

The Familiar Foundation and the Fuller Sense: Ethics Consultation and Narrative

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Abstract

As clinical ethicists and ethics committee members, we strive to create the ideal situation for moral conversation and ethical reflection. Using both the familiar foundation and the fuller sense, the ethicist and ethics committee are aided in participating more fruitfully in a process of resolution. The familiar foundation represents a body of knowledge that ethics consultants and ethics committees should thoroughly understand. In addition, there is a depth of analysis found in the fuller sense, through narrative, that sharpens ethical focus and enables richer understanding of the patient's situation in life.

In using both tools, patients and families are better served than they would be relying on either tool by itself. Stakeholders and their relationships become more clearly assessed and individuals more effectively discover their own legitimate position. This can mean a more thorough representation of moral problems, a deeper understanding of all parties involved, and a greater opportunity to help parties better understand themselves and each other.

This commentary examines ethical expertise and the idea of clinical ethics consulting. The *familiar foundation* and the *fuller sense* are two important tools used in clinical ethics consulting. I will champion the use of both tools for the ethical enterprise and will emphasize that the fuller sense supplements the familiar foundation. In using both tools, patients and families are better served than they would be relying on either tool by itself. The familiar foundation represents a body of knowledge that ethics consultants and ethics committees should thoroughly understand. In addition, there is a depth of analysis found in the fuller sense, through narrative, that sharpens ethical focus and enables richer understanding of the patient's situation in life.

Familiar Foundation

It is of no surprise that the ethical expertise needed for the work of clinical ethicists has been both principle centered and context centered.¹ The knowledge found in the familiar foundation of principle-centered ethical conversation has been instrumental in defining ethical expertise.^{2p657,3p2} This foundation is familiar because it consists of a well-known and well-used core of ethical understanding that depends heavily on theories and principles. The core of this familiar foundation reads like a chapter out of William Frankena's *Ethics*.^{4p12-61} Act-and-rule utilitarianism, act-and-rule deontology, theories of justice,

principles such as autonomy and beneficence, and the use of casuistry all give shape to this familiar foundation. Expert ethical opinion has often been conflated with how well one knows and understands the knowledge that flows from this familiar foundation. An excellent in-depth discussion of ethics expertise can be found in Rasmussen's "An Ethics Expertise for Clinical Ethics Consultation."²

Fuller Sense

In addition to the principle-centered familiar foundation in clinical ethics, there is a knowing that flows from a context-centered fuller sense. The term fuller sense or *sensus plenior* was popularized by biblical scholar Raymond Brown.^{5p92} Brown defines *sensus plenior* or the fuller sense as "that additional, deeper meaning, intended by God but not clearly intended by the human author, which is seen to exist in the words of a biblical text (or group of texts, to even a whole book) when they are studied in light of further revelation or development in the understanding of revelation." In the use of the term fuller sense, one is not to understand the term as a divine communication or a holy path to a singular moral truth that applies to everyone, but as a way to supplement critical questioning and a way of sharpening focus so that ethical conversation and deliberation may be more meaningful. The fuller sense produces a richer understanding about the patient because one has better understood the context of a patient's story by moving deeper into the details of the patient's lived experience and social network. The fuller sense of a patient's story allows the hearer to have a greater understanding of the patient's situation in life.

This deeper sense of the patient's story relies on conceptual coherence, existential meaningfulness, and common human experience.^{6p407-8} The hearer of story draws on personal analogy using this triad and finds in the patient's story *similarities-in-difference*. By analogy, a concept is formed, something is pictured in the hearer's mind, and common roots are mentally acknowledged. There is, in a sense, similarity discovered in variety.

In addition to this similarity in variety, the fuller sense helps the hearer understand how the patient's story can be seen as a metaphor for a particular vision of reality. The hearer passes over from the standpoint of his or her life to the standpoint of the storyteller, finding enrichment and deeper understanding in the process.^{7p243ff}

The context-centered fuller sense of clinical ethics does not need to jettison the familiar foundation. The fuller sense augments the familiar foundation and adds a depth dimension to practicing clinical ethics. The use of both the familiar founda-

tion and the fuller sense emphasizes that the clinical ethicist and the ethics committee do not simply form a repository of institutional morality or become the hospital's conscience. The clinical ethicist and ethics committee gather together as an ethical community to use the knowledge of the familiar foundation and to implement the wisdom of the fuller sense drawn from the patient's narrative. This enables the gathered community of concern,^{8p26-7} including ethicist and ethics committee, to keep open, accessible, and active ethical reflective space where sound and shared processes of deliberation can occur.

The process of deliberation also involves identifying moral understanding that comes from personal narrative. The community of ethicist and ethics committee receives from the narrative the patient's story and patterns of moral thinking. The story forms the tapestry within which morally relevant information can be organized. This calls the listener to polish his/her skills of attention and appreciation. As stories are heard, perceptions are discovered that flow from valuable character traits of the agents found in the story. The wisdom of rich and inclusive life experience of patient story, or narrative, form the concrete reality that give the abstract principles of ethics shape and substance because abstract principles do not decide the cases. The context shapes the vision of the ethical community, the community of concern, to make an ethical recommendation.⁹ Ethical action then flows from a lived social medium that cultivates perceptions to assist the moral agent within the narrative to move toward resolution and produce clarified responsibility along the way. The act, the intent, and the circumstances form the elements of this lived contextual story of the patient narrative, and give texture to the principles of the familiar foundation.

Stories of identity and relationship viewed through this fuller sense shed light upon the ethical consideration and the possible resolution of specific cases. This can show the cost of ethical participation for the parties involved. As Mary Elizabeth Moore stresses, "Narrative can expand the range of our imagination and our courage to act in new directions toward new possibilities."^{10p157}

Narrative can be seen as a helpful tool by showing that certain kinds of things are better or worse for patients from their own perspective. Narrative can also help uncover real-life values and obligations that must be reckoned with. Embedded within narrative lies the answer for how values and obligations can guide patients facing complex problems. Perspectives that form a vehicle for honoring all agents of value in the narrative become expanded. One goes beyond knowing definitions of theories, principles, and concepts to arriving at knowing what they are used for and under what conditions they can help.

The content of a specific patient narrative helps determine ethical responsibilities in the concrete here and now and acts as a tutor for understanding how to use both the familiar foundation and the fuller sense. Consider the case study of the young woman patient presented here.^{11p227-38}

Case Study

A woman, age 34 years, with a long-standing history of alcoholism and alcoholic liver disease was admitted to a local hospital. The patient admits to typically drinking 1½ quarts of

alcohol per day, though for the last few days her father, who often drinks with her, has limited her intake to 2 to 3 glasses of wine per day. One year earlier, she was hospitalized for delirium tremors, alcoholic hepatitis, hemorrhagic gastritis, hemorrhagic duodenitis, and esophageal varices. The patient is divorced and lives with her parents. Her 10-year-old daughter lives with her ex-husband.

The patient was brought to the emergency room by ambulance complaining of vomiting blood. She has had tarry stools for two weeks. The patient's physician of record, when contacted by the emergency medicine physician, states that the patient had been discharged from his practice because of persistent drinking. The patient was admitted to the Intensive Care Unit for transfusion therapy and to control her delirium tremors.

The patient continued to bleed despite transfusion therapy, which itself was complicated because of the patient's rare blood type. The patient was evaluated by a surgeon for possible surgical intervention but it was felt that because of her coagulopathy and poor overall prognosis, the patient would not survive a total gastrectomy.

Initially, when consulted, the patient's mother stated that the patient had expressed the desire not to be mechanically supported, but would consent to surgery if it was a realistic possibility. Wondering, "What if she got better?" the mother resisted a no-code order. Intensive support was therefore continued.

As the patient's bleeding slowed somewhat, the physician followed the family's wishes to have the no-intubation order changed to a full-code order, which would include intubation and mechanical support if necessary. Over a two-day period, the patient became unresponsive and had rapid breathing. Her extremities became bluish. The patient's mother was apprised of her daughter's grim prognosis and told that she was slowly dying. The mother expressed that she still wanted her daughter kept on life support.

The patient stabilized and was transferred to the medical-surgical unit. Her level of alertness improved. She required a paracentesis whereby one liter of fluid was removed. Although she had no further exsanguination, she continued to slowly bleed. Her hepatic function continued to deteriorate. Both parents were again approached and agreed that the patient's status be changed to "no code."

The case was initially brought to the hospital ethics committee by a participating physician who sought guidance with respect to discontinuing treatment. In his view, further treatment, specifically transfusions, would be nonbeneficial. In the course of discussion it became evident that the patient herself had not been consulted because of her perceived questionable mental capacity. After the committee meeting, a psychiatric consultation was obtained and the patient was found to have the mental capacity to make medical treatment decisions on her own behalf. Later that day, the patient stated to her physician and primary nurse that she wanted to

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start all over again, that life was worth living, and that she was “kicking the habit.” After that discussion, the physician rescinded the no-code order. Four days later, the patient began to deteriorate. She had become obtunded and remained unresponsive. An extensive family conference without the patient’s participation was held with the pulmonologist resulting in a unanimous decision to provide only supportive care and comfort measures; no further therapy, including blood transfusions or hyperalimentation would be provided; the patient’s status would be made a no code. The patient’s primary nurse, disturbed by the change in therapeutic plan, brought the case back to the hospital ethics committee.

Two Ethical Approaches

Two ethical processes are reviewed: one from the familiar foundation and one from both the familiar foundation and the fuller sense. In review number one, the clinical ethicist poses the ethical question for the ethics committee and the committee relies heavily upon the familiar foundation for their analysis without any practical commitment to use the fuller sense. The ethical question of review number one takes this form: Does the duty to patient autonomy outweigh a duty to honor the conscientious refusal of the attending physician to provide invasive and intensive measures that may only prolong the dying process?¹²

In answering this question, the bioethics committee felt obligated to honor the patient’s autonomous wishes and believed honoring autonomy was a benefit in itself. This position is grounded in the deep respect for an individual’s right to self-determination and insists that we must honor a patient’s autonomous choice.^{2p657} Although there were burdens associated with this approach (ie, the poor quality of life, therapeutic struggle, and conflict with physician autonomy), the committee remained motivated to offer the following recommendation: temporize and take a wait-and-see approach; attempt care short of offering a liver transplant including a therapeutic trial to include transfusion and hyperalimentation. If the patient makes a remarkable recovery in this trial period, the transplant option could be further discussed.

In review number two, the clinical ethicist relies on the combined insight of both the familiar foundation and the fuller sense in posing the ethical question and assisting the bioethics committee to form a recommendation. The ethical question for this case might be: In alignment with the patient’s previously known wishes and lived values, and to attain the optimum balance of ethical obligation to offer benefit, to prevent harm, and to represent patient autonomy, what is the appropriate treatment plan for his patient in her current clinical context?

In our current situation what ultimately helps in determining what is right or wrong is not solely the patient’s autonomous choice. We must describe how the combination of this case’s situational perspective, combination of grounds for moral judgment, and patient hopes emphasize the way we should form the summation or recommendation for this case. What has been happening in the revealed past for this patient has been the continual offering of second chances while strongly denying the severity of her alcoholic condition. The demands of the pres-

ent situation indicate that the patient has experienced a severe combination of medical trauma that may place her beyond hope of ever recovering healthy hepatic function, of eliminating severe gastrointestinal complications and of reversing her severe hemorrhagic problems (eg, esophageal varices).

Although some medical and ethical authorities would not discount the possibility of this patient receiving a liver transplant, her present condition would deem a transplant extremely extraordinary, likely to fail in prolonging life and to tend toward the “experimental” rather than a treatment of choice. Certainly this would shade toward being less ethically acceptable because of the nature of the circumstances surrounding the patient.

In this case, it is important to discuss how best to honor the dignity of the patient, not completely losing hope for her in her condition while also not subjecting her to extreme measures that would only prolong the dying process without ever coming close to realizing a desirable outcome (ie, some quality of life beyond the hospital doors that would allow her to attempt to overcome her addiction and to “start over” as she commented to her nurse).

As we examine ultimate questions about nature, purpose, and destiny for this patient we must recognize that she never mentioned anything concerning her lived values beyond the comment that life is worth living and that she wanted to “kick the habit.” These ultimate questions could be probed by an appropriate member of the community of concern (eg, chaplain or member of family’s religious affiliation) to help us get in better touch with where the patient sees herself in relation to those questions.

An interesting sphere of justice to examine for this patient would be what an inappropriate “full course of treatment” would look like, with these complications and this case history.

The recommendation presented by ethicist number two and the ethics committee using the fuller sense was similar to the recommendation offered by the ethicist number one and his ethics committee. The temporize, wait-and-see approach with a therapeutic trial to include transfusion and hyperalimentation was offered to the treatment team in hopes of giving the patient some chance to rally without committing to an overzealous treatment plan that might place the patient in a position to suffer beyond the reasonable hope of treatment success. This sensitivity gives honor to the physician’s conscientious refusal to employ nonbeneficial treatment in treating this very ill patient. The option of temporizing with the intention of giving some treatment also gives the community of concern time to separate issues of no-code, intensive care, comfort measure, and moderate invasive treatment.

The final outcome of this case ended in the patient expiring after one week of following the temporize plan that the medical team and family agreed was the wisest and yet most prudent way of dealing with the patient’s situation with dignity and a modicum of hope. As the patient slipped more deeply into a coma the family requested that no heroic measures would be attempted to revive her and she passed away gently in her sleep.³

The ideal situation for moral conversation and a key way to nurture a culture of ethical reflection in clinical medicine is to combine both the familiar foundation and the fuller sense of

the ethical enterprise. With both the familiar foundation and the fuller sense, the ethicist and ethics committee are aided in participating more fruitfully in a process of resolution. Stakeholders and their relationships can become more clearly assessed and individuals become keener in discovering their own legitimate position. This can mean a more thorough representation of moral problems, a deeper understanding of all parties involved, an opportunity to help parties better understand themselves and each other, and a chance to better understand the moral options and the forces that shape them. Using both the familiar foundation and the fuller sense of the ethical enterprise allows us to become those architects of ethical space who empower our patients and clinicians to build enduring consensus. ❖

^a As such a complicated case should include a discussion concerning injustice and a call for responsibility, it should be noted that the committee's deliberation touched these issues. In the patient's final grave medical state and with no known history of psychological counseling or intervention, the best the committee could offer was temporizing with the intention of giving some treatment as the patient's prognosis improved. Dealing with these two issues (injustice and responsibility) was recognized as important but also as a future recommended course of discussion when the patient could possibly benefit from the ramifications of both what would be just for her future and what responsibility was needed for her further total treatment and recovery.

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One Rule

Only one rule in medical ethics need concern you—
that action on your part which best conserves the interests of your patient.

— Martin H Fischer, 1879-1962, German-born American physician and author