ethical basis for public policy formation, moral philosophy built for medical ethics an area of autonomous reflection centered on the use of principles and rules, together with the ethical theories that articulate them through utilitarian or deontological strategies.[13]

Leon Kass comments critically on the inherent value, or lack thereof, of these principles, when applied to particular cases: they translate mainly into concerns to avoid bodily harms and do bodily good, to respect patient autonomy and secure informed consent, to

11 One might think of people like Paul Ramsey, Josef Fletcher, Hans Jonas, Daniel Callahan, and Warren Reich.

12 Classic here remains the work of Tom Beauchamp and James Childress (3), and, most recently, Tom Beauchamp and David De Grazia (22). In my opinion, however, the commitment to a principle-based approach in bioethics extends beyond the work of the authors mentioned above, for it represents a larger theoretical gesture defining mainstream Anglo-American bioethics. See, for an example, Robert Veatch (23) and H. Tristram Engelhardt (24).

13 The term "principlism" was eventually used, in the wake of critical remarks by philosophers Dan Clouser and Bernard Gert, to designate this approach. See K. Danner Clouser and Bernard Gert (25); most recently, Bernard Gert and Danner Clauser (26).

promote equal access to health care and provide equal protection against biohazards. So long as nobody is hurt, no one's will is violated, and no one is excluded or discriminated against, there is little to worry about. The possibility of willing dehumanization is out of sight and out of mind (13).[14]

The Challenge of Post-modernity

The difficulty of a moral reflection that deals with serious questions of meaning is also blamed on the complexity, both epistemic and moral, defining our "post-modern condition" (28). Postmodernity entails the definitive overcoming of the modern philosophical and scientific agenda characterized by the optimism of reason; also, the recognition of a structural fragmentation that, forcing us to the inevitability of contextual interpretations, defies any illusion of totality and, with it, the very pursuit of truth as meaningful.

The theoretical indeterminacy of postmodernism as a philosophical label contrasts with the clear dimensions of the problems it creates in practice. Two are particularly important and worthy of reflection. First, the problem of bringing together the plurality of lived moralities, what we call moral pluralism, under the common denominator of a shared ethos, or a "common morality" in bioethical jargon. Secondly, the difficulty of finding a level of discourse that engages differences among moral traditions on questions of substance. Whereas the former problem concerns the moral climate that structures all practical spheres of reality, the latter pertains, more specifically, to the possibility of a theoretical reconstruction of such moral climate, both in terms of ethical discourse and public policy.

Relying upon an analysis of different typologies of moral argumentation, Alasdair MacIntyre observes: "debate between fundamentally opposed standpoints does occur; but it is inevitably inconclusive. Each warring position characteristically appears irrefutable to its own adherents; indeed in its own terms and by its own standards of arguments it *is* in practice irrefutable. But each warring position equally seems to its opponents to be insufficiently warranted by rational arguments" (29).

A way of solving this predicament is to bridge the gap of cultural fragmentation and the unconvincing nature of arguments between moral agents by surreptitiously reducing ethics to a purely regulatory task, thus progressively diluting the distinction between the legal and the moral. The tendency to sublate ethics under the law rests upon the assumption that dialogue on moral convictions separates people; only the law, now invested with a kind of soteriological meaning, can bring moral differences under the banner of unifying social rules.

I believe such a notion of ethics not only discourages meaningful exchange across different traditions; it actually entails, in the long run, a neutralizing effect upon the *content* of moral conversation as such. An ethical discourse capable of laying out a territory of discussion, where differences can meet and confront each other, will be expunged from the theoretical agenda of ethics. The latter will, at best, provide a grammar of procedural conditions upon which differences among moral traditions may co-exist, without ever coming into contact

14 As an example, one can look at the 1999 document on stem cell research by the National Bioethics Advisory Commission (27). The authors of the document can, ultimately, agree on *safety* as the only moral constraint against the practice of reproductive cloning.

with one another. Rather than focusing on questions of intrinsic value, moral discussion is expected to articulate, at best, rules of reciprocal engagement—the *a priori* of the communication—that will allow each moral participant to remain in a safely protected, yet totally separated, moral universe.

In order to overcome the problems posed by our postmodern condition, it seems imperative to rethink the meaning and purpose of ethical dialogue across different traditions and within the public realm of "secular" society. One must move here between the Scylla and Charybdis of a twofold dead end: the reduction of ethical rationality to a purely procedural function of political regulation, and the intellectual impotence toward an incommensurable pluralism that legitimizes the relativity of different points of view.

RETRIEVING MEANING

Moral reflection, especially in the existentially charged realm of clinical ethics, does not begin with the application of normative principles, nor can it be sustained by an attitude of resignation toward the pursuit of the good. It begins, rather, with a free and open confrontation with the meaning of the experience we face.[15]

Experience is not merely an objectively described empirical entity, though empirical analysis might have an important part in it. Already at the level of its etymological meaning, "experience" entails a reference to subjective intermediation: experience speaks of the predicament of *peiros*, of the passing or living through a situation of crisis, and of the personal growth effected by such existential challenge. We are summoned by meaning in an integral fashion, and the radicalness of such call can be answered only by a synthetic act of reciprocity, a response to an intrinsic source of value (*Wert-antwort*) to borrow from the phenomenological tradition, which we confront with that most intimate and all-encompassing definition of the self we identify with: the notion of *conscience*.[16]

I hear the objection of clinicians: questions of meaning can only have a secondary importance, when tough decisions need to be made, in the *hic et nunc*, the here and now of concrete clinical challenges. In this perspective, "gazing into the meaning of things" can be, at best, an interesting theoretical exercise; at worst, a useless distraction that utterly fails to address the call of the moment. It does indeed make good sense to put meaning in a secondary place and give primacy, instead, to one's immediate reality, when confronting the premature cry for survival in the neonatal intensive care unit, or the puzzlement over the competence of a surrogate decision maker, acting on behalf of an elderly patient now mentally incapacitated.

At the same time, when the larger world of wellness, suffering, being struck with affliction, being sick, dying and so on, does not find its proper way into the decision-making process of clinical ethics; when, instead, clinical ethics relies, in a rather mechanical fashion, on an algorithmic approach to problem-solving, with its plethora of predefined categories – advance directives, consent

15 For a paradigmatic application of this concept to the field of bioethics see Warren T. Reich (30).

16 For the notion of *Wert-antwort* (value response) see Dietrich von Hildebrand (31). A careful study of the notion can be found in Josef Seifert (32), also, Bernard Lonergan (33).

forms, values inventory, etc. – we end up creating obstacles to good habits of moral reasoning, hindering the disclosure of moral meaning while, quite paradoxically, producing the "right" answer for the quandary at stake. Attending to the moral meaning of concrete situations entails recognizing that formal modes of logical argumentation are only *derivative* functions of the moral language. Prudential or practical reasoning unfold as dimensions of a more original form of mindfulness, a synthetic act of *discernment*, which includes elements of detecting, sensing, sifting, discriminating, comparing, connecting, and, ultimately, deciding (compare Pascal's *esprit de finesse* against *esprit de geometrie*).

Richard Zaner puts the matter brilliantly, when analogizing such phenomenological probing with the work of a detective: "(One must) deliberately be alert to the multiple ways in which participants interrelate and variously experience and interpret one another and, with that relationship, the relationship itself. Even a brief moment reveals a number of interrelated voices, each with its own emotional, volitional, valuational, and cognitive tonality… The ethicist's involvement is thus *a work of circumstantial understanding*" (34).[17]

This mode of moral reasoning is certainly relevant to all settings, but it becomes particularly important when questions of meaning need to be addressed beyond the application of normative strategies for "solving" moral problems. In fact, relying upon these strategies might precisely be a way to by-pass larger questions of meaning, questions for which ethicists have long since declared their incompetence, and therefore, gladly pass on to the "care" of alternative agencies, spiritual care personnel, psychologists, etc.

CLINICAL ETHICS FUNCTIONS AS THE ANAMNESIS OF MEANING, NOT ONLY FOR MEDICINE AS A PRACTICE, BUT, MORE IMPORTANTLY, FOR ETHICS ITSELF.

Let me draw my second conclusion, then. Clinical ethics functions as the anamnesis of meaning, not only for medicine as a practice, but, more importantly, for ethics itself. For sure, the search for meaning does not end in a kind of bracketing of the ideological presuppositions that generate ethical discourse. As Paul Ricoeur has suggested, meaning cannot be reached from a position of neutrality (*Voraussetzungslosigkeit*) that fails to objectify the ideological prejudices already operative in the archeology of meaning (36, 37). On the contrary, because it puts questions of meaning at the center of its attention, clinical ethics becomes better equipped at unmasking all sorts of ideological mystifications. Consider, for an example, the notion of medicine that feeds into a mode of thinking defined by the presumption to "fix everything." It is an insidious presumption affecting modern medicine, with disastrous consequences for the motivational and intentional agency of the physician. A medicine with no appreciation for the deepest matters of our humanity will not be able to see how *caring* can

17 The same emphasis on the particularity of moral reasoning, especially in medicine, can be found in casuistic and in hermeneutic approaches to bioethics. For the former see Albert Jonsen and Stephen Toulmin (35); for the latter, Fredrik Svenaeus (36).

Relative to medicine, clinical ethics functions as a reminder of what defines medicine as a human practice, the nature of its action, and its ultimate purpose.

still be part of the definition of medicine, when *curing* is no longer possible.[18]

Indeed, when treatment options cease to offer a *meaningful* hope of recovery, there appears to be no patience for the unsuspected disclosure of *another* meaning, one that escape *production* of any kind because it can only be *received* in the openness of attentive receptivity.[19] It is the call to meaning generally entailed by situations of "vulnerability": the genetically defective fetus, the handicapped child, the elderly patient. In these cases, one comes to a dead end: nothing more can be done, or so we think.

CONCLUSION

In this paper, I have pleaded for a notion of clinical ethics defined by a twofold retrieval of meaning. Relative to medicine, clinical ethics functions as a reminder of what defines medicine as a human practice, the nature of its action, and its ultimate purpose. In reminding medicine of the moral sources that nourish its doing, clinical ethics also functions as reminder of the ultimate nature of ethics in medicine: to be an interpretation of moral experience as the condition for the articulation of moral principles and norms. In the anamnesis of meaning that always inhabits experience, whether of health care professionals or patients, clinical ethics finds its ultimate purpose and scope, as well as the condition of its own significance in the clinical world.

18 For a thorough investigation of the historical roots and contemporary applications of an "ethics of care" see Ludwig Haas (38).

19 What is at stake here is a kind of phenomenological *epoche'* on a naturalistic attitude still closed to the deepest intelligibility of reality. I speak of "attention," with reference to the Simone Weil, in Roberto Dell'Oro (39). Elsewhere I tackle the question in terms of the contrast between *conatus* and *passio essendi*. See Roberto Dell'Oro (40).

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