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Competence in Mental Health Care: A Hermeneutic Perspective

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In this paper we develop a hermeneutic approach to the concept of competence. Patient competence, according to a hermeneutic approach, is not primarily a matter of being able to reason, but of being able to interpret the world and respond to it. Capacity should then not be seen as theoretical, but as practical. From the perspective of practical rationality, competence and capacity are two sides of the same coin. If a person has the capacity to understand the world and give meaning to the situation, he or she is able to make decisions, and is thus competent. People can fail in the area of practical rationality. They can feel ill at ease, uncomfortable or not at home in the situation. Under such conditions, they appear as incompetent, and urge caregivers to respond in such a way that their competence can be raised. The issue is not how to measure their incompetence, but how to help them to become more competent, that is to get a practical grip on their situation and to be able to live out their lives in such a way that they develop their identity in relations with others. From a hermeneutic point of view, assessing a patient's capacity implies focusing on the patient's way of meaning making and regarding her behavior from the perspective of practical rationality. The focus should not be on the assessment as a matter of fact, but on improving capacity. This requires allowing the patient to experience the world meaningfully and affording her, in the context of a supportive and trustful institutional environment, the possibility of developing a personal narrative where her choices are expressed verbally or non-verbally.

KEY WORDS: competence; hermeneutic ethics; phronèsis.

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INTRODUCTION

Since the 1990s, hermeneutic philosophy has developed many links with medical ethics, especially in the field of the ethics of clinical care. Its contribution is mainly characterized by its critical approach to the traditional epistemological models of medical decision making: it criticizes the ideal context free knowledge of the dominant bioethical paradigm and insists on the context-bound character of interpretative understanding of the meaning of an ethical action and decision (Ten Have and Gordijn, 2001; Steinkamp and Gordijn, 2003:225–226,241–243).

Hermeneutic philosophy from the start sees medicine as an institution in a cultural and historical setting. It makes a considered criticism of moral knowledge that merely repeats the dominant moral style applying it and decreeing it universally valid. Hence, it looks critically at a conception of applied ethics exclusively directed towards helping solve problems placed before us by social or scientific facts: from a hermeneutic perspective, applied ethics is not merely a normative discipline that prescribes, judges and develops principles to justify an action (Caplan, 1983; Leder, 1994), it is an interpretative attempt to understand which action is morally meaningful in a specific clinical situation with regard to the patient's narrative, to the institutional narratives and to the confrontation thereof with a meaningful account of a singular caring project (Mattingly, 1994; Steinkamp and Gordijn, 2003:241–243).

Against this background, many authors have argued that a hermeneutic perspective is particularly well suited to the clinical setting, wherein medical practice is interested in, as Leder points out: "questions of freedom, responsibility, mutual obligation, duty, caring, virtue and vice, the good life, and social justice, as they play out in health care and the biological sciences" (Leder, 1994:253). In this setting, a hermeneutic perspective helps to interpret and evoke what is implied in moral experience in health care: it looks at patients, their families and healthcare givers (physicians, nurses and other caregivers) as moral agents having the capacity to deal with the morally relevant aspects of the situation on the basis of their practical knowledge and experience, and it investigates the various meanings of the clinical situation, more particularly what is morally meaningful for all the actors experiencing a particular clinical situation oriented towards helping or healing. This approach fosters healthcare providers to be sensitive to the multiple contexts—personal, social, political—within which a helping or healing story unfolds and to the normative discourses that provide the frameworks of this story. It thus helps to bring various perspectives into contact with one another and to create a space in which they can merge so that new views and new practices can be developed (Widdershoven, 1999; Benaroyo, 2000).

These contributions of the hermeneutic approach to clinical ethics imply a specific way of looking at cases (Leder, 1994). From a hermeneutic perspective, a case is a narrative that gives insight into the moral experiences of people in a practice. Hermeneutic interpretation focuses upon the meaning of the story. The

role of the interpreter is to make explicit the experiences of the participants and to create a space for mutual interaction and dialogue (Poirier and Brauner, 1988). Along this view, hermeneutics presupposes that participants in a practice are able to discern what is morally relevant and to know how to deal with such issues. It entails a specific conception of the moral capacity of caregivers. It also entails theoretical notions relating to the capacity of the care-receiver. Hermeneutic ethics thus enables us to develop a specific concept of the patient's competence—namely the moral capacities of the person receiving care—as evaluated by the caregivers.

In this paper we will focus on a hermeneutic approach to the concept of the patient's competence. We will argue that competence should be regarded as a form of practical reasoning. Our argument will show that patient competence can be understood as correlative to the capacity of the caregivers. After this theoretical part, we will discuss two cases. Our aim is to show that a hermeneutic approach can throw new light on concrete cases by making explicit moral experiences and can help participants to develop new ways of dealing with the situation.

MORAL COMPETENCE AS PRACTICAL UNDERSTANDING

From a hermeneutic perspective, health care is a context-bound moral practice which is, as Brody points out: " in tension between remaining true to its historical roots and traditions and trying to respond sensitively and effectively to the changing values and needs of a society in which it is practiced" (Brody, 1992). Medicine is a practice of care, and as such it aims, as Tronto states, to "maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web." (Tronto, 1993:103).

In this view, medicine aims at restoring or improving—firstly at a personal level—the patient's wounded humanity, responding to the patient's call for being delivered from the burden of suffering. The ethical core of the patient-physician encounter is conceived as an alliance, a caring pact based on mutual trust: both physician and patient are united to fight against disease to relieve suffering (Pellegrino and Thomasma, 1981, 1982, 1988). To approximate the *telos* of medicine the healer's clinical judgment is based on *phronèsis*—the capacity, in a given set of circumstances, to discern what course of action is most conductive to the good of the patient in his institutional and social contexts (Pellegrino and Thomasma, 1993). *Phronèsis* then is first basically oriented towards understanding to what extent the patient's own way of experiencing the illness is lived as an assault of his or her sense of self-worth. Understanding of the patient's situation in its institutional and social context requires then effort and care, imagination and perceptiveness, which are related to the healer's pathos of opening him or herself to what he or she seeks to understand. Understanding the meaning of the patient's experience in context is an interpretative process taking place in the realm of a dialogue. What

elicits understanding is the healer's inclination toward the resolution of the tension between strangeness and familiarity by finding or creating a common belongingness between the healer, the patient and their common meaningful environment. To this end, understanding calls upon the healer's capacity to allow the patient's suffering to speak to him or her and then to balance this suffering with the contextual circumstances (Benaroyo, 2000:229–231).

By referring to the Aristotelian notion of *phronèsis*, the clinical-hermeneutic approach we suggest, following Gadamer's work (Gadamer, 1990), focuses on the practical nature of moral knowledge. Moral knowledge is not primarily theoretical, it is the ability to know what is good in a practical way. Moral knowledge is based upon practical training. It is rooted in one's life and one's body. The ability to care for another person requires a kind of knowledge that shows itself in having right attitudes, adequate emotions and responses to the needs of the other as well as to the needs of society. One has to feel at home in the situation, knowing without prior reflection what is the right way to act.

This Aristotelian conception of moral capacity or competence is also applicable, in our view, to the care-receiver. Patient competence, according to a hermeneutic approach, is not primarily a matter of being able to reason, but of being able to interpret the world and respond to it. Capacity should then not be seen as theoretical, but as practical. From the perspective of practical rationality, competence and capacity are two sides of the same coin. If a person has the capacity to understand the world and give meaning to the situation, he or she is able to make decision, and is thus competent. People are competent if they know how to find their way around in the world, if they can orient themselves in such a way that they know what to do. This feeling of belonging and practical orientation in the world is put under pressure when a person becomes ill or disabled. Yet it can be restored, in that new balances are found. Capacity is related to the concrete situation. A prerequisite for being competent is that one feels at home in the situation. Competence can be furthered by making people feel comfortable. This can be done by adjusting the situation to the person. It can also be realised by empowering the person, inviting or urging her to act in such a way that she learns how to find her way around. Since practical knowledge is based upon traditional ways of dealing with the situation, competence can be fostered by offering people a tradition in which they can live and which can help them to interpret the situation. This implies a process of learning. The issue is not so much how to *assess* capacity, but how to *develop* it through interaction and dialogue.

A possible objection against this approach of competence might be that it becomes difficult to distinguish between competent and incompetent patients. Is not every patient in some sense able to make meaning, and therefore competent? On the one hand, we acknowledge that there is no simple and clear-cut distinction between competence and incompetence. Meaning making may be possible even in cases where there is little or no consciousness left, for instance in the extreme situation of very demented patients. Their physical expressions can be regarded

as elements of meaning-making, which should be taken into account. Tests which focus on cognitive capacities are too crude to do justice to the actual way in which people live their lives. On the other hand, it is very well possible to distinguish between behaviour that is adequate given the situation and behaviour that is not. People can fail in the area of practical rationality. They can feel ill at ease, uncomfortable or not at home in the situation. Under such conditions, they appear as incompetent, and urge caregivers to respond in such a way that their competence can be raised. The issue is not how to measure their incompetence, but how to help them to become more competent, that is to get a practical grip on their situation and to be able to live out their lives in such a way that they develop their identity in relations with others.

In the bioethical debate, the notion of competence is related to the question whether or not the caregiver is allowed to neglect the patient's views and to take over the decision. If a patient does not want to come out of bed, this should be respected if the patient is competent; is the patient incompetent, than the wishes may be overruled. From a hermeneutic perspective, the distinction between competence and incompetence is likewise relevant for the actions of caregivers. If the wish to stay in bed shows practical rationality, a prudent caregiver will more easily accept it; if it appears to lack practical rationality, an experienced caregiver will be inclined to try and persuade the patient. The process of trying to find the right answer to the patient's refusal is essentially driven by the question what the patient's behavior means in the specific situation and what reactions of the caregivers are adequate. Why does she refuse? What is bothering her? Why is the refusal problematic for the caregivers? Can the situation be changed so that coming out of bed is more attractive to her? Or should the caregivers change their views, and stop being demanding and overprotective? Can a solution be found in which the perspective of the patient and that of the caregivers can be merged, so that both parties are satisfied? (Widdershoven, 1999) If such a solution can be reached, the competence of both patient and caregivers is fostered, in that both are able to deal with the situation in a better way.

The example shows that a judgment of competence involves an assessment of whether or not the behavior is appropriate in the concrete situation. It does not suffice to determine whether the person is able to reason; the focus is on whether she can act in a right way. Some people are able to reason perfectly well, but one may doubt the practical rationality of their actions (see the examples of patients suffering from anorexia nervosa (Tan, 2003 and Tan and Fegert in this issue)). Other people are not able to sketch all the consequences of their actions when asked, but nevertheless show a great ability to know what to do when confronted with a specific practical situation (for example a demented patient who refuses to be pushed into the dining room, but responds positively when invited to come to dinner) (cf. Moody, 1992). The latter example show that a judgment of (in)competence requires certain views of what is (in)correct. To resist being pushed and to accept invitations can be seen as indications of practical rationality,

whereas the opposite behavior (to accept to be pushed and to resist invitations) is normally not the right kind of action. This raises the question how to decide what is correct and what not. Following Aristotle, a hermeneutic approach will stress that in practical matters only experienced people can determine what is right and what is wrong. There is no absolute standard in the area of practical rationality, since human action and human morality are historical. It should be noted, however, that other approaches to competence also have to deal with the problem of finding standards. The MacCAT-T raises the question what score is sufficient for declaring a person competent. Here, an absolute standard is also missing. Unlike the MacCAT-T, a hermeneutic approach explicitly acknowledges that establishing whether a person is competent requires that the evaluator is competent (in the sense of practical rationality) herself.

A HERMENEUTIC APPROACH TO CASES IN HEALTH CARE

Given the emphasis which hermeneutics puts on the moral experiences of participants in a practice, cases can be seen as stories which present such experiences. Cases show how people try to make sense of the situation they are engaged in, by responding to each other's needs and developing ways of dealing with them. Case descriptions should be seen in the context of a caring practice, in which the participants use their moral knowledge, take up and attribute responsibilities. A case is not just a puzzle; it contains genuine concerns of people taking part in a practice of care. Commentaries on a case should make explicit moral experiences of the participants as part of a joint enterprise of healing. Against this background, a hermeneutic approach of a case should meet, in our view, the following prerequisites.

(1) When unfolded in the clinical context, a hermeneutic approach should be integrated in a philosophy of medical practice as a practice of healing and care, requiring a specific kind of moral understanding from the participants. Hermeneutics opens the horizon of this understanding and may furthermore help to ameliorate the patient's state of wounded humanity in his particular social and institutional context.
(2) A hermeneutic approach should endeavor to understand what the moral experience of vulnerability and appeal to assistance really means in a particular case, in the realm of a trust-based transpersonal understanding of the existential normative meaning of the patient's complaint.
(3) A hermeneutic approach should strive to understand the moral rules of the institutions in which the patient evolves, namely the normative institutional context that challenges the individual healing and/or caring project. The development of these rules themselves is seen as a practical process of applying them to the concrete situation. Rules are not pre-given, but are developed and refined in practice.

(4) A hermeneutic approach should endeavor to understand which healing and caring project may be elicited in the particular case and context - and describe how this project can be implemented in the realm of a clinical judgment articulating the personal and the institutional normative levels of the helping or healing action.
(5) These methodological guidelines entail, as Leder points out, that the commentator of a clinical case who proceeds from a hermeneutic perspective should not be conceived as a person showing what course of action or moral reasoning should be mandated, but as an *articulator* of perspectives, a *facilitator* of dialogue and a *recaller* of contexts and meanings which are usually obscured and hidden (Leder, 1994:255). This awareness helps to evolve towards richer interpretations and explorations of the authority of various discourses and narratives as normative incentives of action.

COMMENTARY ON CASE A

In one of the clinical cases (case A; "Cases," 2004), a hermeneutic approach may help to look at the patient's mental capacity not just as the exercise of an arbitrary power of choice (as defined in the traditional bioethical framework), but as lived out in an attempt to choose well in the context of one's life-story, with its own plot, aims and values. The health care providers can play a crucial role in developing the patient's capacity by helping the ill person to reconstruct meaning in the face of the thread posed by events. In this context intimate relations may enable the person to function meaningfully and intimate associations may mark moral boundaries for capacity.

Focusing attention on this hermeneutic conception of capacity could however be challenging for the health care givers for two reasons. These reasons often present practical obstacles in unfolding the hermeneutic approach we propose in the clinical context. Being aware of these obstacles may help us to highlight how a hermeneutic approach may proceed, in our view, in medical practice.

Firstly, as it usually occurs in case reports, the case is narrated according to the standard medical record. Yet, this standard report does not reflect the patient's story but the physician's relationship with the patient's illness. In this report, the details of the patient's life are essentially those that reflect the methods—and values—of medicine (rather that the patient's values), which emphasize diagnosis and treatment as well as support in the "system" and objectivity of medical science.[4] The case narrative fits the utilitarian purpose assigned by the medical model: find a solution. Moreover, presenting the story in a narrative style that effaces the

[4]The classical medical record is taylored to fit the medical "system" at the sacrifice of some aspects of the patient's presence (and the physician's presence) to the system of medicine. The classical medical case report is thus a symbolic reappropriation of the case narrative (Poirier and Brauner 1988: 5–9).

narrator and abstracts the person of the patient lends an air of anonymity, authority and absoluteness to the events. The language and form of the medical case report allows thus the physician to be unaware of his own feelings and values.

The structure of this medical genre can prevent certain important questions, ethical questions, from being asked for—or even recognized. Thus, the history, physical examination, assessment and plan format used here by house officers does not provide the sorts of information that are actually needed to really know the patient. At the individual level, the health care provider narrates the illness simply in medical terms, he or she presents only one side of the medical truth without sensitivity and undermines thereby the patient's search for meaning and genuine autonomy largely threatened by illness. The patient may then feel disempowered in the face of a foreign jargon, a strange story which, while it makes sense for the doctor, has little to do with the ground of his own life. However, although the patient's story has taken a radically new turn with the malady, it did not thereby cease to be a story; the illness might be read as a call to increase intimacy with others, especially with healthcare givers. The physician should be able to listen here to and support this personal story, tactfully question destructive elements, and in general play the role of a respectful dialogue partner who hears and speaks to the patient's need for narrative. In this way the patient's values may be better understood and orient the healer's assessment towards what makes sense for him in his daily life.

Secondly, medical institutions described here are designed to empower the physician in his classical medical attitude: the medical diagnosis is pronounced, the esoteric terminology used, the treatment options presented, the whole constituting a discourse which draws the patient ever deeper in the institutional context just described. This context may be disempowering for this patient, and in some sense foster an apparent loss of capacity.

The hermeneutic approach we propose could first help to acknowledge and highlight both obstacles. The 87 years old demented patient has certainly lost various abilities to act in the world and so he surely requires more than usual amounts and kinds of support and care than others. From a hermeneutic perspective, however, dependency should not be conceived as implying a loss of autonomy, provided that the caregivers help him to still maintain an adequate range of identification to sustain his own sense of integrity and worth. This presupposes that the caregivers conceive vulnerability as a source of respect requiring, in this case, a genuine medical authority devoid of its powerful dark side. In the concrete case, then, a contextual hermeneutic account of capacity might give way to a new caring narrative that attends to the phenomenon of actual rather than ideal capacity.

Introducing the concept of meaning-making ability in this context might be helpful. Meaning-making ability measures the impact of an illness or an impairment on the individual's ability to engage and interact meaningfully in the social world, rather than focusing on the presence or absence of disease. Meaning-making ability may be maintained even in the face of chronic disease. In this respect

maintaining a sense of autonomous well-being is consistent with dependencies on medication or professional care if those dependencies help to maintain a sense of integrity in the areas of life that a person values. Dependencies do not conflict with capacity if caregivers help this patient to still maintain a sufficiently adequate range of identifications to sustain his own sense of integrity and worth.

In this view, the 87 years patient's choices that may guide the healer to assess his capacity are choices that are meaningful for him and allow him to develop his own residual narrative identity (Agich, 1993). As, in this respect, some sort of capacity is always present, though sometimes submerged from views as individuals go about their daily lives, a hermeneutic understanding of this patient's choices involves appreciating how the patient is interconnected and how he has developed in terms of his singular historical and social circumstances. For instance, in this case it would be very helpful to know the man's life history. What was his profession? Was he still busy after he retired? How was family life? What were his relationships with his wife, with his daughter? Who were his chess play friends, his sport and walking friends? Are they still alive? Is he still in contact with them?

Against this background, conditions that foster or thwart in this case the development and expression of individuality and self may be more significant than the development of explicit conscious choices. We could ask further, what does it mean for him to wander about? How does his wife describe this behavior? What is he looking for? Does the patient have a specific attitude to risks? What does risk mean for him? Should he then be treated with drugs?

Answering these question could perhaps help health care professionals and others to interact with him in such a way that they support the patient's own unique identifications and sense of self or values and help him to develop these further. To this end, a supportive institutional environment is badly needed with a more adequate responsible staffing—or, better, a helping action could ideally proceed in the context of professional home care. Can meaningful options be offered? Can he be helped by playing chess with him or taking him for a walk?

From a hermeneutic perspective, assessing this patient's capacity entails then a personal and institutional commitment to identifying and establishing conditions that encourage him to face the adversity and threats to self inevitable as a result of the disability and illness. Assessing his capacity requires attending to those things with which he can truly and significantly identify, even when identification is difficult to assess. Patients frequently respond, albeit minimally and in deficient ways, to direct contact with caregivers and others.

COMMENTARY ON CASE B

Case B concerns a second case presented for commentary, the case of B.G. She is extremely vulnerable. She feels safe in the hospital, and develops a type of reaction to a possible discharge that effectively blocks the process. By stating

that she will kill herself after being discharged, she suggests that discharge is so dangerous that it should be prevented. As a whole, her situation does improve, but very slowly.

From a hermeneutic perspective, her behavior is not as strange as it may seem. She feels unsafe in the outside world, while the people who should be trustworthy (her mother, the family friend) appear to be untrustworthy. She needs protection, and finds this in the hospital. Her apparent wish to stay in the hospital is (in a very emotional way) rational: it is related to her most vital needs. If she than runs the risk of being discharged, the reaction is again rational: she does all she can to prevent the discharge. In the context of her (experiential) worldview, this is clearly a rational and logical thing to do.

There are several criteria for capacity: being able to make a choice, being able to understand relevant information, being able to evaluate the character of the situation, and being able to handle information rationally. All those criteria apply to the wish to remain in the hospital, not because of her intellectual performance, but because of her emotional worldview. Her wishes are rational, if we apply the notion of practical rationality in the Aristotelian sense.

If the above interpretation is correct, her (experiential) message is: please do not discharge me. This message is different from the verbal expression that she wishes to kill herself at home. There is a discrepancy between the (emotional) message that she wants to stay in the hospital, and the (verbal) message that she is going to end her life. It seems to us that the emotional message needs to be regarded as more genuine, and needs to be respected. The argument for this interpretation is that the emotional message makes more sense, given her life-history, her present worldview and the situation she is in. The emotional response is comparatively more correct than the rational response, looking at the context and the patient's personal history. The emotional message shows that she knows what is important for her, much more than the verbal message does. (We assume that it is not really in her interest to die, that her case is not fit for, for example, euthanasia). She shows much more signs of a "decision to remain safely in the hospital" than of a "decision to kill herself." Her arguments for the first decision are more rational than those for the second. In line with what was mentioned above on criteria of capacity, she has capacity in deciding to want to stay in the hospital, but no capacity in deciding to end her life (not even at the level of "making the choice," because it is quite unclear that she actually has made this choice!). This interpretation is based upon her total life-history. It should be tested in a dialogue going between all parties who know her (the doctor, the nurses, herself, her parents).

Does this mean that her wish to stay in the hospital should be granted for the rest of her life? Not necessarily. As long as she feels safe, she seems to be able to improve, albeit slowly. This process of improvement might lead to a situation in which she is able to leave the hospital (maybe just for a few hours at first). The (experiential) wish to stay in the hospital should then be first and foremost understood as a wish to feel safe. If she feels safe enough, she might be able to

change her wish to be hospitalized into a wish to be more independent (never totally independent, probably). The staff's policy should then very well be to try and stimulate her to get out of the hospital. But this will take much time and efforts. By staff interventions, her life-history might in the end be changed, so that she no longer needs the hospital to feel safe. But this can only be realized if her present anxieties are taken seriously, and her need for safety is being adequately met.

CONCLUSION

As the commentaries from a hermeneutic perspective of both cases show, hermeneutic ethics raises theoretical considerations which may be helpful to develop a concept of competence which is suitable in medical practice, since it focuses on practical experience and practical reasoning. It also entails methodological considerations, which may help to interpret case histories in such a way that the experiences of all parties involved are made explicit and subject of dialogue. From a hermeneutic point of view, assessing a patient's capacity implies focusing on the patient's way of meaning making and regarding her behavior from the perspective of practical rationality. The focus should not be on the assessment as a matter of fact, but on improving capacity. This requires allowing the patient to experience the world meaningfully and affording her, in the context of a supportive and trustful institutional environment, the possibility of developing a personal narrative where her choices are expressed verbally or non-verbally. The expressed choices are then choices that can help to further capacity: the patient can genuinely identify with them; they acknowledge her own sense of self in the course of a myriad of interactions. In this context, a caring narrative may unfold, creating a different commitment to enhance the patient's values and identifications. To this aim, her vulnerabilities should not be dealt with as a problem reactively but as an integral and essential aspect of the capacity assessment. This may be a valuable and responsible answer to her suffering and help to further develop a practice of care.

REFERENCES

Agich, G.J. (1993) *Autonomy and Long-term Care*. Oxford: Oxford University Press.

Benaroyo, L. (2000) The Contribution of Philosophical Hermeneutics to Clinical Ethics. In D.C. Thomasma and J.L. Kissell (Eds.), *The Health Care Professional as Friend and Healer. Building on the Work of Edmund D. Pellegrino* (pp. 227–232). Washington, DC: Georgetown University Press.

Brody, H. (1992) Assisted Death—A Compassionate Response to a Medical Failure. *The New England Journal of Medicine* **327**, 1384–1388.

Caplan, A.L. (1983) Can Applied Ethics be Effective in Health Care and Should it Strive to be? *Ethics* **93**, 311–319.

Cases (2004) *Health Care Analysis* **12**, 265–266.

Gadamer, H.G. (1990) What is Practice? The Conditions of Social Reason. In *Reason in the Age of Science* (pp. 69–87). Cambridge, MA: The MIT Press.

Leder, D. (1994) Toward a Hermeneutical Bioethics. In E.R., Dubose, R.P. Hamel, and L.J. O'Connell (Eds.), *A Matter of Principles. Ferment in U.S. Bioethics* (pp. 241–259). Valley Forge: Trinity Press International.

Mattingly, C. (1994) The Concept of Therapeutic "Emplotment." *Social Science and Medicine* **6**, 811–822.

Moody, H.R. (1992) *Ethics in an Aging Society*. Baltimore: The Johns Hopkins University Press.

Pellegrino, E.D., and Thomasma, D.C. (1981) *A Philosophical Basis of Medical Practice. Toward a Philosophy and Ethic of the Healing Professions*. New York/Oxford: Oxford University Press.

Pellegrino, E.D. (1982) Being Ill and Being Healed. Some Reflections on the Grounding of Medical Morality. In V. Kestenbaum (Ed.), *The Humanity of the Ill* (pp. 157–165). Knoxville: The University of Tennessee Press.

Pellegrino, E.D., and Thomasma, D.C. (1988) *For the Patient's Good. The Restoration of Beneficence in Health Care*. New York/Oxford: Oxford University Press.

Pellegrino, E.D., and Thomasma, D.C. (1993) *The Virtues in Medical Practice*. New York/Oxford: Oxford University Press.

Poirier, S., and Brauner, D.J. (1988) Ethics and the Daily Language of Medical Discourse. *Hastings Center Report* **18**, 5–9.

Steinkamp, N.L. (2003) European Debates on Ethical Case Deliberation. *Medicine, Health Care and Philosophy* **6**, 225–226.

Steinkamp, N.L., and Gordijn, B. (2003) Ethical Case Deliberation on the Ward. A Comparison of Four Methods. *Medicine, Health Care and Philosophy* **6**, 235–246.

Tan, J. (2003) The Anorexia Talking. *The Lancet* **362**, 1246–1248.

Ten Have, H., and Gordijn, B. (2001) Theoretical Models and Approaches to Ethics. In: *Bioethics in a European Perspective* (pp. 51–82). Dordrecht: Kluwer Academic Publishers.

Tronto, J.C. (1993) *Moral Boudaries. A Political Argument for an Ethics of Care*. New York and London: Routledge (reprinted 1994).

Widdershoven, G.A.M. (1999) Care, Cure and Interpersonal Understanding. *Journal of Advanced Nursing* **29**, 1163–1169.