Monological versus dialogical consciousness
- two epistemological views on the use of theory in clinical ethical practice.

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**Abstract**

In this paper, we argue that a critical examination of epistemological and anthropological presuppositions might lead to a more fruitful use of theory in clinical-ethical practice. We differentiate between two views of conceptualizing ethics, referring to Charles Taylors’ two epistemological models: “monological” versus “dialogical consciousness”. We show that the conception of ethics in the model of “dialogical consciousness” is radically different from the classical understanding of ethics in the model of “monological consciousness”. To come to accountable moral judgments, ethics cannot be conceptualized as an individual enterprise, but has to be seen as a practical endeavor embedded in social interactions within which moral understandings are being negotiated. This view has specific implications for the nature and the role of ethical theory. Theory is not created in the individual mind of the ethicist; the use of theory is part of a joint learning process and embedded in a cultural context and social history. Theory is based upon practice, and serves practical purposes. Thus, clinical ethics support is both practical and theoretical.

**Introduction**

In this article we want to suggest that the way we approach clinical ethical problems in practice and the way we try to come to ethically justifiable solutions depend on the epistemological and anthropological premises from which we start. An indication for this is that many currently accepted common ‘standards’ of clinical ethics are interpreted differently in practice. We give some examples. In the first place, most clinical ethicists today believe that the role of the clinical ethicist in clinical ethics support (CES) should be that of a ‘facilitator’. But does this include heading towards a substantial recommendation at the end of a CES or acting as a mediator and leaving the judgment to the participants? Should a clinical ethicist claim the role of expert or rather not? Another example: it is usually seen as part of good practice to include – if possible – all persons that are involved in the ethical problem in the ethical deliberation during CES. But if this is done, the participants might either be included as ‘clients’ who ask for advice, or as active participants who work together on what they believe is morally right.

A third example regards the function of theory within clinical ethical justification: The well-known debate within bioethics about the so-called ‘applied ethics model’ has resulted in the conclusion that theory cannot be imposed upon practical moral issues in a simple deductive way. In fact, today few bioethicists still defend a strict ‘top-down’ model of moral justification; most adhere to some sort of ‘reflective equilibrium’. But reaching a ‘reflective equilibrium’ in practice can be done in different ways. Many bioethicists regard the balancing process as the act of the ethicist, combining considered moral judgments and theories in a detached way. Yet, bioethical approaches such as hermeneutics, phenomenology, feminism and social constructivism argue that ‘considered moral judgments’ should not be taken as given and that finding a balance should not be seen as an individual achievement, but as a social process in which people influence one another. Bioethical judgments should be aware of and do justice to the performative conditions of language, embodiment, and the subtle inequalities underlying social realities (Abma, Molewijk and Widdershoven 2010; Lindemann, Verkerk and Walker 2009; Agich 2005; Chambers 1999).

We believe that the topic of this ‘Bioethics’ issue, i.e. the function of ethical theories in the process of CES, might be addressed in a more fruitful way, if we first clarify the epistemological and anthropological grounds of our practicing of ethics. Our assumption is that epistemological and anthropological presuppositions entail a specific idea about what ethics is, what it can achieve and how it should be enrolled. This basic idea on ethics is operative in our way of practicing CES. These presuppositions are not specific bioethical theories, but basic assumptions, which inform the way in which we see the world and act in it. In fact, we believe that the presupposition of the way of working in clinical ethics practice are more important than the theories used; these presuppositions lead to different ways of using theories, based on different epistemological and anthropological grounds – leading to different results.
In this article, we will differentiate between two models of conceptualizing ethics (For a discussion of other epistemological approaches to bioethics see: C. Viallora 2006). We refer for this to the writings of Charles Taylor who differentiates between two epistemological models: that of “monological consciousness” and that of “dialogical consciousness” (Taylor 1999). We will elaborate how these models vary in their anthropological and epistemological premises. We will show that the distinction between these premises is especially relevant for the practice of CES as it shows not only how differently we can define the function of theory in the resolution of a clinical ethics case, but also what we believe clinical ethics support can achieve, how we view the role of the professional ethicist, and how we organize the process of deliberation. Based on this we will draw conclusions for the role of ethical theory in CES, referring to John Dewey’s idea of moral inquiry that shares some fundamental premises with the dialogical model.

Taylor’s two models

Margaret Urban Walker holds that many of the current ethical approaches belong to a model of thinking about ethics that,
prescribes the representation of morality as a compact, propositionally codifiable, impersonally action-guiding code with an agent, or as a compact set of law-like propositions that ‘explain’ the moral behavior of a well-formed moral agent [...] by ‘explaining’ what should happen (Walker 2007, p. 8).

Ethics in this sense is thought to be an “internal guidance system of an agent”. This kind of conception of the nature of ethics is based on anthropological and epistemological pre-understandings that belong to modern thought. In modern thought, the moral subject is thought to be an individual, singular self that is responsible for arriving at objective judgments through the right use of his rational capacities by representing his own experience about the world to himself. In various writings, Charles Taylor refers to this anthropological and epistemological concept of modernity as the ideal of “monological consciousness” (Taylor 1997). Since Descartes and Locke – according to Taylor – knowledge has been understood as the “correct representation of an independent outer reality” (Taylor 1997, p. 3). The central idea in Descartes’ philosophy was to show that the congruence between the ideas in the mind and external events, that would lead to genuine knowledge, cannot simply be expected to happen, but has to come through a reliable method that grants evidence. Certainty is achieved through a proper use of reasoning. For arriving at certainty, the contents of the mind have to be carefully distinguished “both from external reality and from their illusory localizations in the body” (Taylor 1997, p. 5). Through this “reflexive turn” – according to Taylor - the mind becomes the central foundation of certainty, by examining its own ideas “in abstraction from what they represent”, that is on the cost of disconnecting itself from the context and the situation in which one understands.

For Taylor this epistemological model has important anthropological consequences: First, the human subject is conceptualized as being an “inner space”, as a mind that is “ideally disengaged” (Taylor 1997, p. 8). Man is seen as a free and rational agent distinct from his natural or social world – even from his body, while his contact with the ‘outside’ world takes place “through representations she or he has ‘within’” (Taylor 1999, p. 33). Second, this “punctual view of the self” gives him as the free agent the right to treat the world instrumentally according to his rational understandings. Third, what follows from this is an “atomistic” idea of society, consisting of a cluster of “disengaged first-person-singular selves” (Taylor 1999, p. 33; similarly also in: Taylor 1989).

This epistemic model is, according to Taylor, highly questionable, as it blinds us to the fact that the human existence is structured in a much richer sense. This approach neglects important features of experience, social interrelatedness and embodiment that have distinct implications for our process of understanding and meaning-making. Authors like Hegel, Heidegger, Merleau-Ponty and Wittgenstein have classically argued, that genuine knowledge does not refer to abstract representations, but is based on experience. In stressing the primacy of practical over theoretical knowledge, Heidegger made clear that for being able to come to disengaged descriptions of things, we already have to be engaged in dealing with the world (“being-in-the-world”) (Heidegger 1927). Our representations of things are grounded in an elementary sense in our non-explicit, practical dealings with the world. This practical engagement entails experiential knowledge. This knowledge is not primarily cognitive or conscious, but mostly inarticulate and operative on a bodily level. This explains how we can for example follow a rule (a street sign or a code of behavior) without first having to think which behavior is right. This does not mean that this knowledge is completely free of cognitive or conscious elements. It rather means that practical, embodied knowledge is seen as more fundamental than the abstract way of knowing in the first epistemic model: “Rather than representations being the primary locus of understanding, they are similarly islands in the sea of our unformulated practical grasp on the world” (Taylor 1999, p. 34).

In line with Gadamer, Taylor emphasizes that human consciousness is dialogical in nature as far as it is already always embedded in social practices. Our experiences are meaningful because we are placed in human and cultural relations that teach us how to understand and value the things we relate to. Knowledge is never a priori, but emerges primarily through dialogical processes in social practices.

This second model – which Taylor calls the model of “dialogical consciousness” – has specific anthropological assumptions. The embeddedness in social practices is constitutive for our self-conceptions as “we define ourselves partly in terms of what we come to accept as our appropriate place within dialogical actions” (Taylor 1999, p. 37).
Consequences for ethics, implications for CES

Taylor does not explicitly elaborate what these two epistemic and anthropological models mean for practical ethics, but it can be argued that they entails different views of what ethics is, what it can achieve and how it should be enrolled. In the following we elaborate on the view of ethics in the two models, and show that they lead to various ways of practising CES. This does not mean that the practice of CES is the result of a prior choice for one of the two models. Rather, the models make explicit the assumptions, which underlie various ways of practising CES and are developed in the very practice of CES itself. We will draw upon various authors contributing from different angles to what can be described as dialogical bioethics (Feminist theories have been among the earliest to reason from a dialogical epistemology and anthropology: Tong 1993; Lindemann. 2001; Walker 2007; Scully 2008; Lindemann, Verkerk and Walker 2009; for postmodernism: Chambers 1999; empirical bioethics: Widdershoven, Abma and Molewijk 2009). While the critique on aspects of ‘monological thinking’ is a constant factor in the general bioethics debate, more recently clinical ethicists have developed more explicitly ‘dialogical’ implications for CES (Zaner 1996; Zaner 2000; Agich 2001; Dzur 2002; Molewijk Abma, Stolper and Widdershoven 2008a; Molewijk, Abma, Stolper and Widdershoven 2008b; Kettner 2011).

In the model of “monological consciousness”, the moral subject is thought to be a singular self that is called upon to arrive at objective moral judgments through the right use of his or her rational capacities. As a free and rational agent he can arrive at morally right solutions by consulting his own mind. In clinical ethical practice, this anthropological assumption underlies various claims and procedures which are presented as part of CES: for example the idea that one can ‘solve’ ethical problems, the claim of the ethicist as ‘specialist’ or ‘expert’ or the idea that a single-minded bioethicist (instead of a team of bioethicists or a cooperation between bioethicists and practitioners) is enough to ‘think through’ ethical difficulties in CES. As a necessary consequence of this way of thinking, a bioethicist working (tacitly or deliberatively) from these premises will most likely be inclined to address the persons involved in a case as the givers of information or as receivers of advice, and she or he will endorse a more or less authoritative position towards the participants in CES.

In the monological model, theory is conceptualized as the discovery of necessary truths about the world by the use of reason. In the area of ethics, this implies the assumption that the source of norms lies in independent theoretical reflection that can justify the right course of action. In this model, the aim of ethics is to discover and justify these norms by pure reasoning and to establish an impersonal, code-like system of moral justification that can explain the moral agent what is ethically the most tenable solution to his problem (Walker 1993, p. 33). Ethics is thought to be an autonomous discipline, based on a strong distinction between the critical function of ethical reflection (‘ethics’) on the one hand and its object, the various unreflected moral convictions (‘morality’) on the other hand.

In CES, this leads to the claim to come to an ethically defensible solution by a process of argumentation in which the right course of action is mainly established by a justification through a specific set of norms or a closed system of principles. This relies on the presupposition of a high degree of objectivity on side of the bioethicist provided that he transfers the ethical theory correctly. In such an approach, emotions and experiential accounts of embodiment and the moral understandings linked to those are disregarded or distrusted. They are seen as irrelevant and detrimental for the understanding and justification of what is morally right (Walker 2007).

In this approach, the description of moral problems is representational and abstract, formulating for example ethical issues in predefined structures, as in two, and only two, opposing and contradictory moral solutions to a problem (Grazia 2001) . An epistemological position like this makes the clinical ethicist blind to the fact that the “process of framing” (Agich 2011) or description of a case in CES is not a neutral undertaking. This bears the danger to override other persons’ experiences, moral understanding or modes of decision-making.

One of the reasons, why the monological approach has been so prominent in bioethics might be, because it can easily fit in with a positivistic scientific approach to medicine that relies on specialist knowledge, functional methodologies and a quite abstract idea of embodiment – which is not astonishing as we find similar anthropological and epistemological pre-assumptions, namely those of modernity, underlying monological ethics as positivistic scientific approaches to medicine.

The conception of ethics in the model of “dialogical consciousness” is radically different from the understanding of ethics in the “monological” account. Here the moral agent is seen as embedded in a social web within which he or she comes first and foremost to develop certain moral understandings (Jaegger 2005). The source of moral norms is seen as created within human social activities and interactions, as an interaction between ethical reasoning and context. In this conception, moral theory is not an abstract set of law-like principles, but is itself a “situated discourse”, a culturally specific set of texts and practices produced by individuals and communities in particular places at particular times” (Walker 2009, p. 4). Ethics is understood as a social practice within which communal negotiation about moral dissent and mutual moral learning can happen through a deliberative process in which nobody knows the outcome at the beginning (Molewijk, Abma, Stolper and Widdershoven 2008a; Molewijk, Abma, Stolper and Widdershoven 2008b; also: Zaner 1996 and 2000; Churchill 1999; Dzur 2002; Verkerk and Lindemann 2009). Similar to Taylor, the American pragmatist John Dewey holds that ethics theory can render personal choice more intelligible, but it cannot replace personal moral engagement and decision. Ethical theories simply do not offer a “table of commandments in a catechism in which the answers are as definite as are the questions which are asked” (Dewey 1985, p. 166).

In the monological model, CES is thought to be an intervention that aims at elaborating an ethically justifiable solution of the moral problem. In the dialogical model, instead, CES is thought to be a reflective practice that strives at a process of mutual
moral learning by coming to an understanding and resolution for the specific situation. This difference in the conceptualization of the ethical tasks in CES reflects in the way the task of ‘facilitating’ can be understood: While the monological approach will tend to see the role of the bioethicist in ‘facilitating’ the solution to a moral conflict by analyzing and justifying objective ethical arguments, conveying expertise, and recommending, ‘facilitating’ in the dialogical model means to enable the participants to engage in a reflective process of discovery of what is morally right and justifiable in the specific situation, supported by the ethicists in reflecting upon experiences and finding out what is important in the situation, combining their own moral insights with their knowledge of the wider normative frame in which they live. In this model the ethicist does not take the role of an “expert of ethics”, but the role of a “scholar” (Verkerk and Lindemann 2009, p. 246), investigating the issues at stake together with the participants in a case (see Ohnsorge and Widdershoven 2011; Steinkamp, Gordijn and ten Have 2008).

In the dialogical model, a bioethicists will acknowledge that persons are equipped with their own practical knowledge that comes from their practical involvement (Abma, Molewijk and Widdershoven 2010) and will strive not only to activate that knowledge and its implicit values, but also to investigate and respect the specific ways of decision making that go along with it.

In this approach, ethical problems are thought to be inevitably situated and structured by the implications of interpersonal interactions, the semantic, institutional and political context, socially structured meanings and pre-understandings. The dialogical approach is aware that the structure of an ethical problem cannot be disconnected from its performative context (Chambers 2009).

Bioethicists reasoning from the model of “dialogical consciousness” will be sensitive for and take into account that clinical ethical problems are conditioned by differences in gender, culture or embodiment. Disabled or ill persons might interpret the world and argue in a way that differs from so-called ‘non-disabled’ or ‘healthy people’ (Frank 1995; Scully 2008). Likewise, the professional socialization in the context of the clinic will influence the moral sensitivities and argument of physicians, nurses, hospital managers or of the employed bioethicist etc. In the course of CES, especially in case of misunderstanding or conflict, these specific moral sensitivities and ways of argumentation should be recognized and addressed.

From a dialogical perspective, our knowledge is only partly present to us through the intellectual use of language and representation, as it is stored in the memory on the bodily level where it functions as a pre-reflective background of meaning. The acknowledgement of these epistemic limits of morality leads to a more reflexive and humble approach in clinical ethics (Scully 2008).

In this model, connecting ethical principles or norms with specific moral situations is not assumed to be neutral or disinterested. Reasoning about practical situations is considered to be situated within “a thick tissue of perceptions and interpretations; these are fed by diverse skills and rooted in varied habits of thought and feeling. Moral competence is thus not reducible to a code-like decision instrument (much less an algorithmic one) any more than carpentry is reducible to a saw” (Walker 1993, p. 34). Situations of ethical difficulty in CES not only contain definable ‘ethical problems’, but also ethically relevant issues that derive from the involvement in the interactions in which these problems are located (Zaner 1999). Being aware of these influences during a CES intervention will influence which questions are asked to the participants about their moral concerns, which roles and responsibilities are attributed during the process of moral deliberation as well as in the plan for the resolution of the moral problem.

Case

To make clear what this means in practice, we want to present a hypothetical case example that will be familiar to ethicists and clinicians. We will illustrate how the case might have been approached differently from a monological and a dialogical perspective.

Our hypothetical reconstruction is based on our own experiences with both models in practice and on the relevant literature. We also use information and insights from helping teams with similar cases.

A renal patient, an elderly widow, has had problems with his health for quite some time, and dialysis is becoming ever more difficult. The doctors have spoken with him about the prospects concerning the use of dialysis in the near future. They discussed with him burdens and benefits and explained that dialysis will become less beneficial, so that stopping (and dying) will become an ever more real option. After giving this information to the patient, they made clear that it is up to him to decide. During the following dialysis session, the patient asks the nurse to stop. The nurse calls the attending physician in. He talks to the patient, but is unsure about his current position. Has he made the decision to stop treatment, or is he just exhausted? The patient repeats that he cannot stand it any longer. The health care team is unsure what to do: should they end the dialysis or not?

An ethicist working from monological presuppositions, in this case would typically listen to the concerns of the patient and the health care team. She would gather information and analyze personal values and contexts. As a ‘facilitator’ she would head the moral discussion asking structured questions (maybe following a check-list) that aim at an analysis of the moral arguments and come to a solid conclusion.

A monological approach would not only entail a specific interaction with the participants; it would also lead to a specific focus of analysis. Relevant points would be: continuation of dialysis will not help, and will add hardly to quantity, and certainly not to quality of life; the patient has recently been informed about this; he had not yet decided to stop (he has come for this treatment), but during treatment the discomfort becomes great, and in his eyes no longer outweighs the benefits (this is of course influenced by the direct feelings of pain, but nevertheless seems reasonable, given that the dialysis will not result in preventing him from dying soon); he expresses his wish to
stop undergoing the dialysis in a consistent way. For the bioethicist who has to give advice this all would tend to lead to the same conclusion: end now. This a) is in line with the few gains of treatment, b) prevents unnecessary suffering and discomfort, c) is in line with what the patient continuously expresses as his wish, after having been informed. The ethicist would therefore very likely give the substantial recommendation to respect the patients’ wishes at this point and stop the treatment.

An ethicist approaching the case from a dialogical perspective would not aim at giving substantial advice. She would rather aim at a practical resolution of this situation by initiating a process of joint moral learning that fosters understanding and moral insight. As a ‘facilitator’ she would enable the participants to formulate for themselves what they hold ethically right in this situation. She would help the patient and the health care team to express their moral concerns and emotions in front of each other. She would carefully address the patient, inviting him to take part in the deliberation, and help to express his emotions, concerns and reasons that motivate his statement. The ethicist would then support the participants to become aware of their own personal or professional values and moral understandings. In becoming aware of their own moral position and by listening to the experience of others, the participants would be enabled to reflect on their experiences and find out what is ethically right. Besides the focus on the content, the ethicist would also pay attention to ethically relevant issues that derive from the interactions in which the problem is located: Who is (more frequently than others) encouraged to speak up, who among the participants has access to what kind of knowledge and who has not, in which way hierarchies between health care workers influence the description of the case, how the subtle interactions between participants structure the understanding of what is at stake or what is right (unspoken prejudice, (un)familiarity between parties, conflicts on other issues etc.), how professional or institutional aspects influence what is said or argued for - all this has a decisive influence on what is understood as an ethical problem and what kind of resolutions are brought forward (Agich 2005).

During the deliberation, the participants would implicitly or explicitly refer to social norms or moral principles. The ethicist would help them to understand and apply these to the situation, and might also introduce other norms or principles, which they had not yet considered. Through this process, the personal arguments would develop a more general ethical character. The patient, the physician and the nurse would then be encouraged to make explicit their own moral point of view and situate it within the existing societal norms, critically investigating their relevance for the situation at hand.

From a dialogical view, the focus would be on understanding the tensions involved in the decision, both for the patient and for the team. Unlike in the monological approach, it would be acknowledged that there is no ultimately right decision. Whatever is decided, might involve costs (a tragedy in the sense of Nussbaum) (Abma, Molewijk and Widdershoven 2010). Thus, the dilemma cannot be solved without some feelings of limitation. Yet, a decision has to be made. Stopping would be motivated by the need to end suffering, and in line with the general conclusion drawn in the team before and discussed with the patient, that at some point in the near future, dialysis would not work anymore. The cost of stopping immediately would be that the decision would be instant, responding to the crisis and the pain of the patient. Continuing would give the patient and the team extra time to reflect and to reconsider the situation and finally decide at a more relaxed moment. The cost would be that the patient and the team might experience this as being urged to reconsider and maybe restate a decision, which actually had been made already, and which thus would be needlessly postponed.

What if the case would have been presented in retrospect to the ethicist? We continue our hypothetical case presentation, to illustrate what a dialogical approach would look like.

Let’s assume that the decision to continue dialysis would have been taken by the team before contacting the ethicist, but the clinical team then later sought reassurance from the clinical ethicist. They now would want to know whether that had been the ethically right decision. They urge the ethicist to provide an answer to that. Was their decision the right one, or should they have ended treatment, given the insistence of the patient? In this way the team positions the ethicist into a monological position: give us the right arguments and the right solution, so that we (in retrospect) know whether we acted in a good or a bad way. Using a dialogical approach the ethicist would not answer this question right away and give an expert opinion, but would respond by inviting the participants to reflect on what had made the decision difficult, and to make explicit the values of the patient and their own values. Was their hesitance about stopping the dialysis based, not on the idea that dialysis would be beneficial, but on their conviction that a decision with such large consequences required an active commitment of the patient and should, if possible, not be made under conditions of time pressure? Although continuing dialysis would have had no use in terms of future health, it would have enabled the patient to recover and to discuss the issue of stopping later in a more open and less stressful way. In encouraging such reflection the ethicist facilitates the development of insight on the part of the team into their own values and the complex nature of the decision they made thus diminishing the need for hearing the expert opinion of the ethicist.

With this example we want to show that different epistemologies and anthropologies will lead to different approaches in practicing CES. Even if the monological account will not be practiced to the extent that Arthur Caplan long ago called the “engineering model” (Caplan 1982) of practicing clinical ethics, we find many practitioners of CES whose attitude will be more that of an expert advisor than of a scholar investigating the case together with the participants. The two approaches differ in their fundamental idea of ethics. In consequence, they come to a different understanding about the aim of CES, about its expected results (ethical advice versus moral learning), but also about the function of ethical theory during the process of deliberation (see next chapter), about the way to achieve ethical justification in CES, about the role of participants, the role of the ethicist and about what it means to ‘facilitate’.

Chapter 2

Monological versus dialogical consciousness
The role of theory in CES practice

If – following Taylor – the source of moral norms is seen as created within human social activities and interactions, as an interaction between ethical reasoning and context, then moral theory cannot be an abstract set of law-like principles, but is itself a ‘situated discourse’. What does this mean for the role of theory in CES? Can theory help the participants to understand their situation and to examine it in a critical way?

From a dialogical perspective, the role of theory in CES is to provide standpoints and methods that enable the participants in a clinical ethics deliberation to understand their experiences, to make explicit their normative positions, to evaluate them in the light of values, virtues or norms that are relevant in the wider frame of social realities in which the participants live, and to find out what is good or bad in the concrete situation. Instead of deducing from theories what constitutes the ‘the’ ethically tenable course of action, this approach makes theory a critical instrument with a tool-like, serving function, that is definitely necessary for a processes of ethical reflection and moral justification in front of others, not in the sense of having the final word, but as an aid for making situations of ethical difficulty more intelligible and ethical argumentation more coherent. The view on theory based on Taylor’s ‘dialogical consciousness’ comes close to John Dewey’s idea of ethics as experimental inquiry. Dewey shares with dialogical thinking not only the idea of the centrality of experience, perspectivism and moral diversity, but recognizes the social situatedness of moral inquiry and criticizes approaches that draw on theories “like a mathematical formula” and “think of moral as confined, boxed, within around of duties and sphere of values which are fixed and final” (Dewey 1985, p. 283).

In line with what John Dewey formulated for practical ethics in general (Dewey 1985, p. 166), we believe that ethical theories in the work of CES have the important function to help

1. the participants to better understand their particular moral problem by placing it in a more generalized context;
2. to make visible particular aspects of the moral problem, but also of the interaction, communication, and engagement that contribute in a wider sense to the situation of moral concern and have to be reflected upon;
3. to propose possibilities for models of argumentation and justification as they have been used in other times and places that might help the participants to render their argumentation more consistent;
4. to point out aspects in the argumentation or in clinical practice that might have been overlooked and to suggest alternatives.
5. to increase self-reflexivity of ethical support by considering its own preconditions of moral reasoning.

In order to make this more concrete, let us turn to the role of theory in the two hypothetical approaches in the case example. The role of theory in the monological approach would be to justify the decision: beneficence, non-maleficence and autonomy could be used to support the aforementioned points a)–c). In the dialogical approach, hermeneutic theory would be relevant, for instance in helping to clarify the notions of tragedy and productivity of time. But also ethical theory could be used, including concepts such as autonomy or responsibility and the notion of a good death. These concepts could help during the process of deliberation, not by providing clear-cut answers, but by opening space for investigation. Which notion of autonomy fits best with the situation? Is it autonomy as a right (to end treatment), or autonomy as an ideal (focusing on the ability to live one’s own life, until death)? These concepts are not merely a product of philosophy; they are actually at work in contemporary healthcare and in western society. This is in line with Dewey’s idea that ethical concepts are historical and contextual. Reasoning in this approach might open space for – as Dewey says – the discovery of unconventional resolutions (Dewey 1985, p. 281). Thus, theory might help the participants to understand the ambiguities and ambivalences involved in stopping the dialysis, and might show a way out of the problem, not by solving it in the best logical way, but by considering the complexity of the situation, including the tensions and emotions involved.

If moral theory is seen as a cultural phenomenon, in which social and cultural beliefs are sedimented, it cannot be the ultimate foundation of moral justification. Justification is an interpretive enterprise that is relative to the context and requires a finely tuned judgment and careful balancing between practical moral understandings and more general ethical norms. Bridging this “phronetic gap” (Taylor 1999, p. 41) between more general norms and what they imply in a certain situation requires the practical virtue of phronesis (Molewijk, Abma, Stolper and Widdershoven 2008a). This does not pave the way for a total relativism. Or, as John Dewey has argued, “it is stupid to suppose that this signifies that all moral principles are so relative to a particular state of society that they have no binding force in any social condition. The obligation is to discover what principles are relevant to our own social institution, culture, and scientific knowledge. Since this social condition is a fact, the principles, which are related to it, are real and significant...” (Dewey 1985, p. 283).

This does not diminish the critical power of normative arguments regarding specific moral claims. Although total transparency is impossible, normative positions can be put under critique. Actually, critique is the core of dialogue as it happens for example in the practice of CES. In a dialogue, the participants in a clinical ethical deliberation do not simply take over views; they only agree if they are truly convinced (Gadamer 1960). Thus, the process of changing one’s views is itself critical. Gadamer argues that the opposition to being part of a shared language and a social tradition and being critical is mistaken (1960). Every critical act presupposes certain preconscious understandings; in the area of ethics, critique is usually based upon emotions such as feelings of injustice, moral discomfort or even anger. In the process of CES, these feelings are often the starting point to establish what the participants hold as morally problematic. For this reason, these feelings do not preclude reflection; they can and should be investi-
gated in processes of CES. Moreover, Gadamer argues, continuing a social and linguistic tradition, for example a certain established clinical practices (i.e. to apply a clinical protocol when or when not to start artificial respiratory support), is itself an act of critical appraisal. Taking up this practice is not the same as following it blindly; it implies a process of judgment about which parts of the practice are relevant for the present situation, and in what sense they are relevant. This requires a form of practical knowledge, which Aristotle has called *phantón*.

Being aware of the fundamental role of embodied, preconscious processes in understanding also enables being critical of such processes. Again, this does not mean that the unconscious becomes fully transparent and judged from an external standpoint of reason. Yet, participants in CES practice are able to investigate for example emotions and examine them critically. In such a process of examination, emotions are not discarded; the focus is on establishing whether they are adequate, whether they are for example not too much or too little. In practice of CES this means to enable participants to see what is suitable and to address each other about this. Thus, a critique of emotions and presuppositions is inherent in social processes of negotiation.

**Conclusions**

Current discussions in clinical ethics about using a ‘top down’ or ‘bottom up model’, about being ‘more sensitive to context’, or about ‘taking into account perspectives’ of all people involved, require reflection upon epistemological and anthropological presuppositions. This may give rise to a new view on the moral agent, the way moral knowledge comes about, and what ethics can contribute to situations of moral concern.

The conception of ethics in the model of “dialogical consciousness” is radically different from the understanding of ethics in the model of “monological consciousness”. Ethics is understood as a social practice within which mutual moral learning can happen through a deliberative process in which nobody knows the outcome at the beginning. This view has specific implications for the nature and the role of ethical theory. Theory is not created in the individual mind of the ethicist; it is a cultural phenomenon with a specific social history and can be used to foster understanding of a specific situation. The model of ‘dialogical consciousness’ does not regard theory as providing decisive criteria for solving problems in practice, but as an instrument, which may help participants in practice to elaborate their concerns and come to a shared understanding of the situation. This instrument is based upon social and historical processes of understanding and interpretation, and is developed and further refined in application. Theory is based upon practice, and can serve practical purposes. As we elaborated in the case, the use of theory in both models might lead to different substantial judgments on the problem. However, the difference that matters is not in the end-result of judgment, but in a more respectful responsiveness and support of who calls for CES, in more reflexive, but also fairer and more democratic processes, and in a more self-reflective professional practice.

**References**


