RICOEUR'S "PETITE ÉTHIQUE": AN ETHICAL EPISTEMOLOGICAL PERSPECTIVE FOR CLINICIAN-BIOETHICISTS

This is a preprint of an article published in *HEC Forum*, 2010 22(4): 311-26.
URL: http://www.springerlink.com/content/jj08821k513u5747/

Marie-Josée Potvin
Programmes de bioéthique, Département de médecine sociale et préventive
Université de Montréal
C.P. 6128, succ. Centre-ville, Montréal, QC, Canada H3C 3J7
marie-josee.potvin@umontreal.ca

ABSTRACT
The passage from a posture of clinician to that of clinician-bioethicist poses significant challenges for health professionals, most notably with regards to theoretical or epistemological views of complex ethical impasses encountered in clinical settings. Apprehending these situations from the only clinical perspective of the nurse or the doctor, for example, can be very unproductive to help solve this kind of situation and certainly poses great limits to the role of the clinician-bioethicist. Drawing on my own experience as a former nurse who, following graduate studies in bioethics has begun providing ethics consultation services, I argue that clinicians must undergo an epistemological transformation in order to become clinician-bioethicists. A source of inspiration or framework for would-be clinician-bioethicists is, I suggest, the "Petite éthique" developed by the contemporary French philosopher Paul Ricoeur. Specifically, clinician-bioethicists should develop specific core ethical competencies (in line with the conclusions of the American Society for Bioethics and Humanities (Core competencies for health care ethics consultation, 1998); namely: savoir or knowing, savoir faire or knowing how to do, and savoir être or knowing how to be.

KEYWORDS
Bioethics – Ethics – Clinical ethics – Paul Ricoeur – Core competencies

ACKNOWLEDGMENTS
I would like to express gratitude to Dr. Bryn Williams-Jones for his in depth revision, comments, support and discussion that have improved this manuscript over the course of its development. I also would like to thank Dr. Marie-E` ve Bouthillier for her feedback on a preliminary version of this paper and for the opportunity of rich discussions about clinical practice. I finally would like to thank Jocelyne Chicoine for all her editorial support throughout the process.

INTRODUCTION

"*It may seem unusual for the ethics consultant to recommend a medical/psychiatric diagnosis and to suggest treatment as part of an ethics consult. Few of us wear only one hat. I am trained as an internist and geriatrician. I cannot ignore more than twenty years of practice*".[1]

As surprising as it may sound for some, this assertion nevertheless represents a common conflict experienced by many health professionals involved in providing clinical ethics consultations. Shifting roles from being a clinician to a bioethicist or clinical ethics consultant is not an easy task. Originally trained as a nurse, I was faced with this ambiguity at the very start of my practice as a clinician-bioethicist.[2] Inspired by the "Petite éthique" (Little Ethics) of Paul Ricoeur[3], and building on a philosophical analysis of a particular experience that occurred during a clinical ethics consultation, this paper is a reflection on my evolving epistemological perspective as a clinician-bioethicist.

The expression "epistemological perspective" needs to be clarified in the context of this analysis in order to avoid confusion about a concept which already has a plurality of meanings in the literature. This expression is used here to focus the reader's attention on the fact that professionals, such as nurses or physicians for example, base their professional judgements and action on knowledge specific to their own field of expertise. I hypothesize therefore, that this knowledge gives these professionals a particular disciplinary or professional "perspective", a way of apprehending reality which is particular to what they have learned and experienced in their professional practice. As I will show, this way of perceiving the clinical world has a direct impact on the clinician's role or approach to performing clinical ethics consultations.

For reasons of confidentiality, and considering that I do not present here a formal case study, the presentation of my experience in a clinical ethics consultation has been modified. Following this contextual set-up, I will describe my initial *clinical epistemological perspective*, that is, my spontaneous reaction during the ethics consultation. I then establish the philosophical path taken in my analysis – part of my own process of thinking through this clinical ethics experience – beginning with a brief biography of Paul Ricoeur and a general survey of his theory, the "Petite éthique".[4] This then provides the basis for an analysis of how some of Ricoeur's key concepts – such as *solicitude*, *naive solicitude*, *critical solicitude*, *practical wisdom*, *argumentation ethics* and *imagination* – could be helpful in better comprehending the tensions (and possible resolution) that arise when the bioethicist's and clinician's epistemological perspectives are combined in the role of clinician-bioethicist.

A STORY FOR REFLECTION

The case upon which I base my reflection involves an eighty year old man, who I will call Mr Miles. For the past ten years, Mr Miles has been suffering from an organic cerebral syndrome and a number of encephalopatic problems. He has been bedridden in a senior's center all this time and is being fed artificially. Mr Miles can no longer speak and does not recognize his visitors. In the past six years, he has been hospitalized four times for treatment of relapsing cellulitis at the feeding tube site. The treatment of this condition requires the removal of the feeding tube and the installation of a feeding alternative; however, considering Mr Miles' general condition, the options are limited.

During his most recent admission, and the one which led to the clinical ethics consult, the treating team decided to introduce a nasograstic tube to feed Mr Miles until the cellulitis could be eliminated. However, complications arose when inserting the nasograstric tube and compromised this option. The effective migration of the feeding tube towards the intestine by peristalsis was

compromised by Mr Miles' sedentarity, and so it became impossible to proceed with the installation. The treating doctor was hesitant to force the tube into place as the procedure would be very painful for the patient, and Mr Miles was incapable of expressing his wishes about this invasive procedure. The medical team believed that it was not in Mr Miles' best interest to continue to undergo such painful intervention which, from a medical perspective, showed little hope of success. Furthermore, the team perceived that Mr Miles' adult children had difficulty "letting go" of their father, in part because of how this decision reflected on their own sense of mortality, but also because their judgment was misguided by their prejudice towards artificial feeding. As a result, the medical team wished to discontinue artificial feeding and to offer only comfort care to the patient, an approach that for them represented the most appropriate strategy given Mr Miles' actual condition.

Mr Miles' children were articulate and composed, and showed love and care for their father. Closely implicated in all the decisions for his care and treatment, they had expressed mistrust about the intentions of the medical team: "We have been told that it is expensive to treat our father, we wonder if this is not the reason why they want to end his life". The children were categorically in favour of continuing with the artificial feeding. The intense emotions generated by this situation were palpable for all involved. These conflicting emotions resonated within me, challenging my perspectives as a clinician (a nurse for more than 20 years) and were one of the major turning points in my training as a bioethicist.

I chose to present this particular consultation (from among many others I had participated in during my bioethics training) because of the intensity and the significance of my reaction, and because of the awareness that it created with regards to my epistemological perspective as a health professional. Moreover, the animated debate around the status of artificial feeding raised by this case, namely to what extent artificial feeding corresponds either to treatment or to basic care, added to the emotional burden created during the consultation.[5]

From the very first meeting with the family, I felt a strong feeling of concern for the children of Mr Miles. I empathised with their suffering, as well as the feeling of helplessness in the face of the power of medical authority, the burden of responsibility in deciding the course of their father's life, and the apprehension of the eventual grief of his death. Spontaneously, I felt a responsibility to restore the relationship of trust between the family and the medical team, which seemed, in light of their words, to have deteriorated over the years. The children used the term "hospital battlefield" to illustrate their feelings about a situation they considered somewhat violent. "Doctors have too much power over a person's life and death", they said.

The situation provoked me to ask myself the following question: "What if this was my own father or mother?" The suffering of this family resonated with my own personal vulnerability; and as a health care professional, my perception of this suffering invited me to act towards this family in a compassionate manner. Compassion and care are at the heart of the nursing act and part of our professional code of ethics. However, this concern – or 'solicitude' in the language of Ricoeur – created a significant tension for me, due to my position as both a nurse and a bioethicist in training. My first impulse, to directly and intensively defend the patient, was clearly driven by an epistemology of nursing that favors *advocacy*, or in other words, *the responsibility related to the defence of the most vulnerable*[6].

Despite its obvious importance in the context of clinical nursing care and its relevance to clinical ethics consultation, the responsibility of nurses to advocate for patients is not necessarily the same as that for clinical bioethicists. The particularity of the situation (e.g., a breach of confidence between the patient/family and members of the health care team) and the ethical

culture of the organisation (e.g., bioethicists who engage in independent ethics consultations with the patients/family, who work as part of clinical ethics committees and/or support the development of ethical competency on the part of health care teams) are some dimensions or responsibilities that could influence the bioethicist's decision to advocate more or less directly for the patient and his family. So while the protection of the most vulnerable is clearly of prime importance for the clinical bioethicist, the way that this responsibility is actualised will certainly vary according to contextual and personal dimensions. To advocate for the patient in a disproportionate manner has the potential to undermine the consultation process, because it involves a bias against the concerns or values of the health care team; such a stance may also demonstrate a loss of critical insight regarding the broader situation and context of the ethical consultation.

Several factors led me to conclude that there was something wrong with my general attitude. In particular, the attitude and interventions of my bioethicist mentor during the consultations, the strong resistance of the medical team and the significant inner tension I personally experienced throughout the whole process led me to reflect on my position in this situation and my work in clinical ethics more generally. How was I to situate myself as an ethicist in such a scenario and to contribute positively to the decision making process? How, in the future, will I face this kind of situation where the power of medical authority appears to me to be abusive? How is it that this almost "unconditional" concern for the interests of the family made the defence of the most vulnerable appear to be the only option? These are the questions that defined my initial feelings of doubt and unease about this case.

During a discussion following the first meeting with the family and the medical team, my ethics mentor advised me that "In clinical ethics, your role is not to defend the patient's rights; this position could become very delicate." Her comments on my attitude and convictions were decisive in guiding my search for a better understanding of the role of the clinician-bioethicist. As a trained health professional, I came to realize that how I perceived this case and reacted to it – that is, my epistemological perspective – was profoundly influenced by my past nursing experience and knowledge. It became evident to me that my first priority in the context of a clinical ethics consultation was to re-evaluate those founding principles which had so significantly shaped my way of thinking as a health professional. It was in the works of the French philosopher Paul Ricoeur (1913-2005), that I found a fertile ground on which to develop a new perspective in clinical ethics.

TOWARD AN ETHICAL EPISTEMOLOGICAL PERSPECTIVE: SOME TOOLS FROM RICOEUR

I propose then, for the purpose of this exercise in epistemological repositioning, to provide a philosophical analysis – inspired by Ricoeur's theory, the "Petite éthique" – of the preceding clinical ethics consultation. But before getting into this analysis, it will be useful to first have a general sense of the history and scope of work produced by this important 20th century philosopher.

It is difficult to ignore the man behind the philosopher Ricoeur; the particularities of his life profoundly contributed to the development of his "Petite éthique" as is clearly expressed in his intellectual autobiography.[7] Ricoeur's thought is of a fine complexity and reflects a humanistic sensitivity in which the subject is the principal actor. Indeed, Ricoeur's life was characterized by numerous challenging experiences, including the premature death of his parents, five years captivity during the Second World War and his son's suicide. Afflicted by suffering, he showed an interest in the reality of *evil* which would become the common

denominator of his entire body of work. In spite of this focus, his work maintained a positive tone and was marked by hope in the *capable man*.[8] Man's suffering is a great source of inspiration from which to question the need for humanity in facing suffering, an element that is fully in line with the goals of this paper.

A philosophy and theology teacher at a number of colleges and universities in France, Ricoeur's intellectual work was not characterized by the elaboration of a unique theoretical approach as has been the case for many philosophers. Instead, he explored and brought together diverse ideologies and approaches which allowed him to contribute, in a creative and constructive way, to the multiple debates of his time.[9] His book (and theory) the *Petite éthique*, which he so named as an expression of "modesty and irony"[10], is the inspiration for the philosophical analysis in this paper.

The "Petite éthique" in Brief

Even if Ricoeur qualifies it as "petite" (little), his ethics reveals a great complexity whose full comprehension would require a laborious in-depth analysis of his numerous writings. I do not pretend in any way to render a full or complete presentation of Ricoeur's "Petite éthique". Instead, I draw on a few of Ricoeur's key concepts in order to first reflect more clearly on my own experience with the case of Mr Miles, and then to propose a new epistemological perspective for clinician-bioethicists.

Relatively few authors in medicine or nursing[11121314] have used Ricoeur's philosophy to directly reflect upon the realities of and challenges arising in clinical practice. This is somewhat surprising given that Ricoeur defines his ethical enterprise as an anthropological philosophy in which action, in practical situations, is the ultimate ethical aim. Ricoeur himself, drew a direct parallel between his fundamental ethics and medical judgment in practice, on the occasion of a 1997 presentation in Germany at the *Ethics – Codes in Medecine and Biotechnology* conference.[15] My paper thus follows the main path and nuances of the specific analysis proposed by Ricoeur. I do not, however, pretend to suggest a normalized or comprehensive view of what should be the ethical experience of health professionals, from a Ricoeurien perspective. I have in mind a more modest goal. Inspired by the main concepts of Paul Ricoeur's essay on medical judgment, I propose a practical way to reflect upon one's ethical experience in a clinical setting.

Ricoeur's ethics is one of *action,* where the aim is "…*the good life* with and for others, in just institutions". [16] Applied to the health care team, then, professionals should act in the best interests of the patient/family, individuals who have become highly vulnerable in the face of disease or disability. The laudable intention of these professionals is to somehow, and according to the very difficult human and institutional circumstances of the clinical setting, provide means for a *better life* with and for the patient/family. In responding to a request for an ethics consultation, the health care team not only provides a means to act in the best interest of their patient, but also provides a means to act in a responsible manner towards their colleague's best interests (e.g., by providing an opportunity to share their concerns). The role of health care professionals in the development of an organization that nurtures and supports all stakeholders is not always explicit, but reflects Ricoeur's pluralistic ethics which places responsibility at the forefront of the ethical endeavour.

This foundational ethics comprises three levels (reflexive, deontological, prudential) inside which are inscribed three elements: Je-Tu-Il (*I-You-It*).[17] The triad *I-You-It* represents Ricoeur's *ethical intention* without which ethics cannot exist. *I*, the first person, makes ethics possible, because it poses and testifies to a liberty which says "*I* want to be and *I* am capable".[18]

The vulnerable patient/family are going through a very challenging and important part of their lives. In the face of the potential death and suffering of their father, Mr Miles, each of the family members struggled to find a sense or meaning for this experience, and to make the best of it. They each faced the situation based on their own values, life project and history. The suffering and vulnerability of patients/families becomes, for some, a place to hope for the best outcome and for the support of others.

You, the second person, joins in a reciprocal relationship which brings us to the heart of ethics: it says "*I* want *your* liberty as well as mine".[19] Members of the health care team, the *professional others*, are moved by the suffering of the patient/family and respond with a sense of professional responsibility, one that is based both on their duty of care and on a more fundamental solicitude towards fellow human beings involved in a difficult situation. These health care professionals are asked to invest, in collaboration with other colleagues, their expertise, resources and judgement in the best interests of and with the patient, in light of the particular circumstances.

But, as we have all experienced in one way or another, relationships are not always happy or rewarding. According to Ricoeur, the existence of *evil* can pervert the reciprocal ideal and thus obliges the introduction of *It*, the third party, which he names *neutral mediation* and is embodied by institutions.[20] The asymmetrical relationship between the *expert* professional and the vulnerable patient/family is a place of potential abuse. This relationship therefore necessitates mediation, often in the form of rules or norms that make possible a fair collaboration between the patient/family and health professionals. The duty to not abandon the patient, the obligation of confidentiality, and expectations regarding patient's participation in their care planning are some examples of these imperatives.

Within Ricoeur's "Petite éthique", the moral experience of agents is expressed through the dynamics of a cyclical test composed of three levels : deontological, reflexive and prudential. The deontological level (moral) of his ethics, inspired by Kant's deontology, corresponds with the organization of good and evil, including rules, norms, laws and imperatives. At the reflexive level, largely influenced by Aristotlelian thought, Ricoeur attributes to ethics all that relates to the good life and the fundamental questioning of moral law. The prudential level, for its part, refers to his situational ethics; the actualisation of actions based on a refined understanding of the situation and context.

According to Ricoeur, in the particular context of medical practice, these three levels of moral judgment operate in a different order, starting with the prudential, then followed by the deontological and reflexive levels.[21] Ricoeur starts his reflexion at the level of practice (prudential), because the virtue of prudence is concerned fundamentally with decisions made in specific practical situations.[22] This is of prime importance as human suffering is the initial circumstance that calls for medical action and ethics. Suffering, along with joy, are the most singular experiences of human existence.[23] The medical context is not the only social domain affected by suffering; along with one's relation to the self (or view of the self), suffering also effects one's relations with others (e.g., family, work colleagues and institutions). But the health care context is arguably the only domain characterized by social relationships that are explicitly motivated by suffering and a particular *telos,* namely, the hope to be helped and even healed.[24] Thus, ethics in the context of the health care system emerges from practice and refers first to the prudential level of Ricoeur's ethics. Clinical ethics, which is also driven by the intent of his foundational ethics, which is to aim for "… *the good life* with and for others, in just institutions", thus implies judgments at three levels: prudential, deontological and reflexive.

At the first level, the judgment (prudential) applies to specific situations formed by an interpersonal relationship between a particular health professional and a particular patient. The judgment (medical) at this level refers to a *practical wisdom*, more or less intuitive, that is acquired through teaching and practice. At the second level, (deontological) judgment refers to norms that transcend the particularity of the patient-health professional relationship; these norms are found in the form of codes of ethics (e.g., for nurses or physicians). The reflexive level, for its part, legitimates prudential and deontological judgments by confronting them with multiple ethical traditions. It is at this level, notably, that are discussed notions such as health, happiness, life and death,[25] which are necessarily linked to the notion of *the good life* and what it is to be in *good health*. Finally, Ricoeur's vision of ethics invites us to engage in a complex and iterative deliberative process, one that involves reflecting on the situation as a whole, including the limits of medical practice, the goals of medicine and where the convictions of each of the stakeholders involved in a situation must be heard.

How then does Ricoeur's "Petite éthique" help to better understand my *initial epistemological perspective*, and the tension created by a nursing perspective (which he would qualify as "naïve solicitude") towards the patient/family, in order to find a perspective more appropriate to my role as a clinical ethicist? I suggest that Ricoeur's "Petite éthique" can support my analysis in two ways. The first consists in determining the nature of my solicitude that was expressed spontaneously at the very beginning of the consultation (the initial epistemological perspective). The second informs me about the necessary transformation of my solicitude in the context of a clinical ethics consultation (a new epistemological perspective).

Spontaneous Solicitude – the *Initial Epistemological Perspective*

My first reaction associated with the ethical consultation described above (the case of Mr Miles) was characterized by an instant reaction in the face of the injustice felt by the family. In particular, the adult children talked about the multiple steps and obstacles they had to face in order to be respected in their "right to choose" the care or treatment they considered appropriate for their father. The medical authority they qualified as abusive, seemed to be at the heart of their feelings of injustice. They also felt such helplessness that it was their intention to eventually take legal action if the medical team kept to its decision to end the artificial feeding of their father and provide him with only comfort care. My first desire to defend the family's rights (*advocacy*), was exacerbated by the attitude some members of the medical team had towards the family.

To *advocate* for patients is to start from the premise that all human beings have the right to take the decisions they judge appropriate for their well-being, supported by the knowledge they have of their pathology.[26] However, it is important to note that, at least in the U.S. and Canada, while patients generally have the right to refuse treatment, they do not have the right to require treatment that professionals deem medically inappropriate.

Advocacy is widely studied and applied in the nursing field.[27] Sally Gadow[28], a leading figure on the subject, proposes a model of advocacy qualified as "existential" in which nurses should assist patients in exercising their freedom of self-determination. For health professionals working in a geriatric context, for example, concern for a suffering patient could allow them to give voice to the patient's suffering and possibly bring to light an abusive situation. The duty, then, for health professionals would be to preserve the well-being of the vulnerable patient by assisting the patient in choices, listening and giving necessary information, or by representing the patient before the authorities or other persons concerned. The principal aim of advocacy is to partner with the patient in order that they retain their individual autonomy. This relationship with

the patient and way of responding actively to patient needs is a skill acquired over time through practical experience, and for many professionals becomes second nature.

The concern or solicitude that I felt for the family right at the beginning of the consultation was likely driven by an ideal drawn from my professional nursing values. Ironically, adopting such a perspective in the context of a clinical ethics consultation and taking as a starting point the responsibility *to fight for the rights of the patient/family against the authority of the medical profession* could seriously compromise the ethicist's impartiality (and career). From a clinical point of view, my spontaneous solicitude revealed a nursing perspective which in turn manifested itself in a *nursing judgement in clinical practice*; it was not a question then, of providing an (ideally) impartial ethical judgment in a particular clinical context. By applying Ricoeur's "Petite éthique" to this case, we see that my state of mind revealed a solicitude which he would describe as *naïve* and which takes place at the reflexive level of his ethics triad. A solicitude towards the patient/family that is appropriate and even encouraged in the context of nursing care would, in the context of a clinical ethics consultation, be unproductive and naïve. Nonetheless, far from suggesting that such a compassionate attitude be suppressed, Ricoeur's "Petite éthique" encourages its transformation in order to make it more productive for the whole process of ethical judgment, and for our purposes, the clinical ethics consultation.

A Necessary Transformation into a *New Epistemological Perspective*

Ricoeur calls for the transformation of this naïve perspective by offering some useful insights for the adoption of a new epistemological perspective, and one more appropriate for the clinician-bioethicist's work. Three concepts drawn from Ricoeur's "Petite éthique" – *practical wisdom*, *argumentation ethics* and *imagination* – will serve as key elements for this part of my reflection.

Practical wisdom

My initial epistemological perspective (nursing/advocacy) posed very important limits in the context of a clinical ethics consultation. Ricoeur's "Petite éthique" thus helps by suggesting that I put my *naïve solicitude* to the test of the rules, conflicts and challenges embodied in practical situations. In other words, the idea is to submit this solicitude to the numerous limits of the clinical context, a difficult and delicate evaluation for a health professional. To solve these conflicts, Ricoeur introduces the notion of *practical wisdom*.[29] Ricoeur's ethics suggests that the particularity of a situation or of a person should express itself within the universal requirements of norms and rules. As health professionals, when making a clinical decision we face a great number of limits due to, for example, national and institutional health policies, resource restrictions, laws, professional practice guidelines and numerous ethics traditions. According to Ricoeur's ethics, we are invited to include in our decision making process the patient's particularities (history, aspirations, wishes) and the contingency of the situation, and to consider these elements as important as all the other aspects proper to clinical practice.

It is the concept of *practical wisdom* that enables Ricoeur to respond to the apparent paradox brought about by the potential conflict between respect for the person and respect for norms. The "Petite éthique" is thus in a sense fundamentally Aristotelian. Yet if his ethics aims at "…*the good life* with and for others in just institutions"[30], we should not be surprised to find at the heart of Ricoeur's ethics project, two ideologies that are usually considered as being in opposition. On the one hand, there are the norms which assure compliance with the moral law (Kant), and on the other hand, individual liberty projects wishing to express themselves

(Aristotle). Conflicts in clinical situations can bring about conflicting logics. Rules force each of the protagonists implicated in the conflict to be "at the extreme of his logic of action which will inevitably be in conflict with the logic of others".[31] Even if the family and the health care team are both guided by respect for life and dignity towards the patient (Mr Miles), the first argue in favour of maintaining artificially their father's life while the second argue for ceasing aggressive medical treatment and offering comfort care to their patient.

In clinical ethical decision making, this vision of Ricoeur seems essential in that it reflects the extreme complexity of clinical practice in which co-exist the duty of respecting the rules (e.g., laws, codes, rules) and the duty of respecting the person (e.g., solicitude, medical condition, life story, particular needs, conceptions of life and death that are specific to a society and individuals). In line with Ricoeur's ethics, then, clinicians become wise when they are able to determine, at the same time, the appropriate rules for the case while grasping the particularity of the whole situation.[32]

A full presentation of Ricoeur's view of practical wisdom is beyond the scope of this paper. Nonetheless, it is important to remember that through this concept, Ricoeur invites us in the context of clinical practice to look for ways of acting that most respect the patient's particularities while also respecting the rules imposed by professional norms of practice and the numerous limits of the health care system. Furthermore, we can and should operationalize our capacity for ethical judgment through a three level approach (prudential, deontological, reflexive). Finally, Ricoeur also invites us to accept the complexity of the situation in order to transform naïve solicitude (limited to the reflexive level) into a *critical solicitude* (submitted to all three judgment levels: prudential, deontological and reflexive) that is more appropriate for the demands of clinical ethics.

The bioethicist's epistemological perspective, I argue, is different from that of the clinician. Ethics consultations are characterized by their own complexity, and as such, being a clinician-bioethicist forces me in some cases to distance myself from the caring type relationship in which I was initially trained as a clinician. The horizons of the ethical analysis must extend beyond (but not ignore) a focus on the clinician-patient relationship and the suffering of the patient or family. Ricoeur's "Petite éthique" leads the clinician-bioethicist to use – as two axes for an ethics reflection – the unquestionable value of the patient-clinician relationship *and* the need to attend to patient/family suffering. A third critical axis is attention to the contingency of the situation, that is, the discomfort of the medical team, the many stakeholders' convictions and sensitivities, the ethical/legal considerations and the economic imperatives of the health care system. These elements of Ricoeur's "Petite éthique" are thus the basis for what I have called the *ethicist's epistemological perspective*.

The clinician-bioethicist's solicitude allowed me to respond more adequately to the challenges related to my role and responsibilities as a bioethicist. It was not a question of suppressing my solicitude towards the patient/family but instead finding a place for its evolution and transformation. My *naïve solicitude,* rooted at the reflexive level, was a singular ethical posture particular to my nursing expertise that, while important, could not take into account the larger context of the patient-clinician relationship. Given the multiple limits (and challenges) imposed by the clinical context, Ricoeur argued that it was of primary importance to submit this naïve (professional) solicitude to critical judgment brought about by reflecting on the larger context.

All health professionals should strive to reach a more critical understanding of their own perspectives as advocates for their patients, regardless of whether they are working as clinicians,

as ethicists or as consultants on an ethics committee. I suggest that the clinician-bioethicist, to be in a position to effectively support ethical discussions in a multidisciplinary working context, must be prepared to help clinicians broaden their clinical perspective to an ethical perspective. This exercise should be done within an educational *telos* so that health professionals become more empowered to address the complex ethical situations that will inevitably arise in their clinical practice.

Argumentation ethics

Bouthillier[33] summarizes in a very clear manner the nature of the task proposed by Ricoeur: it is a critical one which occurs through an *argumentation ethics* while focused on the contextual conditions of the requirements for universalization. This task involves communication practices between the protagonists, aiming through discussion to bring out the very best arguments. Through these interpersonal relationships, practical wisdom manifests itself as critical solicitude.[34] Ricoeur's ethics encourages discussion between the actors involved in a situation; the purpose is to clarify the complexity of the situation and to refine, so to speak, professional ideals by submitting them to the reality of the situation. To be active and fully present in clinical ethics consultations, I needed to modify my perspective because it was motivated by my desire to advocate for the patient/family. By taking into consideration only the suffering of the patient/family, I remained in a nursing role and by that fact, became a member of the health care team without assuming my role as clinical ethicist. Embracing the complexity of the situation, however, moves the analysis from the periphery of ethical complexity (*patient/family advocacy*) towards its center (the intention: *how to do well*).

This passage is not without difficulty; it necessitates a letting go of the therapeutic-type relationship with the patient/family and requires a bracketing of clinical judgement, but at the risk of being eventually confronted with decisions or courses of actions that while still ethically defensible, might be different from what would have otherwise been chosen.[35] The bioethicist acts as a facilitator or negotiator through the ethical complexity of a case, and in so doing enables a kind of *language mediation play* between the multiple protagonists directly involved with the patient/family.[36] The bioethicist's role, contrary to that of the clinician, is neither to take decisions concerning the patient/family nor to settle the argument. Despite the relatively difficult feelings the clinician has to go through, it appears necessary in order to find the *ethical stage* on which the bioethicist can fulfil her role.

As a clinical ethicist, one task amongst many is to consider fully the health care team's discomfort in order to face the whole reality of the situation. A relationship of relative trust, between my mentor, the team and myself allowed an in-depth discussion that was central to grasping the nature of this experience and to resituate it within the larger problem. The bioethicist's feelings and emotions that arise in the face of certain challenging clinical situations should not be repressed but instead taken into account and submitted progressively to the complexity of the situation, something which unfolds through discussion between the various stakeholders. For example, as my mentor noted "the availability of resources does not create the duty to use them. A medical judgement is needed in order to evaluate reasonable success in their use".[37] This nuance, amongst others, helped put into perspective the patient/family's absolute right to decide for their father's care and treatment by testing it with the medical judgement which revealed a very low chance of success. Moreover, it put into perspective the anger and sense of injustice which I felt at the very start of the consultation. It became evident that attention

to the multiple elements which composed the reality of this patient/family and health care team were necessary for this ethics consultation process to be truly effective.

Each member of the healthcare team, along with the patient's adult children, where to be considered as moral agents participating, from their own particular perspective, in a collaborative decision making process. The family's expressed desires were thus submitted to the professional expertise and experience of the health care team, so that they could provide care that was most medically and humanely appropriate, and which respected what the patient would have wished given the circumstances.

Most of the problems submitted to clinical ethics consultants or committees in health care institutions have already been exposed to the critical judgement and the intense clinical experience of the health care team. To address these problems, usually riddled with paradoxes, in a linear manner that takes into account only one of its components will generally lead to the same impasse which motivated the team to request a clinical ethics consult in the first place. Moreover, to perceive reality in a unidimensional way involves risks, notably a limited way of thinking that eliminates the complexity of a situation, distorting its reality.

A good example of the distortion of reality is found in the family's expressed feelings. The children spoke of the reasons used by a health professional to argue for ceasing the artificial feeding of their father, that is, the associated costs of this medical procedure. If one considers this in an isolated manner, this assertion would certainly be seen as shocking and lacking all compassion. However, in any health care system, resources are limited and difficult choices often have to be made. If we refer to Ricoeur's "Petite éthique" (and in line with other ethical frameworks), this justification taken alone would not in any way constitute the only or a sufficient reason for a decision to end treatment. In this regard, the "Petite éthique" provides a framework which invites us to take into account the complexity of the whole situation, in order to avoid potential abuse caused by a too superficial reflection. Ricoeur's thought informs us about the grounds for epistemological ethics as well as certain aspects of the bioethicist's inner world.

Imagination

Central to Ricoeur's "Petite éthique" is the injunction that moral actors should, as well as positioning themselves at the heart of complexity, adopt an attitude of empathy. Ricoeur invites the subject, through his notion of *imagination*, to "put oneself in the other one's shoes" in order to better understand their personal experience. Combining this notion of imagination with my own experience with ethics consultation taught me that alongside dialogue between stakeholders, the bioethicist can and should also benefit from her own inner dialogue. Such self-reflection or inner dialogue is a means of ensuring the constant evolution of one's convictions, which are themselves constantly confronted by the critical dynamic established by Ricoeur's complex ethics.

My inner dialogue played an important role in the transformation of my epistemological perspective. The difficult emotions I felt, generated by the family's suffering regarding the probability of their father's death, required me to analyse these emotions in order to be able to interpret them as an influence in possibly taking the wrong decisions in my capacity as a bioethicist (e.g., taking a one-sided and thus inappropriate approach to the case, using the wrong techniques to facilitate the discussion). But the anger I felt at the beginning of the consultation, in relation with some of the physician's attitudes, was clearly useful for me in understanding some of clinical ethic's most central challenges. A sustained general self-reflection throughout the

consultation process enabled me to see through the demanding nature of the bioethicist's work to identify my strength and to set goals to improve the quality of my interventions. Ricoeur's concept of *imagination* commands a double obligation: to be conscious of one's own inner world, and to see to its evolution.

CONCLUSION

Adopting a new epistemological perspective poses a significant challenge for the clinician who is a novice in bioethics. I now better understand that my role as a clinical ethicist is no longer always to interact directly with the patient as would the nurse or physician, but to be a discussion facilitator between the situation's key stakeholders (e.g., patients, family, health care professionals, administrators, lawyers) in order to help them choose the best action to take while respecting the criteria of good clinical practice and the patient/family's wishes. The task is not to disown one's past professional experience, but rather to recognise that this new way of being, i.e., as a bioethicist, can and should benefit from the experience and expertise developed as a health care professional. It would be unreasonable (impossible?) to ignore the expertise developed with regards to relational capacity, judgement, analysis, listening and empathetic support, all elements that can clearly contribute to doing good clinical ethics consultations.

By way of Ricoeur's philosophy, I better understand the limits of my initial epistemological perspective (nursing) and so have worked to open myself up to a new perspective (Ricoeur's ethics) that I argue is more appropriate to my role as practicing bioethics. Integrating the "Petite éthique" into one's practice is not easy; it is not an ethics that aims to simplify a situation's complexity, but instead demands that one put into perspective all the constituent elements. Ricoeur's ethics requires three obligatory ethical judgement levels (prudential, deontological, reflexive) through which are submitted the actual situation, the rules and the multiple foundations of ethics. Each of these levels constitutes a triad without which ethics cannot exist: the *I* (e.g., medical team members), the *you* (e.g., patient/family) and the *it* (e.g., health care institutions) which interact together, each inspired by their own particular ideals within a specific medical context.

The continual *putting to the test* of these multiple dimensions and realities creates tensions that Ricoeur does not try to neutralize. In the actual ethical consultation, I was obliged to transcend the family/patient's suffering by integrating into my deliberation all the dimensions involved in the situation: contextual (e.g., artificial feeding debate), professional and legal (e.g., the duty to offer treatment as opposed to treatment futility, the availability of economic means as opposed to reasonable treatment success); psychological and existential (e.g., the suffering of the patient/family and medical team, the patient's desires, the sensitivity of each protagonist) along with institutional realities (e.g., values, economic imperatives, politics, mission). This new epistemological perspective is much more than simply an intellectual exercise; it is also a living experience, engaging the bioethicist in a dynamic and continuous calling into (sometimes difficult) question one's vision of reality, values , beliefs and more general attitude towards life and death.

To fully understand Ricoeur's "Petite éthique" poses obvious challenges, and applying it in practical situations poses others which I consider even more demanding. Complexity is certainly the core characteristic of a clinical ethics judgement. It implies for the bioethicist acquiring three competencies essential to clinical ethics practice: 1) *savoir faire* or "Knowing how to do" (e.g., development, implementation and management of a clinical ethics service, analysis, animation, teaching); 2) *savoir* or "Knowing" (e.g., bioethics, law, politics,

institutions); and 3) *savoir être* or "Knowing how to be" (e.g., empathy, ethical sensitivity, compassion, patience, courage, flexibility, integrity, self critique). This observation is in line with the conclusions of the *American Society for Bioethics and Humanities* (ASBH, 1998).[38]

It is surely not a coincidence that Ricoeur refers to practical wisdom as a living tension. Nor should it be surprising that his ethical project relies on maintaining a tension between different dimensions at three ethical levels (reflexive, deontological, prudential) by the means of a discussion between the stakeholders who are dealing with the uncertainties of life. This exercise calls for constant challenges to oneself and the need for courage and excellence, capacities that seem to me totally in step with the profoundly delicate nature of the life and death considerations that are so common in the clinical context, considerations that can significantly alter the life course of fragile patients and their families. Ricoeur's "Petite éthique", I suggest, can be very inspiring and helpful for clinicians who are passing from a clinical (e.g., nursing) epistemological perspective to one that is more appropriate for the clinician-bioethicist.

REFERENCES

[1] Graig D, Winslow GR. When the patient refuses to eat. In: Ford PJD, D.M., ed. *Complex Ethics Consultations: Cases that Haunt Us*. Cambridge: Cambridge University Press, 2008 p.99.

[2] This experience happened at the beginning of a clinical ethics mentorship with a senior clinical ethicist, and took place in three different health care institutions in which I was involved for more than a year and a half.

[3] Ricoeur P. *Soi-même comme un autre*. Éditions du Seuil ed. Paris: Point; 1990

[4] See note 2, Ricoeur 1990.

[5] Doucet H. Faut-il toujours alimenter une personne malade? In: Soigner en centre d'hébergement : repères éthiques. Montréal: Fides; 2008;41-62.

[6] MacDonald H. Relational ethics and advocacy in nursing: literature review. *Journal of Advanced Nursing* 2007;57(2):119-26; Nickel J. Human Rights. In: *Standford Encyclopedia of Philosophy*. Standford: Standford University; 2006.

[7] Ricoeur P. *Réflexion faite : autobiographie intellectuelle*. Éditions Esprit ed. Paris; 1995.

[8] Ricoeur P. *Le Juste 2*. Éditions Esprits ed; 2001; p.88-91.

[9] Bouthillier ME. *Santé publique, réduction des méfaits et travail de proximité: les problèmes éthiques d'intervenants montréalais* [Thesis]. Montreal: Montreal University; 2006; p.56.

[10] See note 6, Ricoeur 1995; p.8.

[11] Qualtere-Burcher P, Qualtere-Burcher P. The just distance: narrativity, singularity, and relationality as the source of a new biomedical principle. Journal of Clinical Ethics 2009;20(4):299-309.

[12] Pedersen KL. Narrated experience from the clinical instructor as “a judge” when giving the nurse student a failing grade for the clinical course -- an analysis based on the text theory of Paul Ricoeur. Nordic Journal of Nursing Research & Clinical Studies / Vordi Norden 2005;25(2):21-5.

[13] Sorlie V, Kihlgren A, Kihlgren M. Meeting ethical challenges in acute nursing care as narrated by registered nurses. Nursing Ethics 2005;12(2):133-42.

[14] Sitvast JE, Abma TA, Widdershoven GAM, Lendemeijer HHG. Photo stories, Ricoeur, and experiences from practice: a hermeneutic dialogue. Advances in Nursing Science 2008;31(3):268-79.

[15] Ricoeur P. Les trois niveaux du jugement médical. In: Le Juste 2. Éditions Esprit ed. Paris; 2001:227-44.

[16] See note 2, Ricoeur 1990; p.202.

[17] See note 7, Ricoeur 2001; p.227.

[18] See note 2, Ricoeur 1990; p.220-222.

[19] See note 2, Ricoeur 1990; p.220-222.

[20] See note 2, Ricoeur 1990; p.264.

[21] See note 7, Ricoeur 2001; p.227.

[22] See note 7, Ricoeur 2001, p.228.

[23]See note 7, Ricoeur 2001, p.229.

[24] See note 7, Ricoeur 2001, p.229.

[25]See note 7, Ricoeur 2001, p.228-229 .

[26] Welchman J, Griener GG. Patient advocacy and professional associations: individual and collective responsibilities. Nursing Ethics 2005;12(3):296-304.

[27] Murphy N, Aquino-Russel C. Nurses Practice Beyond Simple Advocacy to Engage in Relational Narratives: Expanding Opportunities for Persons to Influence the Public Space. The Open Nursing Journal 2008;2:40-7 ; 1. Thacker KS. Nurses' Advocacy Behaviors in End-of-Life Nursing Care. Nursing Ethics 2008;15(2):174-85.

[28] Gadow S. Existential advocacy: philosophical foundations of nursing. In: Spicker SG, S.Editors, ed. Nursing Image and Ideals. New York: Springer publishing; 1980:79-101.

[29] See note 2, Ricoeur 1990; p.312

[30] See note 2, Ricoeur 1990; p.202

[31] Michel J. Paul Ricoeur, une philosophie de l'agir humain. Éditions du Cerf ed. Paris; 2006 ; p.318.

[32] See note 2, Ricoeur 1990; p.206

[33] See note 10, Bouthillier; p.71

[34] See note 2, Ricoeur 1990, p.318

[35] Ford PJD, D.M. Complex Ethics Consultations. Paul J. Ford and Denise M. Dudzinski ed. Cambridge: Cambridge University Press; 2008.

[36] See note 2, Ricoeur 1990; p.334

[37] Keating B. L'alimentation et l'hydratation artificielles des patients en état végétatif permanent: la discussion américaine et les interventions romaines récentes. Laval théologique et philosophique 2008;64(2):485-525.

[38] American Society for Bioethics and Humanities [ASBH] (1998), *Core Competencies for Health Care Ethics Consultation*. [online]. http://www.asbh.org/publications/core.html (Consulted March 12 th, 2009)